STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056338	A. Building B. Wing	09/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Morning Star Post Acute	111 Barstow Ave. Clovis, CA 93612

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to recognize and appropriately act on the clinical change in condition for one of three residents, (Resident 1), when: Nursing staff did not notify the physician on 9/12/25 for abnormal blood lab results. Nursing staff did not notify the physician on 9/13/25 for Resident 1's low blood pressure of 91/55 millimeters of mercury (mmHg- unit of measurement), (normal BP 120/80), elevated heart rate (HR) 116 beats per minute (bpm), (normal range 60-100 bpm). Nursing staff did not recognize and act on the clinical decline of Resident 1 on 9/14/25 when Resident 1 had altered mental status, was weaker than normal, had declined in communication, exhibited shortness of breath and distress, with a BP 86/64 mmHg, HR 118 bpm, temperature 99.2 Fahrenheit (F-unit of measurement) and Oxygen saturation (amount of oxygen in the blood) 75% (normal range 95%-100%). These failures resulted in the grandson (GS) of Resident 1 bringing a change in Resident 1's condition to the attention of the nursing staff. This led to avoidable emergency transport to the local acute care hospital (ACH) emergency department and an admission from September 14 through October 3, 2025. During the hospitalization, Resident 1 was diagnosed with potentially avoidable sepsis (a life-threatening condition that occurs when the body's immune system overreacts to an infection) and acute kidney injury (AKI- when the kidneys suddenly are not able to filter waste products from the blood), which required admission to the intensive care unit (ICU-refers to specialized hospital unit that provides close monitoring and critical care to patients with life-threatening conditions). During a review of Resident 1's admission Record (a summary of important information regarding a patient, which include patient identification, past medical history, insurance status, care provider, family contact information and other pertinent information), the admission Record indicated, Resident 1 was admitted to the facility on [DATE] with diagnoses including hemiplegia (total paralysis of the arm, leg and trunk on the same side of the body), hemiparesis (weakness on one side of the body), cerebral infarction (stroke-when part of the brain was damaged, because it did not get enough blood and oxygen), dysphagia (when a person had trouble using language because of brain damage, often from a stroke) and diabetes mellitus (a disease where the body had trouble controlling the amount of sugar (glucose) in the blood. During a review of Resident 1's Minimum Data Set (MDS-resident assessment tool which indicates physical and cognitive abilities), the MDS indicated a Brief Interview for Mental Status (BIMS-an assessment of cognitive function) score of 11 (0-7 severe cognitive impairment, 8-12 moderate cognitive impairment, 13-15 no cognitive impairment) indicating Resident 1 had moderate cognitive impairment.During an interview on 9/16/25 at 10:04 a.m., with Adult Protective Services Representative (APS- a public social program services that receives and investigates reports of abuse, neglect, in vulnerable adults), the APS Representative stated she received a call from Resident 1's grandson (GS) on 9/15/25. The APS Representative stated GS reported on 9/14/25, GS visited the facility and found Resident 1 warm to touch, and unresponsive. GS requested staff to check Resident 1's temperature which was recorded at 99 F (Fahrenheit-a temperature [normal range 97.7-98F] scale). The APS Representative stated the staff told GS since the temperature was only 99 F, there was no need to call 911. During an interview on 9/16/25 at 12:54 p.m., with the GS, the GS stated Resident 1 was admitted in the facility for acute rehabilitation (an intensive, goal-oriented therapy that begins soon after a severe injury or illness to help patients regain function and independence) after hospitalization for a stroke (occurs when blood flow to the brain is interrupted). The GS stated, on 9/14/25, between 3 and 4 p.m., he arrived at the facility and observed Resident 1 sitting up in bed with her head tilted back in an uncomfortable position, unresponsive, unable to speak, and felt hot to touch. The GS stated he requested assistance to check Resident 1's temperature. The GS stated the charge nurse took Resident 1's temperature, which was 99 F, but dismissed the findings, stating it was only 99. The GS stated he requested staff to call 911 three times while staff obtained Resident 1's oxygen saturation, which was 75%. The GS stated Resident 1 was transferred to an acute care hospital and later diagnosed with sepsis secondary to urinary tract infection (UTI- infection in the bladder). During an interview on 9/17/25 at 9:18 a.m. with the Director of Nursing (DON), the DON stated the GS of Resident 1 had visited the facility on 9/14/25. The DON reported GS was very upset and requested Resident 1 be sent to the hospital. The DON confirmed Resident 1 was sent to the hospital following his request. During a record review of Resident 1's Acute Care Hospital document titled ED [Emergency Department] Provider Notes (EPN) dated 9/14/25, the EPN indicated, Chief Compliant: Altered Mental Status (AMS hot and tachycardic [elevated HR]). [AGE] year old Spanish