

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055258	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/30/2024
NAME OF PROVIDER OR SUPPLIER Community Subacute and Transitional Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3003 N Mariposa Fresno, CA 93703	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40641</p> <p>Based on observation, interview and record review, the facility failed to ensure residents were treated with dignity and respect for three of 11 sampled residents (Resident 37, Resident 43, Resident 69) when:</p> <ol style="list-style-type: none"> Registered Nurse (RN) 1 administered medication to Resident 37's and did not provide privacy. <p>This failure resulted in Resident 37 not being provided with respect and dignity while taking her medication.</p> <ol style="list-style-type: none"> RN 1 checked Resident 69's blood pressure (B/P-measures the pressure of circulating blood against the walls of blood vessels [channels that carry blood throughout the body]) and did not provide privacy. <p>This failure resulted in Resident 69 not being provided with respect and dignity while her B/P was checked.</p> <ol style="list-style-type: none"> Resident 43's privacy curtain was tied in a knot. <p>This failure resulted in Resident 43 not being provided his right for a respectful and dignified existence and denied Resident 43 the right to have an environment that promotes maintenance or enhancement of his quality of life.</p> <p>Findings:</p> <ol style="list-style-type: none"> During an observation on 8/29/24 at 8:59 a.m. in Transitional Unit, RN 1 prepared Resident 37's medications, walked in Resident 37's room and administered her (Resident 37) medications and did not provide privacy. RN 1 did not close the privacy curtain or closed the door, staff and other residents walking by. <p>During a review of Resident 37's Admission Record, dated 8/30/24, the Admission Record indicated, Resident 37 was admitted to the facility with diagnoses which included heart failure, liver disease and hypertension (high blood pressure).</p> <p>(continued on next page)</p>

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: 055258	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/30/2024
NAME OF PROVIDER OR SUPPLIER Community Subacute and Transitional Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3003 N Mariposa Fresno, CA 93703	
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)		
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 37's Minimum Data Set (MDS- an assessment tool used to identify resident cognitive[pertaining to reasoning, memory and judgement] and physical functional level), assessment dated [DATE], indicated Resident 37's Brief Interview for Mental Status (BIMS-screening tool used in nursing home to assess cognition) assessment score was 13 out of 15 (0-15 scale [0-6 severe cognitive deficit, 7-12 moderate cognitive deficit, 13-15 no cognitive deficit]) indicating Resident 37 had no cognitive deficit.</p> <p>During an interview on 8/29/24 at 10:05 a.m. with RN 1, she stated she administered medications to Resident 37 in her room and did not close the privacy curtain or the door. RN 1 stated it was Resident 37's right to have privacy when she took her medications. RN 1 stated she should have closed the privacy curtain and or the door because staff, residents and visitors were walking by.</p> <p>During an interview on 8/29/24 at 11:30a.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated it was important to close the privacy curtain to provide privacy to residents when administering their medications because there are residents, staff and visitors walking by and could see what was going on inside resident's room.</p> <p>During an interview on 8/29/24 at 2:25 p.m. with LVN 1, she stated the practice was to always pull the privacy curtain when administering medications to residents in their room and never administer medication in the hallway. LVN 1 stated residents need to have their privacy respected including taking their medications.</p> <p>2. During an observation on 8/29/24 at 9:18 a.m. in Resident 69's room, Resident 69 was lying in bed dressed appropriately. RN 1 approached Resident 69's bedside and checked Resident 69's blood pressure without closing the privacy curtain or the door. Staff, residents, and visitors walked by.</p> <p>During a review of Resident 69's Admission Record, dated 8/30/24, the Admission Record indicated, Resident 69 was admitted to the facility with diagnoses which included hypertension, hyperlipidemia (high cholesterol) and pain.</p> <p>During a review of Resident 69's Minimum Data Set, assessment dated [DATE], indicated Resident 69's Brief Interview for Mental Status (BIMS-screening tool used in nursing home to assess cognition) assessment score was 9 out of 15 (0-15 scale [0-6 severe cognitive deficit, 7-12 moderate cognitive deficit, 13-15 no cognitive deficit]) indicating Resident 69 had moderate cognitive deficit.</p> <p>During an interview on 8/29/24 at 10:10 a.m. with RN 1, RN 1 stated she checked Resident 69's blood pressure in her room and did not close the privacy curtain or the door. RN 1 stated Resident 69's bed was closest to the door and anyone walking by could see what was going on inside the room. RN 1 stated it was important to respect resident their rights to their privacy, RN 1 stated she did not realize she did not close the privacy curtain or the door.</p> <p>During an interview on 8/29/24 at 11:35 a.m. with LVN 2, she stated residents have rights to their privacy and that includes checking their blood pressure or administering medications. LVN 2 stated the facility practice was to ensure resident rights are respected.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055258	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/30/2024
NAME OF PROVIDER OR SUPPLIER Community Subacute and Transitional Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3003 N Mariposa Fresno, CA 93703	
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)		
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 8/30/24 at 10:22 a.m. with the Director of Nursing (DON), The DON stated she did not see an issue of privacy when the nurse administered oral medications to Resident 37 and checked Resident 69's blood pressure and did not close privacy curtain. The DON stated she would be more worried if the nurse administered medication through a tube feeding and or checking the blood sugar because resident would have been exposed. DON stated residents have rights and facility staff must give their rights to their privacy.</p> <p>During a review of facility's policy and procedure (P&P) titled, Resident Rights, dated 3/20/24, the P&P indicated, . right to a dignified existence . be free of interference, coercion . right to be fully informed . right to personal privacy and confidentiality .</p> <p>During a review of facility's P&P titled, Medication Administration General Guidelines, dated 1/23, the P&P indicated, . Medications are administered in accordance with written orders . Provide for privacy .</p> <p>48424</p> <p>3. During an observation on 8/26/24 at 3:29 p.m. in Resident 43's room, Resident 43's privacy curtain was tied in a knot, hanging near the door and out of reach.</p> <p>During an observation on 8/29/24 at 10:08 a.m. in Resident 43's room, Resident 43's privacy curtain was tied in a knot hanging on the left side of the Resident's bed.</p> <p>During a concurrent observation and interview on 8/29/24 at 11:36 a.m. with certified nursing assistant (CNA) 6 outside of Resident 43's room, Resident 43's privacy curtain was tied in a knot. CNA 6 stated Resident 43's curtain should not have been tied in a knot. CNA 6 stated having the curtain tied in a knot did not provide Resident 43 privacy or dignity. CNA 6 stated Resident 43 had the right to have his curtain in its intended condition and appearance.</p> <p>During an interview on 8/29/24 at 1:53 p.m. with licensed vocational nurse (LVN) 4, LVN 4 stated Resident 43's curtain was not supposed to be tied up in a knot. LVN 4 stated having the curtain tied up in a knot did not provide Resident 43 with privacy and dignity. LVN 4 stated every other resident in the facility has their curtains in a normal condition and Resident 43 had the right to have his curtains in the same condition as everybody else.</p> <p>During an interview on 8/29/24 at 2:45 p.m. with the environmental services manager (EVSM), the EVSM stated housekeeping staff would not tie curtains in a knot if they needed to clean the room. The EVSM stated all resident curtains should have been hanging freely towards the ground and not tied in a knot.</p> <p>During an interview on 8/29/24 at 3:11 p.m. with Director of Staff Development (DSD), the DSD stated, nursing staff should have untied the curtain if they saw it tied in a knot. The DSD stated having a proper hanging curtain was important to be able to provide privacy.</p> <p>During an interview on 8/30/24 at 8:41 a.m. with CNA 5, CNA 5 stated he was unsure why a</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055258	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/30/2024
NAME OF PROVIDER OR SUPPLIER Community Subacute and Transitional Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3003 N Mariposa Fresno, CA 93703	
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)		
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>curtain would be tied in a knot and no one else's curtain was like this. CNA 5 stated it was important to not have resident curtains tied in a knot because it helped provide privacy when used properly.</p> <p>During an interview on 8/30/24 at 9:43 a.m. with Licensed Vocational Nurse (LVN) 5, LVN 5 stated she did not know who would tied Resident's 43's curtain in a knot. LVN 5 stated she doubted the resident would be able to do it himself because he does not have control of his lower extremities. LVN 5 stated it was important to have the curtain untied and hanging down so it was easy to access in order to provide privacy.</p> <p>During an interview on 8/30/24 at 10:53 a.m. with the Director of Nursing (DON), when asked if it is acceptable to have curtain tied in a knot and hanging out of reach of the Resident, the DON stated Resident 43 could have done it himself and he can do more than we think. When asked if the DON's expectation was for curtains to be tied in a knot for any resident, DON stated Resident 43 probably did it himself.</p> <p>During an interview on 8/30/24 at 1:43 p.m. with Administrator (ADM), the ADM stated she expected staff to untie curtains if they saw them tied in a knot.</p> <p>During a review of the facility's Policy and Procedure (P&P) titled, Philosophy, dated 7/02/2024, the P&P indicated, It is the philosophy of CSTCC to provide resident care based on each resident's physical, psychosocial and clinical needs; focusing on each resident's overall well-being . 1. The facility will show respect for each resident's individuality, offering choices . 3. The facility will provide privacy and dignity when care is delivered.</p> <p>51134</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055258	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/30/2024
NAME OF PROVIDER OR SUPPLIER Community Subacute and Transitional Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3003 N Mariposa Fresno, CA 93703	
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)		
<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40641</p> <p>Based on interview and record review, the facility failed to ensure the Minimum Data Set assessment (MDS-assessment of physical and psychological functions and needs) accurately reflected resident's health and functional status for one of three sampled residents (Resident 6) when Resident 6's antipsychotic medication (used to treat severe mental disorder in which a person loses the ability to recognize reality or relate to others) use was inaccurately coded in the MDS assessment.</p> <p>This failure had the potential to result in Resident 6's care needs not met.</p> <p>Findings:</p> <p>During a review of Resident 6's Admission Record (document with resident demographic and medical diagnosis information), dated 8/29/24, indicated Resident 6 was admitted in the facility on 8/30/23 with diagnoses which included unspecified psychosis (mental health problem that causes people to perceive or interpret things differently from those around them) and end stage renal disease (terminal illness that occurs when kidneys can no longer function on their own).</p> <p>During a review of Resident 6's Minimum Data Set, assessment dated [DATE], indicated Resident 6's Brief Interview for Mental Status (BIMS-screening tool used in nursing home to assess cognition) assessment score was 14 out of 15 (0-15 scale [0-6 severe cognitive deficit, 7-12 moderate cognitive deficit, 13-15 no cognitive deficit]) indicating Resident 6 had no cognitive deficit.</p> <p>During a review of Resident 6's Order Summary, dated 8/29/24, the Order Summary Report indicated, . OLANZAPINE 10 MG [milligram-unit of measurement] TABLET. Give 1 (one) tablet by mouth at bedtime for UNSPECIFIED PSYCHOSIS .</p> <p>During a concurrent interview and record review on 8/29/24 at 3:39 p.m. Resident 6 annual MDS assessment dated [DATE], section N was reviewed by the Minimum Data Set Coordinator (MDSC). The MDSC stated Resident 6 received antipsychotic medication. MDSC stated Resident 6 use of antipsychotic medication was not coded on the annual MDS assessment. MDSC stated Resident 6 should have been coded as receiving antipsychotic medication.</p> <p>During an interview on 8/30/24 at 10:45 a.m. with the Director of Nursing (DON),</p> <p>the DON stated her expectation was for MDS assessments to be accurate. DON stated MDS nurses are responsible in making sure their assessments are accurate.</p> <p>During an interview on 8/30/24 at 2:20 p.m. with the administrator (ADM), the</p> <p>ADM stated her expectation was accurate documentation from MDS. ADM stated MDS nurse needed to accurately assess residents use of psychotropic medications.</p> <p>During a review of the facility document titled, RN MDS Coord-CSTCC Job Description, reviewed date 10/31/23, the Job Description indicated, . Responsible for accurate and timely completion and transmission of Minimum Data Set (MDS) assessment of all residents in the facility .</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055258	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/30/2024
NAME OF PROVIDER OR SUPPLIER Community Subacute and Transitional Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3003 N Mariposa Fresno, CA 93703	

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)
<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's policy and procedure (P&P) titled, Minimum Data Set (MDS) Assessment and Care Planning, dated 4/9/24, the P&P indicated, . The facility will complete resident assessments based on the most current Resident Assessment Instrument (RAI) guidelines .</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055258	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/30/2024
NAME OF PROVIDER OR SUPPLIER Community Subacute and Transitional Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3003 N Mariposa Fresno, CA 93703	
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)		
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40641</p> <p>Based on observation, interview and record review the facility failed to ensure drugs and biologicals were labeled in accordance with current accepted professional principles and facility policy and procedures for one of two medication carts in Transitional Unit when medication cart contained Resident 53's (Fluticasone Propionate brand name- used to relieve allergic and non-allergic nasal symptoms) 50 mcg (microgram-unit of measurement) was found to not have an open date and beyond use date (BUD-the last date you can safely use a medication).</p> <p>This failure had the potential for Resident 53's medication to be administered past the discard date which could result in loss of effectiveness of medication leading to poor management of Resident 53's condition.</p> <p>Findings:</p> <p>During a concurrent observation and interview on [DATE] at 2:06 p.m. at the medication cart in Transitional Unit with Licensed Vocational Nurse (LVN) 1, Resident 53's (Fluticasone propionate brand name) was found with no open date and BUD. LVN 1 stated there was no open date and BUD because the facility followed the expiration date provided by pharmacy.</p> <p>During a review of Resident 53's Admission Record, dated [DATE], the Admission Record indicated, Resident 53 was admitted to the facility with diagnoses which included paraplegia (loss of muscle function in the lower half of the body, including both legs) and Chronic Obstructive Pulmonary Disease (COPD-lung disease causing restricted airflow and breathing problems).</p> <p>During an interview on [DATE] at 2:18 p.m. with LVN 1, LVN 1 stated, . They told me the policy was to label medication [Fluticasone-brand name] with the date it was opened as soon as the box was opened . LVN 1 stated open date should have been placed on the box when it was first opened and the used by date.</p> <p>During a concurrent interview and record review on [DATE] at 10:37 a.m. with the Director of Nursing (DON) the DON stated pharmacy labels the medication (Flonase-brand name). The DON stated the medication was given to Resident 53 daily so it will run out before the expiration date of ,d+[DATE]. The DON reviewed facility policy and procedure titled Medication Administration Medication Guidelines and stated the facility will follow their policy and procedure and pharmacy recommendation.</p> <p>During a review of facility's policy and procedure (P&P) titled, Medications and Medication Labels, dated , d+[DATE], the P&P indicated, . Multi-dose vials should be labeled to assure product integrity . Nursing staff should document the date opened on multi-dose vials .</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055258	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/30/2024
NAME OF PROVIDER OR SUPPLIER Community Subacute and Transitional Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3003 N Mariposa Fresno, CA 93703	

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)
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of facility;s policy and procedure (P&P) titled, Medication Administration General Guidelines dated ,d+[DATE], the P&P indicated, . No expired medication will be administered to a resident . The nurse shall place a 'date opened' sticker on the medication . and enter the date opened . multi-dose vials and ophthalmic drops have shortened end-of-use dating, once opened, to ensure medication purity and potency .</p> <p>During a review of Lexicomp, a nationally recognized drug reference, the manufacturer for (Fluticasone propionate/ Salmeterol brand name) indicated, After removing from box and foil pouch, write the Pouch opened and Use by dates on the label on top of the device. The Use by date is 1 (one) month from date of opening the pouch.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055258	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/30/2024
NAME OF PROVIDER OR SUPPLIER Community Subacute and Transitional Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3003 N Mariposa Fresno, CA 93703	
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)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41608</p> <p>Based on observation, interview, and record review, the facility failed to store, prepare, and serve food in accordance with professional standards for food service safety when:</p> <ol style="list-style-type: none"> 1. The cook failed to follow the diet order for three of three residents (Residents 56, 69, and 88). 2. The facility failed to have an air gap (an unobstructed vertical space between the water outlet and the flood level of a fixture), under the food preparation sink. <p>These failures had the potential to result in residents being exposed to contaminated food which could lead to food born illness for all residents who receive food prepared in the kitchen and had the potential for Resident 56, Resident 69 and Resident 88 to have weight gain or loss by diet orders not being followed.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During a concurrent observation and interview on 8/27/24 at 12:20 p.m. with the Dietary Manager (DM), in the facility's kitchen, the [NAME] (DA), did not follow the recipe for three residents with small portion diet orders during the lunch service tray line. The DA used the gray 1/2 cup serving scoop and not the blue 1/4 cup serving scoop as indicated on the resident diet orders. The DM stated, the gray scoop was to be used for regular portions and the blue scoop was to be used for small portions. The DM stated, the DA should have switched scoops for the residents on with small portion diet orders. Not using the correct portions could lead to residents gaining undesired weight. <p>During an interview on 8/27/24 at 2:15 p.m. with the Dietary Director (DD), the DD stated the expectation of the cook is to follow the diet orders exactly as ordered. The DA should have switched to the blue scoop for the small portion diets.</p> <p>During an interview on 8/30/24 at 2:50 p.m. with the Administrator (ADM), the ADM stated, the expectation for the DA is to follow diet orders as written.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Meal Service dated 11/28/22, indicated, . Patient service parameters encourage accuracy of meal service within identified guidelines .</p> <p>During a review of the facility's P&P titled, [NAME] Job Description (undated), indicated, . follows standard recipes .</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055258	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/30/2024
NAME OF PROVIDER OR SUPPLIER Community Subacute and Transitional Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3003 N Mariposa Fresno, CA 93703	
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)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During a review of Residents 56's Minimum Data Set (MDS- a resident assessment tool used to identify resident cognitive and physical function) Section C assessment dated [DATE], indicated Resident 8's Brief Interview of Mental status assessment (BIMS - assessment of cognitive status for memory and judgement) scored 14 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, 00-07 indicates severe impairment and 99 indicates they are unable to complete the interview). The BIMS assessment indicated Resident 56 had no cognitive impairment.</p> <p>During a review of Resident 56's Admission Record (AR), dated 8/29/24, the AR indicated, Resident 56 was admitted on [DATE] with diagnosis of Cardiomegaly (enlarged heart), Systematic Inflammatory Response Syndrome (SIRS - an exaggerated defense response of the body to a noxious stressor (infection, trauma, surgery, lack of oxygen, or cancer), and Hyperglycemia (high blood sugar).</p> <p>During a review of Resident 56's Physician Order (PO), dated 8/12/24, the PO indicated . ease of chewing and promoting weight loss . small portion starch .</p> <p>During a review of Resident 69's AR dated 8/29/24, the AR indicated, Resident 69 was admitted on [DATE] with diagnosis of Aortic Aneurysm (a bulge or weakening in the aorta, the main artery that carries oxygenated blood from the heart to the body), Pain, and Hyperlipidemia (high levels of fat in the blood).</p> <p>During a review of Resident 69's MDS Section C dated 4/30/24, indicated Resident 69's BIMS score was 09. The BIMS assessment indicated severe cognitive impairment.</p> <p>During a review of Resident 69's PO, dated 5/8/24, the PO indicated . small portion starch .</p> <p>During a review of Resident 88's AR dated 8/29/24, the AR indicated, Resident 89 was admitted on [DATE] with diagnosis of Hypertension (high blood pressure), and Cerebrovascular Accident (CVA - a medical emergency that occurs when the blood flow to the brain is stopped).</p> <p>During a review of Resident 88's MDS Section C dated 6/28/24, indicated Resident 88's BIMS score was 15. The BIMS assessment indicated no cognitive impairment.</p> <p>2. During an observation on 8/27/24 at 2:30 p.m. in the facility's kitchen, the food preparation sink was observed not having an air gap under the sink.</p> <p>During a concurrent observation and interview on 8/29/24 at 2:50 p.m. with the Building Maintenance Supervisor (BMS), in the facility's kitchen, the BMS stated the facility should have an air gap under the food preparation sink to prevent sewage back up into the sink and exposing food to contaminated water.</p> <p>During an interview on 8/30/24 at 10:10 a.m. with the ADM, the ADM stated the food prep sink should have had an air gap to prevent backup of sewer into food being prepared for residents.</p> <p>During a review of the FDA Food Code Section 5-402.11 Backflow Prevention dated 2022, the FDA Food Code indicated, . 5-402.11 Backflow Prevention. (A) Except as specified in (B), (C), and (D) of this section, a direct connection may not exist between the SEWAGE system and a drain originating from EQUIPMENT in which FOOD, portable EQUIPMENT, or UTENSILS are placed .</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055258	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/30/2024
NAME OF PROVIDER OR SUPPLIER Community Subacute and Transitional Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3003 N Mariposa Fresno, CA 93703	

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)
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During a review of the Food and Drug Administration (FDA), Food Code Section 5-203.14 Backflow Prevention Device dated 2022, the FDA Food Code indicated, . A PLUMBING SYSTEM shall be installed to preclude backflow of a solid, liquid, or gas contaminant into the water supply system at each point of use at the FOOD ESTABLISHMENT, .backflow prevention is required by LAW, by: (A) Providing an air gap .</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055258	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/30/2024
NAME OF PROVIDER OR SUPPLIER Community Subacute and Transitional Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3003 N Mariposa Fresno, CA 93703	
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)		
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40641</p> <p>Based on observation, interview, and record review the facility failed to maintain medical records which were complete, and accurately documented in accordance with accepted professional standards and practices for three of seven sampled residents (Resident 6, Resident 55 and Resident 41) when Resident 6, Resident 41 and Resident 55's copy of Physician Orders for Life-Sustaining Treatment (POLST-a medical document which outlines a patient's preferences for end-of-life care) were incomplete and not readily available as part of Resident 6 and 55's current medical records.</p> <p>These failures had the potential risk for Resident 6, Resident 41 and 55's decision regarding their healthcare treatment options not being honored.</p> <p>Findings:</p> <p>During a review of Resident 6's Admission Record, (AR-document containing resident profiles) dated 8/29/24, the AR indicated, Resident 6 was admitted to the facility on [DATE] with diagnoses which included end stage renal disease (occurs when the kidneys are no longer able to function properly and filter waste from the blood) and heart failure.</p> <p>During a review of Resident 55's Admission Record, dated 8/29/24, the AR indicated, Resident 55 was readmitted to the facility on [DATE] with diagnoses which included Transient Ischemic Attack (TIA-occurs when there's a brief interruption in blood supply to the brain) and schizophrenia (chronic mental illness that affects a person's thoughts, feelings, and behaviors).</p> <p>During a concurrent interview and record review on 8/27/24 at 11:42 a.m. with Director of Staff Development (DS) Resident 41's Physician Orders for Life Sustaining Treatment (POLST [form is a written medical order from a physician, nurse practitioner or physician assistant that helps give people with serious illnesses more control over their own care by specifying the types of medical treatment they want to receive during serious illness]) was reviewed. The POLST did not have the preparation date filled out on the form. DSD validated the date of preparation of the POLST form was missing. DSD stated the POLST must be totally filled out to be considered complete and accurate.</p> <p>During a concurrent interview and record review on 8/28/24 at 8:47 a.m. with Licensed Vocational Nurse (LVN 1), Resident 41's POLST form was reviewed. LVN 1 stated, the POLST form should have been filled out to ensure accuracy.</p> <p>During a concurrent interview and record review on 8/29/24 at 10:17 a.m. with Registered Nurse (RN) 1, Resident 6 and Resident 55's POLST form was reviewed, RN 1 stated the POLST forms of Resident 6 and Resident 55 was incomplete. RN 1 stated Resident 6 and Resident 55's POLST forms did not have dates when forms were prepared and completed. RN 1 stated POLST forms have to be completed, each column filled, signed and dated.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055258	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/30/2024
NAME OF PROVIDER OR SUPPLIER Community Subacute and Transitional Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3003 N Mariposa Fresno, CA 93703	
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)		
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and record review on 8/29/24 at 11:25 a.m. with LVN 2, LVN 2 stated POLST forms are completed on admission by the admission nurse. Resident 6 and Resident 55's POLST forms was reviewed. LVN 2 stated Resident 6 and Resident 55's POLST forms are incomplete, because there was no date when the POLST forms were prepared and there should have been.</p> <p>During a concurrent interview and record review on 8/30/24 at 10:50 a.m. with the Director of Nursing (DON), the DON reviewed Resident 6 and Resident 55's POLST forms and stated there was no date when POLST forms were prepared. DON stated Resident 6 and Resident 55's POLST forms are incomplete because it was missing the date when the forms were completed.</p> <p>During an interview and record review on 8/29/24 at 2:10 p.m. with the Director of Nursing (DON), Resident 41's POLST was reviewed. The DON stated, the POLST form needs to be filled out because it's part of the form. The DON stated, a complete form should have all areas that need to be filled out be completed. The DON stated, an incomplete form could have created uncertainty about the accuracy or validity of the from.</p> <p>During a review of facility's policy and procedure (P&P) titled, Physician Orders for Life-Sustaining Treatment (POST), dated 2/5/24, the P&P indicated, .Completion of a POLST form should reflect a process of careful decision making by the resident . Once the POLST form is completed, it must be signed by the resident, or . resident's legally recognized healthcare decision maker, and the attending physician . The POLST will be reviewed by the facility interdisciplinary team during the quarterly care planning conference .</p> <p>During a review of the professional standards by the Centers for Medicare and Medicaid Services (CMS) titled, Standing Orders, dated, October 2008, the CMS Professional Standard indicated, .orders should be reviewed .all orders must be dated and authenticated promptly .All patient medical record entries must be . complete, dated .and authenticated in written or electronic form by the person responsible for providing or evaluating the services provided.</p> <p>48430</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055258	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/30/2024
NAME OF PROVIDER OR SUPPLIER Community Subacute and Transitional Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3003 N Mariposa Fresno, CA 93703	
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)		
<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48424</p> <p>Based on observation, interview and record review the facility failed provide one of 11 residents an accessible call system when Resident 43's call light (a device that is used by a resident to call staff for assistance) was out of reach and wrapped around the television arm behind the resident's bed.</p> <p>This failure resulted in Resident 43 being unable to call for assistance and had the potential to delay care during an emergency and cause adverse outcomes.</p> <p>Findings;</p> <p>During a review of Resident 43's Admission Record (AR), dated 8/29/24, the AR indicated Resident 43 had been admitted on [DATE]. Resident 43's admitting diagnoses included: nontraumatic subarachnoid hemorrhage (bleeding in the space between the brain and the surrounding membrane), chronic obstructive pulmonary disease (COPD- lung disease that causes restricted airflow and makes it difficult to breathe) with acute exacerbation (a sudden worsening of respiratory symptoms), epilepsy (a chronic brain disorder that causes seizures, which are episodes of abnormal electrical activity in the brain), and schizophrenia (mental health condition that affects how people think, feel, and behave).</p> <p>During an observation on 8/26/24 at 3:25 p.m. in Resident 43's room, Resident 43's call light was out of reach and wrapped around the television arm behind the resident's bed.</p> <p>During an observation on 8/27/24 at 2:00 p.m. in resident 43's room, Resident 43's call light was was out of reach and wrapped around the television arm behind the resident's bed.</p> <p>During an interview on 8/28/24 at 9:27 a.m. with Licensed Vocational Nurse (LVN) 4, LVN 4 stated the resident had the ability to call for help. LVN 4 stated sometimes Resident 43 would yell out for help when someone walks by the room. LVN 4 stated Resident 43 would use his call light in the past.</p> <p>During an interview on 8/28/24 at 2:34 p.m. with Certified Nursing Assistant (CNA) 5, CNA5 stated all residents should have had their call light next to them so they could use it if needed. CNA 5 stated there was no instance where it would not be placed by a resident, it must always be within reach.</p> <p>During a concurrent observation and interview on 8/29/24 at 11:34 a.m. with CNA 6 outside of Resident 43's room, Resident 43's call light wire was laying on right side of the bed with call button on the floor. CNA 6 stated, [Resident 43] is very cooperative and aware . I reinforce call light education every time I am in the room.</p> <p>During interview on 8/29/24 at 1:54 p.m. with LVN 4, LVN 4 stated, It is important for [residents] to have a call light to tell us their needs even if unable to use one . No matter what their function is, it's important to have one. LVN 4 stated she was unsure why Resident 43's call light was wrapped around the base of the TV arm connected to the wall behind Resident 43. LVN 4 stated Resident 43 should have had his call light placed next to him.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055258	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/30/2024
NAME OF PROVIDER OR SUPPLIER Community Subacute and Transitional Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3003 N Mariposa Fresno, CA 93703	
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)		
<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During interview on 8/30/24 at 9:43 a.m. with LVN 5, LVN 5 stated it is important for residents to have call light next to them. LVN 5 stated having a call light was important for safety and in case he needed help. LVN 5 stated every resident needs a call light because it was their right to have one even if they could not use it.</p> <p>During an interview on 8/30/24 at 10:53 a.m. with Director of Nursing (DON), when shown a photo of Resident 43's call light on the television arm connected to the wall behind the Resident's bed, DON stated I did not observe this. When asked if it were an acceptable practice to have call light away from patient, DON stated I did not observe this. DON stated, residents do have call light by them. Call lights should be placed next to residents. Important so call light is accessible. When asked if it were okay for Resident 43 to not have call light near them, DON stated she already answered the question.</p> <p>During an interview on 8/30/24 at 1:42 p.m. with Administrator (ADM), shown a photo of Resident 43's call light on television arm connected to the wall behind the Resident's bed. When asked if this is acceptable, ADM stated, resident will tell you if he needs help and will act based on his behavior. He's not a normal patient. When informed call light was like this all day on Monday and Tuesday, ADM stated Resident 43 may have placed it their himself. ADM stated, usually would like to have call light as close to resident as possible.</p> <p>During a review of the facility's Policy and Procedure (P&P) titled, Call System, Residents, dated 9/2022, the P&P indicated, 1. Each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor . 4. If the resident has a disability that prevents him/her from making use of the call system, an alternative means of communication that is usable for the resident is provided and documented in the care plan.</p>		