

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 12/19/2025
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)		
F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, interview and record review, the facility failed to ensure daily nurse staffing information contained all required information and was posted in a prominent readily accessible place to residents and visitors when:1. Daily nurse staffing information was posted behind nursing station 1 and nursing station 2, which was inaccessible to residents and visitors.2. Daily nurse staffing information did not include the actual hours worked by Registered Nurse (RN)s, Licensed Vocational Nurse (LVN)s, and Certified Nursing Assistant (CNA)s.This failure resulted in restricted public access to posted nurse staffing information for 99 out of 99 residents admitted within the facility which had the potential to result in residents not knowing how many total or actual direct care hours were provided.During an observation on 12/19/25 at 11:26 a.m. at nursing station 1, Transitional Care, the facility's posted daily nurse staffing information titled, Report of Nursing Staff Directly Responsible for Resident Care, dated 12/19/25, was observed behind nursing station 1. The document did not include posted actual hours worked by RNs, LVNs, or CNAs. The document stated, .Daily posting of this information is required for nursing homes participating in Medicare and Medicaid. Pursuant to Section 941 of the Medicare, Medicaid & SCHIP Benefits Improvement. Pursuant to Section 941 of the Medicare, Medicaid & SCIP Benefits Improvements and Protection Act of 2000 (BIPA). During an observation on 12/19/25 at 11:28 a.m. at nursing station 2, Sub-Acute Care, the facility's posted daily nurse staffing information titled, Report of Nursing Staff Directly Responsible for Resident Care, dated 12/19/25, was observed behind nursing station 2. The document did not include posted actual hours worked by RNs, LVNs, or CNAs. The document stated, .Daily posting of this information is required for nursing homes participating in Medicare and Medicaid. Pursuant to Section 941 of the Medicare, Medicaid & SCHIP Benefits Improvement. Pursuant to Section 941 of the Medicare, Medicaid & SCIP Benefits Improvements and Protection Act of 2000 (BIPA).During a concurrent interview and record review on 12/19/25 at 2:06 p.m. with the Director of Staff Development (DSD), the facility's posted daily nurse staffing information titled, Report of Nursing Staff Directly Responsible for Resident Care, dated 12/19/25 was reviewed. The DSD stated daily nurse staffing information was posted behind nursing station 1 and nursing station 2. The DSD stated actual hours worked by RNs, LVNs, and CNAs were not included in the posted daily nurse staffing information. The DSD stated only facility staff had access to nursing station 1 and nursing station 2. The DSD stated residents and visitors were not allowed behind the nursing stations. The DSD stated total, or anticipated, nurse staffing information was not posted in a prominent readily accessible place to residents and visitors. The DSD stated actual daily nurse staffing information was not posted in the facility for staff, residents and visitors to view. The DSD stated staff, residents and visitors had a right to know how many total and actual hours of licensed and unlicensed nursing care hours were provided daily to ensure adequate care was scheduled and provided. During a concurrent observation and record review on 12/19/25 at 2:50 p.m. with Administrative Assistant (ADA) 1, posted daily nurse staffing information was observed behind nursing station 1 and nursing station 2. ADA 1 stated night shift licensed nursing staff posted total, or anticipated, daily nurse staffing information behind the nursing stations. ADA 1 stated posted total daily nurse staffing information was not in a prominent readily accessible place to residents and visitors. ADA 1 stated she calculated actual daily nurse staffing information each morning for the (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
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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	previous day. ADA 1 stated actual hours worked by RNs, LVNs, and CNAs were completed the following day to ensure accuracy of all hours worked by licensed and unlicensed nursing staff. ADA 1 stated actual hours worked by RNs, LVNs, and CNAs could be different than total, or anticipated, hours worked if there were call outs, no shows, or assignment changes. ADA 1 stated total, or anticipated, daily nurse staffing information were important to post in a prominent readily accessible place so residents and visitors could ensure the facility scheduled required staff to meet their needs. ADA 1 stated it was important to post actual daily nurse staffing information so residents and visitors could ensure enough care was provided to meet their needs. During an interview on 12/29/25 at 4:09 p.m. with the Director of Nursing (DON), the DON stated total, or anticipated, daily nurse staffing information was posted behind nursing station 1 and nursing station 2. The DON stated nursing stations were not accessible to residents or visitors. The DON stated total, or anticipated, daily nurse staffing information was not posted in a prominent readily accessible place to residents and visitors. The DON stated it was important to post total, or anticipated, daily nurse staffing information in prominent readily accessible locations so residents and visitors could ensure enough licensed and unlicensed staff were scheduled to meet their needs. The DON stated actual daily nurse staffing information was not posted after it was calculated. The DON stated staff, residents, and visitors had a right to ensure licensed and unlicensed staffing hours met their needs. The DON stated she expected the facility to be in compliance at all times with posted daily nurse staffing information. During a review of the Center for Medicaid and State Operations document titled, BIPA 941 Nursing Home Requirement Effective January 1, 2003; Follow-up to S&C-03-03 Memorandum of October 10, 2002, dated 1/9/23, the document indicated, . the required facility nursing staff numbers must be prominently displayed in a public area. this information must include the actual number of licensed and unlicensed nursing staff directly responsible for the care of residents for that particular day on each shift. This may mean that the nursing facility would post each shift staff numbers very close to the beginning of the shift in order to ensure that the posted numbers are the actual staff working the shift.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview and record review, the facility failed to establish and maintain a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable (contagious) diseases and infections for four of ten sampled residents (residents 107, 7, 39, and 42) when: 1. A dignity bag was not correctly put on Resident 107's urine catheter bag and the urine catheter bag was touching the floor. This failure placed Resident 107 at risk to develop a Catheter-Associated Urinary Tract Infection (CAUTI - a serious infection occurring when germs enter the urinary system through a urinary catheter). 2. A medication tray was not cleaned or disinfected in between use and contact with Resident 42, Resident 7 and Resident 39, whom were on Enhanced Barrier Precautions (EBP-- an infection control intervention designed to reduce transmission of resistant organisms using gown and glove use during high contact resident care activities). This failure placed Resident 42, Resident 7, and Resident 39 at risk for the spread and introduction of Multidrug-Resistant Organism (MDROs germs resistant to antibiotics, making infections difficult to treat) which could result in serious medical condition. 1. During a review of Resident 107's admission record (AR), dated 12/18/25, the AR indicated Resident 107 was admitted from an Acute Care Hospital (GACH), on 12/05/25 with the diagnosis of fracture of lumbar (lower back region) vertebrae (the small, individual bones that stack up to form the spinal column [backbone], in humans and other vertebrates, protecting the spinal cord, providing body structure, and allowing for movement), fracture of right pubis (part of the hip bone that joins the two sides at the pubic symphysis [a cartilage joint] and forms part of the pelvis, protecting organs and providing muscle attachment), and benign prostatic hyperplasia without urinary tract infection [UTI]). During an observation on 12/16/25 at 9:38 a.m. in Resident 107's room. Resident 107 had a urinary drainage bag that was not placed in the dignity urine cover bag (cover or holder designed to conceal the urine from view) and was touching the floor. During a concurrent observation and interview on 12/16/25 at 1:30 p.m. with Licensed Vocational Nurse (LVN) 1 in the hall outside of Resident 107's room. LVN 1 stated the dignity bag should be covering the entire urine bag and it should not be touching the ground. The urine bag touching the ground could be a source of infection for the resident. During a concurrent observation and interview on 12/17/25 at 10:30 a.m. with Certified Nursing Assistant (CNA) 2. CNA 2 stated, the catheter bag must be covered so that no urine is seen. The dignity bag is to provide privacy for the resident. The bag should not touch the floor because germs could get onto the bag and infect the resident. During a concurrent observation and interview on 12/18/25 at 11:10 a.m. with the Infection Preventionist (IP), the IP stated the catheter bag was not up to her expectations. The urine drainage bag should have been completely covered by the dignity bag and should never touch the floor. Having the catheter touch the floor could cause the resident to get a CAUTI. During a concurrent observation and interview on 12/19/25 at 4:02 pm with Director of Nurses (DON), the DON stated, it is not her expectation to have catheter bag touching floor it could cause infection. During a review of the facility's policy and procedure titled, Indwelling Urinary Catheter Insertion, Maintenance and Removal dated 9/22/25, indicated, . be sure the catheter tubing and drainage bag are off the floor at all times. cover urinary drainage bags with a modesty bag .). (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a record review of Resident 42's Care Plan Report (CP), dated 11/7/25, the CP indicated, .resident is on enhanced barrier precautions [related to] increased risk for MDRO.goal.to prevent the transmission of MDROs to the resident during high-contact activities. During a record review of Resident 39's Care Plan Report (CP), dated 11/7/25, the CP indicated, .resident is on enhanced barrier precautions [related to] increased risk for MDRO.goal.to prevent the transmission of MDROs to the resident during high-contact activities. During a record review of Resident 7's Care Plan Report (CP), dated 11/7/25, the CP indicated, .resident is on enhanced barrier precautions [related to] increased risk for MDRO.goal.to prevent the transmission of MDROs to the resident during high-contact activities. During an observation on 12/17/25 at 2:46 p.m. in Resident 42's room, with LVN 6, LVN 6 was observed entering Resident 42's room carrying a medication tray (MT) with Resident 42's medication. LVN 6 was observed placing the MT on top of Resident 42's bedside table. LVN 6 was observed administering Resident 42's medication through his gastrostomy tube (a tube inserted through the wall of the abdomen directly into the stomach). LVN 6 was observed touching the MT with her gloved hand after handling Resident 42's gastrostomy tube. LVN 6 was not observed disinfecting the MT after use. LVN 6 was observed placing the MT on Resident 7's bedside table, Resident 42's roommate, while she removed her gown, gloves and washed her hands in the resident restroom. LVN 6 was observed picking up the MT from Resident 7's bedside table, exiting the room and placing the MT on top of the medication cart. LVN 6 was not observed disinfecting the MT after use. LVN 6 was observed placing Resident 39's medication into the MT. LVN 6 was observed entering Resident 39's room carrying the MT with Resident 39's medication. LVN 6 was observed placing the MT on Resident 39's bedside table. LVN 6 was observed administering Resident 39's oral medication. LVN 6 was not observed disinfecting the MT after use. LVN 6 was observed placing the MT on top of the medication cart. LVN 6 was not observed disinfecting the MT. During an interview on 12/18/25 at 3:16 p.m. with LVN 6, LVN 6 stated she could not remember if she cleaned (removes debris and some germs) or disinfected (kills germs with chemicals) the MT after use. LVN 6 stated she typically cleaned the MT with soap and water in the resident restroom before exiting the room. LVN 6 stated it was important to disinfect the MT after use to prevent the spread of infection. During an interview on 12/18/25 at 4:20 p.m. with the IP, the IP stated soap and water could clean the MT and remove visible debris, but would not disinfect the MT. The IP stated soap and water could be used prior to disinfection, but not as a sole practice for disinfection of the MT. The IP stated the facility had designated wipes, which included chemicals, intended for disinfection and required a 2-minute dwell time per manufacture guidelines to ensure reusable equipment was disinfected prior to use with the next resident. The IP stated licensed nursing staff were not meeting infection control standards of practice when reusable medical equipment between resident use was not disinfected. The IP stated licensed nursing staff were not meeting infection control standards of practice using soap and water only to disinfect reusable medical equipment after resident use. The IP stated residents with indwelling medical devices, such as tracheostomies (a tube inserted into the airway) and gastrostomy tubes, were on Enhanced Barrier Precautions (EBP- an infection control intervention designed to reduce transmission of resistant organisms using gown and glove use during high contact resident care activities). The IP stated residents on EBP were at an increased risk for acquiring Multidrug-Resistant Organism (MDROs germs resistant to antibiotics, making infections difficult to treat). The IP stated the MT was a reusable medical equipment device and needed to be disinfected (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	after use or contact with residents and their environment to prevent the introduction and spread of infections to residents. During an interview on 12/19/25 at 4:09 p.m. with the DON, the DON stated she expected all licensed nursing staff to follow infection control standards of practice. The DON stated all reusable medical equipment needed to be disinfected after use. The DON stated the facility had designated wipes, which included chemicals, intended for disinfection and required a 2-minute dwell time per manufacture guidelines to ensure reusable equipment was disinfected prior to use with the next resident. The DON stated facility policy and procedures were not followed when the MT came into contact with Resident 42, Resident 7, and Resident 39 and their environment without being disinfected. The DON stated it was important to disinfect reusable medical equipment after use to prevent the spread and introduction of infection to residents. During a review of the facility's policy and procedure (P&P) titled, Infection Prevention Plan-CMC, dated 2/27/25, the P&P indicated, .the goal of the CHS Infection Prevention Program is to minimize the risk of acquiring and transmitting healthcare-associated infections (HAI)/infectious diseases to patients, employees, medical staff, residents, volunteers, contractors, students and visitors. The overall goals of CHS Infection Prevention program include.limiting unprotected exposures to pathogens.limiting the transmission of infections associated with procedures.limiting the transmission of infections associated with the use of medical equipment, devices, and supplies. Standard Precautions are practices to reduce healthcare associated infections used with all patients, regardless of diagnosis or isolation status. Apply to interacting with blood, body fluids, secretions and excretions except sweat, regardless of whether they contain visible blood, non-intact skin and mucous membranes. During a review of the facility's P&P titled, Enhanced Barrier (Standard) Precautions, dated 9/29/25, the P&P indicated, .MDRO .can be transmitted from patient to patient in the absence of effective infection control precautions.passage of an infectious agent.to another person either directly or, more commonly indirectly via.medical equipment that has not been cleaned and disinfected adequately between patients.disinfect shared equipment after use on a Resident and before removal from the room. During a professional reference review retrieved from https://www.cdc.gov/infection-control/hcp/core-practices/index.html titled, CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings, dated 4/12/24, the professional reference review from CDC indicated, . Use Standard Precautions to care for all patients in all settings. Standard Precautions include.Standard Precautions are the basic practices that apply to all patient care, regardless of the patient's suspected or confirmed infectious state, and apply to all settings where care is delivered. These practices protect healthcare personnel and prevent healthcare personnel or the environment from transmitting infections to other patients.When information from manufacturers is limited regarding selection and use of agents for specific microorganisms, environmental surfaces or equipment, facility policies regarding cleaning and disinfecting should be guided by the best available evidence and careful consideration of the risks and benefits of the available options.Clean and reprocess (disinfect or sterilize) reusable medical equipment.prior to use on another patient or when soiled.Maintain separation between clean and soiled equipment to prevent cross contamination .		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain the dignity and privacy for one of 11 sampled residents (Resident 50) when Resident 50 was observed from the hallway of his room without any clothing on two occasions. This failure violated Resident 50's right to maintain his privacy. Findings: During a concurrent observation and interview on 12/16/25 at 10:20 a.m. in Resident 50's room, Resident 50 was observed in bed covered with a sheet, holding the sheet to his chin with both hands. Resident 50 was asleep but woke up when knocked on the door and introduction made. Resident 50 stated he had been at the facility for three weeks, because he went to Mexico. Resident 50 did not answer any further questions. During a review of Resident 50's admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 12/18/25, the AR indicated Resident 50 was admitted to the facility on [DATE] with diagnoses of non-traumatic subarachnoid hemorrhage (bleeding in the space between the brain and the membrane that covers it, not caused by trauma), schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly), epilepsy (a seizure [a burst of uncontrolled electrical activity between brain cells that causes temporary abnormalities in muscle tone or movements, behaviors, sensations, or states of awareness] disorder), and chronic pain (longstanding pain that persists over three months, or beyond the usual recovery period). During a review of Resident 50's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 9/17/25, the MDS section C indicated Resident 50 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive (involving the process of thinking, learning and understanding) understanding on a scale of 1-15) score of 9 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 50 was moderately impaired. During an observation on 12/16/25 at 12:36 p.m. from the hallway outside Resident 50's room, Resident 50 was observed sitting on the side of his bed without wearing any clothing eating his meal. A staff member was seen leaving Resident 50's room carrying a meal tray cover. Resident 50's door was open, and his curtain was not pulled to protect Resident 50 from being observed from the hallway. During a concurrent observation and interview on 12/18/25 at 3:42 p.m. with Certified Nursing Assistant (CNA) 3, in hallway outside Resident 50's room, Resident 50 was observed in his room without wearing any clothing in his wheelchair in his room. CNA 3 stated Resident 50 did not like wearing gowns and clothes. CNA 3 stated Resident 50 had schizophrenia and preferred laying down naked. CNA 3 stated being naked comforted and calmed Resident 50, it helped Resident 50 sleep. CNA 3 stated staff were not supposed to keep Resident 50's door closed as Resident 50 was a fall risk. CNA 3 stated Resident 50's curtain had to be in a certain position, so no one was able to look in Resident 50's room, but Resident 50 opened his curtain. CNA 3 stated staff had to keep an eye on Resident 50 as he came out of his room naked in his wheelchair. CNA 3 stated Resident 50 needed his curtain to be closed for privacy. CNA 3 stated Resident 50's curtain should have been drawn so no one could see Resident 50 naked in his room. CNA 3 stated it was a risk to Resident 50's dignity and privacy to have his curtain open when he was naked in his room. CNA 3 stated a reasonable person would have wanted the curtain closed so no one could see in their room. During a concurrent interview and record review on 12/18/25 at 4:32 p.m. with Licensed Vocational Nurse (LVN) 5, Resident 50's CP, undated was reviewed. The CP indicated, . Resident prefers to remain unclothed while in bed, which may affect dignity, privacy, safety, and temp regulation. Date initiated: 12/06/25 . resident will maintain dignity, comfort and safety while honoring his preference to remain unclothed . ensure door, privacy curtain is drawn when needed to maintain dignity . date initiated: 12/06/25 . LVN 5 stated Resident 50 was unclothed all the (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	time. LVN 5 stated Resident 50's curtain was often pulled from the door to his bed. LVN 5 stated staff asked Resident 50 to cover himself if he was in his wheelchair uncovered. LVN 5 stated Resident 50's curtain should have been pulled to prevent seeing Resident 50 naked. LVN 5 stated it was a risk for Resident 50 to be exposed, which could have compromised Resident 50's dignity. During an interview on 12/19/25 at 4:00 p.m. with the Director of Nursing (DON), the DON stated it was important to preserve Resident 50's dignity whenever he was naked by ensuring he had his sheet to cover himself, make sure his curtain was pulled, and provide redirection of Resident 50 if needed. The DON stated the facility needed to preserve Resident 50's dignity. The DON stated Resident 50's nakedness was a preference and sometimes Resident 50 wanted to be naked, and sometimes he did not want to be naked. The DON stated if staff discovered a trend with residents, a care plan should have been implemented at that time. The DON stated the purpose of the care plan is for staff to be aware of the residents' plan of care. The DON stated there was a risk to the residents if no care plan was in place due to staff's lack of awareness of each resident's plan of care. The DON stated if a resident had a specific need, it should have been care planned and the care plan should have been followed. The DON stated every resident should have had a care plan specific to their plan of care. During an interview on 12/19/25 at 4:39 p.m. with the Administrator (ADM), the ADM stated care plans were very thorough and reviewed often. The ADM stated staff checked for any residents that had a specific need to make sure they had a care plan for their needs. The ADM stated she expected the resident's care plans to be individualized and person- centered. The ADM stated she expected the residents' needs to be met. The ADM stated some residents did let staff draw their curtains and sat in front of their window naked. The ADM stated she expected staff to check on the residents and remind them to cover themselves. The ADM stated it was important to have the naked resident's curtain drawn to respect the resident's dignity. During a review of the facility's policy and procedure (P&P) titled, Behavioral Health Services, dated 10/21/25, the P&P indicated, . Purpose . to ensure all Residents receive necessary behavioral health services to assist them in reaching and maintaining their highest level of mental and psychosocial functioning . staff must promote dignity, autonomy, privacy, socialization and safety as appropriate for each Resident and are trained in ways to support Residents in distress . the assessment and care plan will include goals that are person-centered and individualized to reflect and maximize the Resident's dignity, autonomy, privacy . and safety . During a review of the facility's P&P titled, Resident Rights, dated 3/3/25 the P&P indicated, . it is the policy of this facility to provide each Resident and their responsible party (if applicable) with a copy of Resident Rights on admission . During a review of the facility document titled, California Standard admission Agreement for Skilled Nursing Facilities and Intermediate care Facilities, dated 5/24, the document Attachment F indicated, . Resident [NAME] of Rights . to be treated with consideration, respect and full recognition of dignity and individuality, including privacy in treatment and in care of personal needs . a right to dignity, privacy and humane care . Dignity. The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect .		

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation, interview, and record review the facility failed to ensure one of nine sampled residents (Resident 5) received personal privacy and confidentiality of his personal and medical records when Licensed Vocational Nurse (LVN) 4 left Resident 5's Medication Administration Record (MAR) computer screen visible in the hallway while administering medications. This failure resulted in Resident 5's personal and medical records being visible to staff, residents and visitors, which could lead to unauthorized access to confidential personal and medical records. During an observation on 12/17/25 at 12:18 p.m. Medication Cart 3 (MC 3) was observed next to Resident 5's room with the drawers and computer screen facing out toward the facility hallway. Licensed Vocational Nurse (LVN) 4 was observed removing medication from MC 3. LVN 4 was observed donning personal protective equipment (PPE) and entering Resident 5's room. LVN 4 was observed closing Resident 5's room door. MC 3 was observed unattended in the hallway, next to Resident 5's room, with the drawers and computer screen facing out toward the facility hallway. MC 3's computer screen was observed with Resident 5's Medication Administration Record (MAR) profile visible. The MAR profile included Resident 5's name, profile picture, identification number, isolation information, status, location, gender, date of birth, age, physician, allergies, code status, current vital signs, medication orders, enteral feed orders, non-pharmacological ordered interventions for as needed medications, and heel protector orders. During an observation on 12/17/25 at 12:26 p.m. MC 3 was observed next to Resident 5's room with the drawers and computer screen facing out toward the facility hallway. MC 3's computer screen was observed with Resident 5's Medication Administration Record (MAR) profile visible. LVN 4 was observed exiting Resident 5's room and returning to MC 3. During a concurrent interview and record review on 12/17/25 at 3:57 p.m. with LVN 4, a picture of MC 3 dated 12/17/25 at 12:18 p.m., was reviewed. LVN 4 stated he entered Resident 5's room to administer medications and closed the room door. LVN 4 stated MC 3 was left unattended with the drawers and computer screen facing out toward the facility hallway. LVN 4 stated he did not log off or lock MC 3's computer screen. LVN 4 stated Resident 5's MAR profile was visible on MC 3's computer screen while he was in Resident 5's room administering medication. LVN 4 stated the computer screen on MC 3 should have been logged off or locked to protect Resident 5's personal and medical record information from unnecessary view by staff, residents, and visitors. LVN 4 stated Resident 5's personal and medical record information was only to be viewed by staff providing care and Resident 5 had the right to secure and confidential medical records. During a concurrent interview and record review on 12/18/25 at 5:06 p.m. with LVN 5, a picture of MC 3 dated 12/17/25 at 12:18 p.m., was reviewed. LVN 5 stated medication cart computer screens were expected to be logged off or locked when unattended to prevent unauthorized use or view of confidential resident information. LVN 5 stated licensed nursing staff were responsible for protecting resident personal and medical records from being accessed by unnecessary staff, residents, and visitors. LVN 5 stated Resident 5's privacy was violated when MC 3 was unattended and Resident 5's MAR profile was visible on the computer screen from the facility hallway. During an interview on 12/19/25 at 4:09 p.m. with the Director of Nursing (DON), a picture of MC 3 dated 12/17/25 at 12:18 p.m., was reviewed. The DON stated she expected licensed nursing staff to maintain resident privacy and confidentiality during medication administration. The DON stated privacy and confidentiality of resident personal and medical records were maintained by logging off or locking computer screens on medication carts when unattended or not in use. The DON stated facility policy and procedure was not followed when Resident 5's MAR profile was visible from the facility hallway on MC 3 and unattended. The DON stated Resident 5's privacy and confidentiality of personal and medical records was violated when Resident 5's MAR profile was visible from the facility hallway on MC 3 and unattended. The DON stated Resident 5 was at risk for personal and medical records being accessed by unauthorized staff, residents and visitors. During a review of the facility's policy and procedure (P&P) titled, HIPAA Security and Information (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 12/19/2025
NAME OF PROVIDER OR SUPPLIER Community Subacute and Transitional Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3003 N Mariposa Fresno, CA 93703	
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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Security Workstation Use, dated 10/6/22, the P&P indicated, .workforce members shall use workstations in the appropriate manner to properly protect the sensitivity of ePHI [electronic protected health information] and to minimize the possibility of unauthorized access to such information.workstations will be placed in locations so that the information displayed on the workstation may not be viewed by unauthorized persons.workstation users will abide by the following.users sharing a workstation with other users must log off prior to leaving the workstation. Those using a dedicated workstation, or one in which the user is the sole user, should either log off or lock the system when leaving the workstation to prevent the unauthorized use.close files and programs when not in use. During a review of the facility's P&P titled, Medication Administration General Guidelines, dated 1/2023, the P&P indicated, .Resident's health information needs to remain private. The pages of the MAR notebook containing resident health information must remain closed or covered when not in direct use .During a review of the facility's P&P titled, Resident Rights Under Federal Law, undated, the P&P indicated, .the resident has the right to personal privacy and confidentiality of his or her personal and clinical records.		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review the facility failed to ensure two out of 22 residents (Resident 38 and Resident 87) received a level II Pre-admission Screening and Resident Review (PASRR- evaluation for individuals suspected of having a Serious Mental Illness (SMI) or Intellectual/Developmental Disability (I/DD)/Related Condition (RC), triggered by a positive Level I screen, to determine if they need specialized services, ensuring placement in the least restrictive setting) evaluation by the designated entity to determine if SMI, ID/DD/RC conditions were present when: 1. Resident 38 had a PASRR level I screening result positive for SMI, and the facility did not ensure a PASRR level II screening was completed. 2. Resident 87 had a PASRR level I screening result positive for SMI, and the facility did not ensure a PASRR level II screening was completed. These failures resulted in Resident 38 and Resident 87 not receiving the required PASRR level II screening which had the potential to result in missed identification of specialized services needed and put Resident 38 and Resident 87 at risk of delayed treatment. 1. During a review of Resident 38's admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 12/18/25, the AR indicated Resident 38 was admitted to the facility on [DATE] with diagnoses of cerebral infarction (blood flow to part of brain gets blocked) and major depressive disorder (mood disorder causing persistent sadness, loss of interest, and impacts daily life). During a concurrent interview and record review on 12/18/25 at 1:47 p.m. with the Minimum Data Set Coordinator Nurse (MDSN), Resident 38's document titled, Pre-admission Screening and Resident Review (PASRR) Level I Screening, dated 11/14/25, and PASRR level II screening notice titled, Notice of Attempted Evaluation, dated 11/18/25, were reviewed. The MDSN stated PASRR level I screenings were completed on all residents who were admitted or had a significant change in condition. The MDSN stated if a PASRR level I screening was positive for SMI a PASRR level II screening was required to be completed by the Department of Health Care Services (DHCS) to determine appropriate nursing facility services and specialized services. The MDSN stated Resident 38 had a PASRR level I screening completed on 11/14/25 which indicated he was positive for SMI and required a PASRR level II screening. The MDSN stated Resident 38 had not received a PASRR level II screening. The MDSN stated the facility received a notice on 11/18/25 titled, Notice of Attempted Evaluation, which indicated DHCS could not reach the facility on two or more attempts to complete Resident 38's PASRR level II screening and the case had been closed. The MDSN stated the facility was responsible for ensuring Resident 38's PASRR level II screening was completed. The MDSN stated the facility had not resubmitted a PASRR level I screening to reopen Resident 38's case. The MDSN stated it was important that PASRR level II screenings were completed to ensure residents received the most appropriate placement in the least restrictive setting, and whether specialized services were needed. The MDSN stated PASRR level II screenings were a screening tool and without it residents could be placed at risk for delayed treatment, identification of care or services. During an interview on 12/18/25 at 2:29 p.m. with Social Worker (SW) 1, SW 1 stated the MDSN was responsible for ensuring positive PASRR level I screenings were followed up with a PASRR level II screening by the designated authority. SW 1 stated residents were at risk for delayed services and care if they had a PASRR level I screening positive for SMI and a PASRR level II screening was not completed. SW 1 stated PASRR level II screenings were required to ensure the facility could meet and provide the care residents needed. During a concurrent interview and record review on 12/19/25 at 4:09 p.m. with the Director of Nursing (continued on next page)		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(DON), Resident 38's PASRR level II screening notice titled, Notice of Attempted Evaluation, dated 11/18/25, was reviewed. The DON stated the document indicated Resident 38's PASRR level II screening had not been completed. The DON stated the document indicated Resident 38's PASRR level II screening was not completed due to facility failure to respond. The DON stated the MDSN was responsible for ensuring PASRR follow-up and completion with the required state-designated authorities. The DON stated it was important PASRR level II screenings were completed to ensure residents received appropriate services and care for their needs. The DON stated if PASRR level II screenings were closed without being completed residents were at risk for not having their care needs met by the facility. During a review of Resident 38's PASRR level II screening notice titled, Notice of Attempted Evaluation, dated 11/18/25, the document indicated, .unable to complete level II evaluation for serious mental illness (SMI).the California Department of Health Care Services (DHCS) administers the PASRR process when the level I screening returns a positive result for possible SMI. In the event of a positive SMI level I screening, a SMI level II Mental Health Evaluation is required to determine if the individual can benefit from specialized services. However, a SMI level II Mental Health Evaluation was not scheduled for the following reason: facility staff were unresponsive to two or more separate attempts of communication within 48 hours of the level I screening.this case is now closed. To reopen, the facility must resubmit a new level I screening.please note this letter is a courtesy notice for administrative purposes only and does not comprise a completed individualized determination. During a review of the facility's policy and procedure (P&P) titled, Pre-admission Screening and Resident Review (PASRR), dated 10/15/25, the P&P indicated, .PASRR.its purpose is to identify individuals with serious mental illness (SMI) or intellectual/developmental disabilities (IDD) and ensure they receive appropriate services and placement. all new admissions and readmissions are screened for serious mental disorders (SMI), intellectual disability (ID) /developmental disability (DD), or related conditions (RC), per the Medicaid PASRR process.Level I screening and Level II (if needed), and determination must be completed for any individual regardless of the individual's age or payor source . If the Level I screening is positive for an individual having, or is suspected of having, a PASRR condition, i.e., SMI, ID/DD, or RC, then a Level II Evaluation will be performed by the state-designated authority to help determine the most appropriate placement of an individual, considering the least restrictive setting, and whether specialized services are needed.The Department of Health Care Services (DHCS) is responsible for SMI Level II Evaluations, which by law must be performed by a third party contractor. 2. During a review of Resident 87's AR, dated 12/18/25, the AR indicated Resident 87 was admitted on [DATE] with a re-admission on [DATE] from a nursing home with diagnoses of intracerebral hemorrhage (bleeding in the brain caused by a ruptured blood vessel), depression (persistent feelings of sadness, despair, loss of energy, and difficulty dealing with normal daily life), obstructive and reflux uropathy (when urine cannot drain and backs up into the kidney), and chronic pain (longstanding pain that persists over three months, or beyond the usual recovery period). During a review of Resident 87's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 11/2/25, the MDS section C indicated Resident 87 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive (involving the process of thinking, learning and understanding) understanding on a scale of 1-15) score of 9 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 87 was moderately impaired. (continued on next page)		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 12/18/25 at 1:53 p.m. with the MDSN, Resident 87's DHCS document titled, Preadmission Screening and Resident Review (PASRR) Level 1 Screening, dated 3/11/25 was reviewed. The PASRR indicated, .Level I &ndash; Positive for SMI. The MDSN stated the PASRR screening was completed for new admission, or if residents had a change of condition (COC). The MDSN stated since Resident 87 was positive for a PASRR level I assessment for SMI, she needed to have a PASRR level II assessment. The MDSN stated she was unable to find if a documented PASRR level II assessment was completed for Resident 87. During a concurrent interview and record review on 12/18/25 at 2:00 p.m. with the MDSN, Resident 87's DHCS document titled, Notice of Attempted Evaluation, dated 3/17/25 was reviewed. The document indicated, . facility staff were unresponsive to two or more separate attempts of communication within 48 hours of the Level I Screening.the case is now closed. To reopen, the facility must resubmit a new Level I Screening. The MDSN stated there was no documentation that someone called DHCS to follow up on Resident 87's level II PASRR screening. The MDSN stated Resident 87's PASRR screening was incomplete. The MDSN stated she should have followed up with Resident 87's PASRR Level II assessment. The MDSN stated SMI indicated a serious mental illness, and the PASRR assessment determined if the resident required any treatment or specific needs to be met and if the facility was able to care for the resident. The MDSN stated the facility could not make a determination of SMI or the specific needs of the resident without completion of the PASRR. The MDSN stated there was a possible risk for the facility to not meet Resident 87's needs if the PASRR Level II assessment was not completed. The MDSN stated per DHCS and federal guidelines, the facility had to complete the PASRR screening for every resident. During an interview on 12/18/25 at 2:30 p.m. with SW 1, SW 1 stated the MDSN was responsible for the completion of PASRRs. SW 1 stated if a level II PASRR assessment was identified on resident admission, the MDSN followed up with DHCS to see if the resident needed a level II assessment. SW 1 stated the Level II assessment results had a determination letter with recommendations for the resident's care. SW 1 stated the SW department was only involved if a Level II was positive and the resident needed referrals for the indicated recommendations for care. SW 1 stated the PASRR was important for positive Level II assessments as it helped identify if resident placement was appropriate for their facility and if additional services were needed so the resident would benefit from the facility's care. SW 1 stated if a resident had a positive Level I assessment and a PASRR level II was not completed, and if the resident had a positive level II PASRR assessment, there was the possibility the resident would receive delayed services and would not receive services the resident could potentially benefit from. During an interview on 12/19/25 at 4:00 p.m. with the DON, the DON stated the PASSR was the preadmission screening tool for mental illness to provide a plan of care for residents. The DON stated the PASRR screening helped determine care plan interventions for residents. The DON stated if the PASRR level II assessment was positive and if interventions were needed, the interventions would have been care planned and carried out by staff. The DON stated her expectation was for level I PASRR assessments to be completed prior to admission for resident clearance, and that positive level II PASRR assessments had been completed to verify the facility was able to accommodate the resident. The DON stated if a level II PASRR assessment was needed, her expectation was for MDS to do a significant change assessment and get the level II PASRR assessment completed. The DON stated if the resident had a positive PASRR level I assessment and the PASRR level II assessment was not completed, the resident could have had different risks for care than other residents and their care would be undetermined because the facility would not have known what the risks were. (continued on next page)		

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Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/19/25 at 4:39 p.m. with the Administrator (ADM), the ADM stated the PASRR was used to determine the appropriate care for the residents. The ADM stated the DON oversaw the MDSN, and all staff were involved with PASRRs. The ADM stated her expectation was for residents to have a completed level II PASARR for a positive level I PASRR screen. The ADM stated she expected staff to follow up on closed PASRRs. During a review of the facility's policy and procedure (P&P) titled, Pre-admission Screening and Resident Review (PASRR), dated 10/15/25, the P&P indicated, .PASRR.its purpose is to identify individuals with serios mental illness (SMI) or intellectual/developmental disabilities (IDD) and ensure they receive appropriate services and placement. all new admissions and readmissions are screened for serious mental disorders (SMI), intellectual disability (ID) /developmental disability (DD), or related conditions (RC), per the Medicaid PASRR process.Level I screening and Level II (if needed), and determination must be completed for any individual regardless of the individual's age or payor source . If the Level I screening is positive for an individual having, or is suspected of having, a PASRR condition, i.e., SMI, ID/DD, or RC, then a Level II Evaluation will be performed by the state-designated authority to help determine the most appropriate placement of an individual, considering the least restrictive setting, and whether specialized services are needed.The Department of Health Care Services (DHCS) is responsible for SMI Level II Evaluations, which by law must be performed by a third party contractor. During a review of the facility's P&P titled, Behavioral Health Services, dated10/21/25, the P&P indicated, .to ensure all Residents receive necessary behavioral health services to assist them in reaching and maintaining their highest level of mental and psychosocial functioning . facility staff will implement person-centered care approaches designed to meet the individual goals and needs of each Resident, which includes non-pharmacological interventions . Procedure . the facility utilizes the comprehensive assessment process for identifying and assessing a Resident's mental and psychosocial status and providing person-centered care . 1. complete PASRR screening.		

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. Based on observation, interview and record review the facility failed to ensure residents had a well-balanced diet that meets their daily nutritional and special dietary needs when the facility's approved therapeutic diet manual:1. Was not based on current standard of practice or nationally recognized diet for residents with diabetes when the facility had a Reduced Concentrated Sweets (RCS) diet order for nutrition care with diabetes for one sampled resident (Resident 107); and 2. Did not contain a small portion diet or menu for one sampled resident (Resident 29) when the physician's diet order was for a small portion diet. These failures had the potential to result in inconsistent nutritional management related to therapeutic diet planning, limiting resident choices and failure to have all the diet choices in the diet manual could result in resident's receiving incorrect portions of food items. 1. During kitchen observation on 12/16/25 at 10:49 a.m. with Dietary Aid (DA) 1, DA 1, was observed preparing Resident 107's lunch tray. DA 1 stated his job was to place condiments, drinks, and plates on the tray for residents as well as checking meal tickets. During observation of the lunch meal service on 12/16/25 at 11:53 a.m. Resident 107's meal ticket dated 12/16/25, indicated diet Reduced Concentrated Sweets (RCS) texture regular .Profile Note.Large portions protein and non-starchy vegetables for weight gain. During a review of Resident 107's admission Record (AR- a document that provides resident contact details, a brief medical history, level of functioning, preferences, and wishes), dated 12/18/25 , the AR indicated Resident 107 had the following diagnoses but limited to: diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), and major depressive disorder (MDD- a serious mood disorder causing persistent sadness, hopelessness, and loss of interest in activities, and significantly interfering with daily life, involving symptoms like sleep/appetite changes, fatigue, concentration issues, and feelings of worthlessness, not just a bad mood). During a review of Resident 107's Minimum Data Set (MDS- resident assessment tool which indicated physical and cognitive abilities), dated 12/18/25, the MDS indicated a Brief Interview for Mental Status (BIMS- an assessment of cognitive function) score of 13 (0-7 severe cognitive impairment, 8-12 moderate cognitive impairment, 13-15 no cognitive impairment), indicating Resident 107 had no cognitive impairment. During a review of Resident 107's Order Summary (OR) dated 12/18/25, the OR indicated, .RCS diet-Regular texture.Large portions protein.) During a review of the facility's Diet Manual and Enteral Nutrition Formulary 2025, revised 9/25, indicated Carbohydrate Modification.incorporated consistent carbohydrate intake. During a review of the facilities document titled Daily Nutrient Summary: Week 1 undated, indicated, a wide variation in total caloric and Carbohydrate intake from meal to meal and day to day. The documentation did not reflect a consistent carbohydrate distribution or standardized caloric range. During an interview on 12/17/25 at 4:06 p.m. with the Registered Dietitian (RD), RD stated a few duties of the RD were to participate in resident assessments, nutrient analysis and menu (continued on next page)		

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	development. The RD stated the RCS diet was used to make carbohydrate intake as consistent as possible while allowing a more liberalized diet. The RD stated the facility reduced sugar by modifying dessert portions, such as reducing portions by half, rather the eliminating items completely. The RD stated the facility focused on making less certain foods instead of not offering them at all. The RD acknowledged the facility did not follow the standard of practice for the diet for residents with diabetes During an interview on 12/18/25 at 8:37 a.m. with Medical Director (MD), MD stated he signed off on the facility's policies and procedures, including the diet manual, reviewed them as part of his role. The MD stated he had not seen the RCS diet used at other facilities. The MD stated he was not aware the RCS diet was not considered standard of practice. The MD stated he was familiar with concentrated carbohydrate or consistent carbohydrate diets recommended for diabetic residents, and stated residents may prefer items such as ice cream instead of other carbohydrate sources, which he stated made sense to him. During an interview on 12/18/25 at 9:50 a.m. with the RD, she acknowledged in Academy in Nutrition and Dietetics (AND) Nutrition Care Manual stated that the RCS diet was obsolete and they will do Consistent Carbohydrate Diet and update diet manual and menus. During a review of the facility's policy and procedure (P&P) titled, Diet Manual and Enteral Nutrition Formulary Nutrition Care Manual, dated 9/30/25, the P&P indicated, To provide a reference source for use by the medical staff, nursing, and nutrition service staff. and .reflects current research and changing standards of care. During a review of the Academy of Nutrition and Dietetics current Nutrition Care Manual (NCM), dated 2025, the NCM indicated, Obsolete diets and Diet Terminology; For condition Type 1 Diabetes and Type 2 Diabetes Obsolete Diet Name.No Concentrated Sweets diet, No Sugar Added, Low Sugar, Liberal Diabetic Diet. During a review of the Academy of Nutrition and Dietetics current Nutrition Care Manual (NCM), dated 2025, the NCM indicated, A consistent carbohydrate diet provides the same amount of total carbohydrate daily, distributed evenly across all meals and snacks. A consistent amount of carbohydrate at each daily meal is the goal. The exact amount and type of carbohydrate served is individualized by the registered dietitian nutritionist (RDN). The name of the diet used in your facility should no longer emphasize the restriction of sugar or sweets but rather emphasize consistent carbohydrates or carbohydrate controlled . During a review of Management of Diabetes in Longterm Care and Skilled Nursing Facilities: A Position Statement of the American Diabetes Association, dated February 2016, the article indicated, No concentrated sweets or no sugar diet orders are ineffective for glycemic [A measure of the increase in the level of blood glucose (a type of sugar) caused by eating a specific carbohydrate (food that contains sugar) compared with eating a standard amount of glucose] management and should not be recommended. Instead, a consistent carbohydrate meal plan that allows for a wide variety of food choices (e.g., general diet) may be more beneficial for both nutritional needs and glycemic control in patients with type 1 diabetes or type 2 diabetes . 2. During a concurrent observation and record review on 12/16/25 at 12:40 p.m. in the kitchen, with the Dietary Aid (DA)1, the DA1 checked Resident 29's meal tray ticket and prepared the meal tray for lunch. Resident 29's meal tray ticket indicated three meatballs for small portions. DA1 plated 1.5 (continued on next page)		

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	meatballs in Resident 29's lunch tray. During a record review of Resident 29's admission Record (AR), dated December 18,2025, the AR indicated, Resident 29's admission date was on 9/20/21. The AR indicated Resident 29's diagnosis included Muscle weakness and Vitamin D Deficiency (not enough vitamin D). The Order Summary Report (OSR), dated 7/27/2, indicated, Regular diet. Regular texture. Small portions for weight loss also per RD recommendations. During an interview on 12/17/25 at 4:06 p.m. with the Registered Dietitian (RD), the RD stated small portion diet is separate and is an extension of the menu. The RD stated small portions is a preference so not listed as a diet in the diet manual. During a concurrent interview and record review on 12/18/25 at 12:12 p.m. with the RD, Resident 29's OSR, dated 12/18/25 was reviewed. The OSR indicated, Resident 29's physician order was small portion. RD acknowledged Resident 29 had a physician diet order dated 7/27/25 for the small portion diet. RD stated, the facility did not have a small portion menu and that it should be in the diet manual but was not. During a review of Resident 29's Meal tray ticket, dated 12/16/25, the meal tray ticket indicated, .Lunch I 2025-12-16 Diets: Regular, Texture: Regular. Fluids: Regular/Thin Liquids. [3 each] Beef Meatballs [2 oz] Marinara Sauce [1(4z spoodle)] Spaghetti Noodles [0.5 cup] Sauteed [NAME] Beans [0.5 cup] Peaches [1 each] Breadstick [4 fl.oz] Apple Juice [4 fl.oz] Cranberry Juice. Daily Note: SPOONS ONLY, SMALL PORTION STARCH AND PROTEIN. Small portions for weight loss also per RD recommendations. During a review of the facility's policy and procedure (P&P) titled, Patient Diet Orders and Menus, dated 07/28/2025, the P&P indicated, .Diet orders will be ordered and produced in accordance with the guidelines referenced in the diet manual.		

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 12/19/2025
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)		
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record reviews, the facility failed to prepare, distribute and serve food in accordance with professional standards for food service safety when two of three kitchen staff (Dietary aid 1 and 2) did not have hair and facial hair fully restrained or covered during meal preparation and service. This failure had the potential to compromise food sanitation and resident safety. During an observation of lunch meal service on 12/16/25 at 12:35 pm, in the kitchen, Dietary Aid (DA)1 was wearing a baseball cap with longer hair in back and hair was not fully covered. DA 1 was not wearing hairnet. DA 1 was calling out trays, checking out meal tickets and meal trays with food, putting cold beverages on meal trays and placing meal trays into food carts. During a concurrent observation and interview on 12/17/25 at 12:32 pm with DA 2 in the kitchen, DA 2 was wearing surgical mask, the side of face had facial hair and was uncovered. DA 2 stated that he was mixing Juven (medical drink mixture with vitamins and minerals), diet cranberry beverages in cups and food preparation for residents. During a concurrent interview and record review on 12/18/25 at 10:04 am with the Certified Dietary Manager (CDM), the facility's policy and procedure (P&P) titled, Uniforms and Personal Hygiene, dated 12/18/25 was reviewed. The P&P indicated, Provided hair covering must be worn at all times within the department. All hair must be restrained by hair covering. [NAME] nets will be worn if any facial hair is evident. The CDM stated, the facility policy is for all hair to be covered or restrained. The CDM stated, that the DA 1 and 2 were not wearing hairnet during food preparation.		