STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055626	A. Building B. Wing	06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Healthcare Centre of Fresno	1665 M Street Fresno, CA 93721

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48713 Based on observation, interview, and record review the facility failed to provide needed care according to professional standards of practice for one of three sampled Residents (Resident 1) when Resident 1 did not receive pain medication according to physician ' s order for three days. This failure had the potential to result in inadequate pain management for Resident 1. Findings: During a concurrent observation and interview on 6/11/24 at 9:31 a.m. with Resident 1 in Resident 1's room, Resident 1 was observed lying in bed guarding her abdomen with hands and complaining of abdominal pain. Resident 1 stated she did not want to talk at the moment regarding alleged incident and continued to complain of abdominal pain. During a review of Resident 1's Admission Record (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), indicated, Resident 1 was admitted to the facility on [DATE] with diagnosis, of hemiplegia (paralysis of one side of the body), aphasia (loss of ability to understand or express speech, caused by brain damage), major depressive disorder (mood disorder that causes low mood and loss of interest), facial weakness, type 2 diabetes mellitus (is a disease that occurs when blood sugar is too high). During a review of Resident 1's Minimum Data Set [MDS a resident assessment tool used to identify cognitive (mental processes) and physical functional level assessment] dated 6/10/24, the MDS indicated, Resident 1's Brief Interview for Mental Status [BIMS screening tool used to assess resident cognitive level] score was 12 out of 15 [0 - 7 indicated severe cognitive impairment [memory loss, poor decision making skills] 8 -12 moderate cognitive impairment, (13 -15) cognitively intact] which indicated Resident 1 was moderately cognitively intact. During a review of Resident 1 ' s Change of Condition Evaluation (COC), dated 6/8/24, the COC indicated, . Resident came back by herself inside the facility. Staff notified this writer that resident stated her family member (FM) beat her up on stomach . Resident complains of pain to lower abdomen and ribs area . (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/11/24 at 9:31 a.m. with certified nursing assistant (CNA) 1, CNA 1 stated Resident 1 had behavior episodes manifested by agitation and yelling. CNA 2 stated Resident 1 did not have noted injuries but was complaining of abdominal pain and covering her abdomen. CNA 2 stated this was not a normal complaint for Resident 1. During a concurrent interview and record review on 6/11/24 at 9:52 a.m. with licensed vocational nurse (LVN) 1, Resident 1 ' s, Discharge Summary, dated 6/8/24 was reviewed. The summary was observed located in Resident 1's paper chart. The summary indicated, . Ibuprofen (pain medication) 800 mg (unit of measurement) every 6 hours as needed for pain . LVN 1 stated Resident 1 returned from a leave of absence (LOA) from the facility complaining of abdominal pain following an attack while on LOA and was sent to acute care hospital (ACH). LVN 1 stated Resident 1 was discharged from the ACH with order for pain medication three days ago on 6/8/24. LVN 1 stated the Ibuprofen 800 mg order was not completed or added to Resident 1 ' s orders and was not administered to Resident 1. LVN 1 stated it was important to record the medication order in Resident 1 ' s medication orders to ensure Resident 1 had proper pain management. During a review of Resident 1 ' s Medication Administration Record (MAR) dated June 2024, the MAR indicated Resident 1 did not have an order for Ibuprofen. During a concurrent interview and record review on 6/11/24 at 10:56 a.m. with the director of nursing (DON), Resident 1 ' s, Discharge Summary, dated 6/8/24 was reviewed. The Discharge Summary indicated, . Ibuprofen 800 mg every 6 hours as needed for pain . The DON stated the order was not completed and Ibuprofen was not administered to Resident 1 since returning from ACH on 6/8/24. The DON stated, Resident 1 had an order for a different pain medication and therefore the physician order was not completed. The DON stated the order from the ACH was not clarified with Resident 1 ' s physician upon arrival to the facility. The DON stated the expectation was for the charge nurse to call the physician to clarify the orders recommended from the ACH. The DON stated it was important to follow orders to make sure Resident 1 ' s pain was controlled. During an interview on 6/11/24 at 11:23 a.m. with the administrator (ADM), the ADM stated it was the facility expectation for the nurses to clarify and input any new orders into Resident 1 ' s medication orders. During a review of the facility ' s policy and procedure (P&P) titled, Physician Orders dated 8/21/2020, the P&P indicated, . The licensed nurse will confirm that physician orders are clear, complete and accurate as needed . the licensed nurse receiving the order will be responsible for documenting and carrying out the order . (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a professional reference review titled, Lippincott Manual of Nursing Practice 11th Edition dated 2020, pages 15 indicated, . Standards of Practice . General Principles . These standards describe what nursing is, what nurses do, and the responsibilities for which nurses are accountable . A deviation from the protocol should be documented in the patient ' s chart with clear, concise statements of the nurse ' s decisions, actions, and reasons for the care provided, including any apparent deviation. This should be done at the time the care is rendered because passage of time may lead to a less than accurate recollection of the specific events . Common Departures from the Standards of Nursing Care . Legal claims most commonly made against professional nurses include the following departures from appropriate care: .follow physician orders, follow appropriate nursing measures, communicate information about the patient . document appropriate information in the medical record . and follow physician ' s orders that should have been questioned or not followed . Common Legal Claims for Departure from Standards of Care . Failure to implement a physician ' s . order properly .