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	07/31/2024

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 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48713 Based on observation, interview, and record review the facility failed to ensure residents were free form involuntary seclusion not required to treat the resident's medical symptoms for two of three sampled residents (Resident 1 and Resident 2), when Licensed Vocational Nurse (LVN) 1 closed the door to Resident 1 and Resident 2's room while the needs of both residents (Resident 1 and Resident 2) were not met. This failure resulted in isolation for Resident 1 and Resident 2 and their basic care needs were unmet. Resident 1 expressed feeling sad, unheard and angry when she did not receive the assistance to leave her room to a quiet area of choice and was instead left in her room with Resident 2, while Resident 2 was yelling with closed door. Findings: During a concurrent observation and interview on 7/31/24 at 9:16 a.m. with Resident 1, in Resident 1's room. Resident 1 was observed crying while recalling events that transpired on 7/13/24. Resident 1 stated on the night of 7/13/24, Resident 2 was experiencing behaviors that included yelling. Resident 1 stated she asked Resident 2 to stop yelling because she could not sleep with all the noise. Resident 1 stated she called for assistance from CNA 1 using the call light. Resident 1 stated when CNA 1 entered the room, they were unable to communicate due to a language barrier. Resident 1 stated she understood CNA 1 saying she would notify LVN 1 and exited the room. Resident 1 stated she continued to call out for assistance until LVN 1 entered her room. Resident 1 stated she tried to report to LVN 1 that the yelling and screaming from Resident 2 was keeping her up and awake. Resident 1 stated she could not communicate with LVN 1 due to a language barrier. Resident 1 stated LVN 1 exited the room without speaking and closed the door to Resident 1's room. Resident 1 stated she felt angry and unheard when the LVN 1 left the room and closed the door while Resident 2 continued yelling. Resident 1 stated she had lowered her bed to the lowest position in an attempt to drag herself out of bed and crawled to the room door to open it and yell for help. (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 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 1'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), the AR indicated Resident 1 was admitted to the facility on [DATE] with diagnoses of Major Depressive Disorder (mental health disorder causes persistent low or depressed mood), muscle wasting and atrophy (thinning or loss of muscle), muscle weakness, rheumatoid arthritis (long lasting condition that affects the joints), heart failure, type 2 diabetes mellitus (lack of insulin production used to lower blood sugar), invasive pulmonary aspergillosis (infection affecting the lungs) . 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 4/17/24, the MDS indicated, Resident 1's Brief Interview for Mental Status (BIMS screening tool used to assess resident cognitive level) score was 7 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 cognitively impaired. During a review of Resident 1's Progress Note (PN) social services , dated 7/16/24, the PN indicated, . Saturday early morning [Resident 2 name] was screaming and yelling, and even using her little bell that she uses to call for assistance, [Resident 1 name] informed that [Resident 2 name] was being like this all of Friday night, so at 2:00 a.m. when [CNA 1 name] came to change her she asked her to put her in a wheelchair so she can sit in the lounge or where she can be out of her room, [CNA 1] stepped out and Resident 1 started yelling for assistance because she wanted to be taken out of the room. At that moment [LVN 1] came and shut the door without saying anything, Resident 1 feels very upset . During a concurrent observation and interview on 7/31/24 at 9:32 a.m. with Resident 2, Resident 2 was observed lying in bed watching television, Resident 2 was calm and quiet. Resident 2 stated she could not recall any specific events that occurred on the night of 7/13/24. During a review of Resident 2's Admission Record (AR), the AR indicated Resident 2 was admitted to the facility on [DATE] with diagnoses unspecified dementia (loss of memory, language and other thinking abilities) with mood disturbance, anxiety disorder (persistent and excessive worry that interferes with daily activities), Major Depressive Disorder, chronic obstructive pulmonary disease (COPD-lung disease causing restricted airflow and breathing problems) and repeated falls. During a review of Resident 2's MDS, dated [DATE], the MDS indicated, Resident 2's BIMS score was 7 out of 15 which indicated Resident 2 was cognitively impaired. During a review of Resident 2's Progress Note (PN) social services , dated 7/16/24, the PN indicated, . Resident was able to recall on Friday (7/13/24) during night shift a staff member came into the room, I asked her something, and she said she would get a CNA and walked out closing the door behind her . (continued on next page)

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/31/24 at 10:00 a.m. with CNA 2, CNA 2 stated Resident 1 and Resident 2 were having issues because they were unable to communicate with each other because of the language barrier. CNA 2 stated Resident 2 had episodes of yelling and hollering out to her family. CNA 2 stated she would communicate with Resident 2 by requesting assistance from another staff member who spoke the language Resident 1 spoke or by using the facility language line. CNA 2 stated it was unacceptable to ignore Resident 1's request for assistance because all facility staff have the resources to properly communicate with Resident. During an interview on 7/31/24 at 10:06 a.m. with CNA 3, CNA 3 stated she would communicate with Resident 1 using the language line in the facility or by requesting assistance from another staff member who would speak the same language. CNA 3 stated it was not acceptable for LVN 1 to walk out of Resident 1's room and close the door without attempting to figure out what Resident 1 was needing assistance with. During an interview on 7/31/24 at 10:11 a.m. with LVN 2, LVN 2 stated all residents had rights in the facility and should have been treated with dignity. LVN 2 stated that when LVN 1 left Resident1's room and closed the door, it was unacceptable. During an interview on 7/31/24 at 10:18 a.m. with RN 1, RN 1 stated the facility process was for the facility staff to use the language line to communicate with the residents who spoke a different language. The RN 1 stated it was not appropriate for LVN 1 to exit Resident 1's room and close the door. RN 1stated Resident 1 had the right to be safe and respected. During a review of LVN 1's training titled, Preventing Resident Abuse , dated 6/1/17, the training indicated, . This also includes depriving residents of goods or services that are necessary to attain or maintain their physical, mental, and psychosocial well-being . neglect is failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness . involuntary seclusion . confinement to his or her room against residents will or the will of the resident's legal representative .Employee signature [LNV1] .date . 4/13/21 . During a concurrent interview and record review on 7/31/24 at 11:18 a.m. with the Director of Staff Development (DSD), LVN 1's training titled Preventing Resident Abuse , dated 6/1/17, the training indicated, . This also includes depriving residents of goods or services that are necessary to attain or maintain their physical, mental, and psychosocial well-being . neglect is failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness . involuntary seclusion . confinement to his or her room against residents will or the will of the resident's legal representative . The DSD stated, LVN 1's last abuse training was conducted upon hire on 4/13/21. The DSD stated the abuse training was a mandatory training that should have been conducted yearly after hire date but was not completed for LVN 1. (continued on next page)

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/31/24 at 11:56 a.m. with the DSD, the DSD stated Resident 1 had reported that on the night of 7/13/24, LVN 1 had closed her door after she had requested assistance when Resident 2 was yelling and screaming causing Resident 1 to stay awake. The DSD stated Resident 1 reported that she felt tired and had requested for CNA 1 to assist her onto her wheelchair to leave the room. DSD stated CNA 1 reported to have informed LVN 1 of Resident 1's request. The DSD stated CNA 1 reported that LVN 1 had closed Resident 1's door when she had gone to Resident 1's room. The DSD stated she had informed CNA 1 that closing Resident 1's room caused her to become anxious. The DSD stated that Resident 1's room door should not have been closed or partially closed unless the resident had requested it. During an interview on 7/31/24 at 12:08 p.m. with the Assistant Director of Nursing (ADON), the ADON stated LVN 1 slightly closed door of Resident 1 and Resident 2's room. ADON stated based on the facility's internal investigation it was concluded that LVN 1 did not have an ill intent toward Resident 1 and met Resident 1's needs.The ADON stated it was appropriate for LVN 1 to slightly close the door to reduce noise out of respect to other residents in the facility. During an interview on 7/31/24 at 12:22 p.m. with the Administrator (ADM), the ADM stated that based on the facility's internal investigation, it was concluded that Resident 1's allegation toward LVN 1 was partially substantiated. The ADM stated that LVN 1 slightly closed Resident 1's room door to minimize noise and respect other residents residing on the unit. During a review of the facility's Reporting Form , dated 7/16/24, the form indicated, .Resident reported that on 7/13/24, Resident 2 had been screaming and using her bell to call for assistance. Resident 1 also turned on her call light and yelled for assistance for Resident 2. Around 2:00 a.m. CNA 1 came change Resident 2 and Resident 1 asked CNA 1 to take Resident 2 out of the room, to the lounge or somewhere where Resident 1 would not hear her scream. Resident 1 stated that the charge nurse . came to the room and shut the door on both of the residents . upon investigation and speaking with the CNAs and the nurse on duty that shift, it was found that the nurse (LVN1) was in the room assisting both residents and attended to all needs. As the nurse left the room, she did close the door slightly due to both residents (Resident 1 and Resident 2) were making a lot of noise and for respect to the other residents in the hallway . During a record review of the facility's policy and procedure P&P titled, Abuse -Prevention, Screening, & Training Program , dated July 2018, the P&P indicated, . Abuse is defined as the willful, deliberate infliction of injury, unreasonable confinement, involuntary seclusion, physical or chemical restraint not required to treat symptoms and/or imposed for the purpose of discipline or convenience, intimidation, exploitation, misappropriation of resident property, mistreatment, and injuries of unknown source or punishment with resulting harm, pain, or mental anguish. Abuse also includes the neglect and deprivation of goods and services that are necessary to attain or maintain physical, mental and psychosocial well-being . involuntary seclusion, unreasonable confinement, and isolation are defined as separation from other residents or from their room, or confinement to their room, with or without roommates, against their will, or the will of their resident representative . training, the facility conducts mandatory staff training programs during orientation, annually and as needed on prohibiting and preventing abuse, neglect, exploitation, misappropriation of resident property or mistreatment, identifying what constitutes abuse, neglect, exploitation misappropriation of resident property or mistreatment . understanding resident behavioral symptoms that may increase the risk of abuse and neglect and how to respond . (continued on next page)

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a record review of the facility's P&P titled, Resident Rights , dated 01/1/2012, the P&P indicated, . purpose to promote and protect the rights of all residents at the facility . employees are to treat all residents with kindness, respect, and dignity and honor the exercise of resident rights . these rights include, but are n limited to, a resident's right to . voice grievances and have the facility respond to those grievances in a prompt manner . the resident is encouraged to make choices about aspects of his or her life in the facility, including rooming with the person of his or her choice .