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	08/15/2024

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** 38961 Based on interview and record review, the facility failed to provide services which met professional standards of quality for one of nine sampled residents (Resident 1) when, Licensed Vocational Nurses (LVN)s did not administer oxygen (O2- a colorless, odorless and tasteless gas essential for life) per physician's order for Resident 1 and physician ordered parameters for O2 administration were not followed. LVNs did not document the administration of O2 treatment for Resident 1 in Treatment Administration Record (TAR). This failure had the potential for Resident 1 to receive inadequate amount of O2 which could affect her health and well-being. Finding: During a review of Resident 1's Admission Record (AR) (a document containing demographic information), undated, the AR indicated, Resident 1 was admitted to the facility on [DATE], with diagnoses that included Type 2 Diabetes Mellitus (body has trouble controlling blood sugar) Adult Failure to Thrive, Shortness of Breath, Hypoxemia (absence of enough oxygen in tissue to sustain bodily functions), Dependence on Supplemental Oxygen. During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool used to identify resident cognitive (mental) and physical functional level) assessment, dated 05/07/24, the MDS indicated, Resident 1's Brief Interview for Mental Status (BIMS) assessment score was 15 out of 15 (0-6 severe cognitive (pertaining to reasoning memory and judgement) deficit, 7-12 moderate cognitive deficit, 13-15 no cognitive deficit). BIMS scores indicated Resident 1 had no cognitive deficit. During a review of Resident 1's clinical record, The order Summary Report dated 04/30/24, indicated, . Oxygen @(at)3Liters/min (minutes-unit of measurement) via nasal cannula (thin plastic tube that delivers oxygen directly into the nose through two small prongs) to keep O2 Sat (measurement of oxygen in the blood) at/above 93% for shortness of breath every shift . (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 a concurrent interview and record review on 08/15/24 at 1:30 p.m. with LVN 1, Resident 1 ' s TAR dated May 2024, was reviewed. LVN 1 stated, the May 2024 TAR indicated, there were fifteen days 5/1, 5/2, 5/3, 5/5, 5/6, 5/7, 5/8, 5/9, 5/10, 5/15, 5/18, 5/19, 5/20, 5/27 and 5/31 physician ' s order was not followed for Resident 1. LVN 1 stated Resident 1 received 2 LPM (Liters Per Minute) of O2 instead of 3LPM per physician's order. LVN 1 stated the physician ' s order was not followed and Resident 1 could have difficulty breathing and O2 levels could drop. LVN 1 stated not following physicians order could endanger a resident ' s life. LVN 1 stated Resident 1 was dependent on oxygen. LVN 1 stated there was no documentation in the TAR for nine days 5/4, 5/13, 5/14, 5/16, 5/17, 5/21, 5/26, 5/28 and 5/31 that LVNs provided the physician ordered 02 treatment for Resident 1. During a concurrent interview and record review on 08/15/24 at 1:30 p.m. with LVN 1, Resident 1's TAR dated June 2024 was reviewed. LVN 1 stated there were thirteen days 6/1, 6/4, 6/6, 6/8, 6/10, 6/11, 6/12, 6/13, 6/14, 6/15, 6/18, 6/19, and 6/23 physician ' s order was not followed, and Resident 1 received 2 LPM of oxygen instead of 3 LPM. LVN 1 stated there was no documentation in the TAR for nine days 6/2, 6/3, 6/5, 6/6, 6/7, 6/10, 6/11, 6/12, and 6/23 that LVNs provided the physician ordered O2 treatment for Resident 1. During a concurrent interview and record review on 08/15/24 at 1:30 p.m. with LVN 1, Resident 1s TAR dated July 2024 was reviewed. LVN 1 stated there were four days 7/5, 7/9, 7/14, and 7/16 physician ' s order was not followed, and Resident 1 received 2 LPM of oxygen instead of 3LPM. LVN 1 stated there was no documentation in the TAR for one day 7/10, that LVNs provided the physician ordered O2 treatment for Resident 1. During a interview on 08/15/24 at 2:35 p.m. with LVN 2, LVN 2 stated staff failed to provide safe administration of O2 therapy as ordered by physician. LVN 2 stated, staff failed to follow physician orders. LVN 2 stated O2 orders were a priority order that should be always followed for the health and wellness of a resident. During a concurrent interview and record review 08/15/24 at 2:55 p.m. with Director of Nursing (DON) the TAR for Resident 1 dated May 2024, June 2024 and July 2024 was reviewed. The DON, stated the physician orders were for Oxygen @3Liters via nasal cannula to keep O2 sats at/above 93% for sob every shift. The DON, stated Resident 1 did not receive the physician ' s ordered O2 for seventeen days in May, instead Resident 1 received 2 LPM of O2. The DON stated, Resident 1 did not receive the physician ordered 02 for thirteen days in June. The DON stated Resident 1 did not receive the physician ordered 02 for four days in July. The DON stated LVNs did not follow physician orders. The DON stated she was responsible to provide oversight to ensure physician ' s orders were followed by LVNs. The DON stated she did not provide the oversight and was unaware the physician orders were not followed by LVNs for three months for Resident 1. During an interview on 08/15/24 at 3:30 p.m. with Assistant Director of Nursing (ADON). The ADON stated, the LVNs did not administer the physician ' s ordered amount of O2 to keep Resident 1 safe. The ADON stated Resident 1 could have experienced shortness of breath. and become hypoxic (absence of enough oxygen in tissue to sustain bodily functions). ADON stated the Medical Records Director (MRD) informed him of the missing information on Resident 1 ' s TAR but he did not follow up. ADON stated We have no way of knowing LVNs carried out the physician orders. (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 telephone interview on 08/16/24 at 10:26 a.m. with (MRD), the MRD stated she was responsible for daily audits of Medication Administration Record (MAR) and TARs. MRD stated she reviews the MARs and TARs for unsigned LVNs signature and medication administration and treatment by the LVNs. MRD stated when she noticed the documents were unsigned for Resident 1 in the TAR, she notified the LVNs. MRD stated she notified the DON and ADON regarding the unsigned TARs. During a review of the facility ' s policy and procedure (P & P) titled, Oxygen Therapy, dated 11/2017, the P&P indicated, .To ensure the safe storage and administration of oxygen in the Facility . Oxygen is administered . to meet the resident need . Licensed Nursing staff will administer oxygen as prescribed . Administer oxygen per physician order .Obtain O2 saturation levels as ordered by the physician .Oxygen orders will have parameters specified by the physician . During a review of the facility ' s P&P titled, Physician Orders dated 8/21/20, the P&P indicated, .To have a process to verify that all physician orders are complete and accurate . During a review of the facility ' s document titled, LVN STAFF NURSE JOB DESCRIPTION undated, the P&P indicated .A licensed professional nurse under the supervision of a Registered Nurse who provides nursing care and services to residents in a long term care setting .Ability to provide quality patient care in accordance with applicable standards, policies and procedures .Provides nursing care as prescribed by physician/health care professional in accordance with the legal scope of practice. Administers professional services and provide care consistent with allowing residents to attain or maintain his or her highest practicable physical, mental, and emotional well-being .Completes medical treatment as indicated and ordered by the physician .