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	02/04/2026

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure residents received necessary services for activities of daily living to maintain personal and oral hygiene for three of four sampled residents (Resident 1, Resident 2, Resident 3), when the facility staff did not provide oral care or grooming to Resident 1, Resident 2 and Resident 3 daily. These failures resulted in Resident 1, Resident 2 and Resident 3 to feel unclean and placed residents at risk for loss of dignity and potential tooth decay, oral, respiratory and skin infections.Findings:During a review of Resident 1's admission Record (AR- a summary of information regarding a resident 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 diagnosis for hemiplegia (weakness or complete loss of movement in the arm, leg, and sometimes face on that side) affecting left non-dominant side, Dysarthria (speech disorder making words hard to form due to weak, slow, or uncoordinated speech muscles), Contracture (stiff joints and reduced, painful mobility) of muscle multiple sites, muscle weakness, Contracture right hand, Contracture left shoulder, elbow, wrist.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 1/14/26, the MDS indicated, Resident 1's Brief Interview for Mental Status (BIMS screening tool used to assess resident cognitive level) score was 10 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 had moderate cognitive impairment.During an observation and interview on 2/4/26 at 11:53 a.m. with Resident 1 in Resident 1's room, Resident 1 was observed to have long fingernails with brown substance inside, teeth were observed with white buildup and breath had foul odor, Resident 1 was observed with long facial hair. Resident 1 stated he could not remember the last time his teeth were brushed and nails were cut or trimmed. Resident 1 stated he does have a history of refusing showers but never refused to brush his teeth, shave or cut his nails. Resident 1 stated the facility staff should have automatically included teeth brushing and grooming as part of his activities of daily living as this was important to him. Resident 1 stated the staff did not offer to brush his teeth on a daily basis. Resident 1 stated he should not have to ask facility staff to assist him with performing activities of daily living as they were a part of his plan of care. Resident 1 stated at the time of the interview, he had not been assisted to complete his activities of daily living for grooming from any staff in the facility.During a concurrent observation and interview on 2/4/26 at 11:55 a.m. with certified nursing assistant (CNA) 1, Resident 1 was observed to have long fingernails with brown substance inside, teeth were observed with white buildup and breath had foul odor, Resident 1 was observed with long facial hair. CNA 1 stated Resident 1 appeared as if it had been longer than a few days since personal hygiene was completed as Resident 1 had long facial hair, long and dirty (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	fingernails and dirty teeth with visible buildup.During a record review of Resident 1's document titled, Activities of Daily Living, dated 2/2026, the document indicated, Resident 1 had nail care completed on 2/1/26 and 2/2/26, oral hygiene completed on 2/2/26 and 2/3/26 and shaved on 2/3/26.During a concurrent observation, interview and record review on 2/4/26 at 12:03 p.m. with Registered Nurse (RN) 1 in Resident 1's room, Resident 1 was observed to have long fingernails with brown substance inside, teeth were observed with white buildup and breath had foul odor, Resident 1 was observed with long facial hair. During a record review of Resident 1's document titled, Activities of Daily Living, dated 2/2026, the document indicated, Resident 1 had nail care completed on 2/1/26 and 2/2/26, oral hygiene completed on 2/2/26 and 2/3/26 and shaved on 2/3/26. RN 1 stated Resident appeared to have not been shaved for a few weeks, teeth appeared to not have been brushed for more than a few days, and nails appeared dirty, long and uncut. Resident 1 told RN 1 that his nails had not been cut or trimmed for months. RN 1 stated the expectation was for the CNAs to complete all personal hygiene for every resident daily. During a review of Resident 1's document titled, Activities of Daily Living Care Plan, dated 2/11/2023, the care plan indicated, The Resident has an ADL self-care performance deficit and resident at risk for declining self-performance related to limited mobility. interventions. Oral hygiene: the resident requires maximum assistance by one staff with oral care. Personal hygiene: the resident is dependent on one staff for personal hygiene.During a review of Resident 2's admission Record, the AR indicated, Resident 2 was admitted to the facility on [DATE] with diagnosis for Visuospatial deficit (issues with depth perception, spatial orientation, and object recognition), hemiplegia affecting left non-dominant side, muscle weakness, Gastroesophageal reflux disease (GERD- a condition where stomach acid flows back into the throat, causing chest pain, and difficulty swallowing), need assistance with personal care.During a review of Resident 2's Minimum Data Set, dated [DATE], the MDS indicated Resident 2's Brief Interview for Mental Status score was 12 out of 15 which indicated Resident 2 had moderate cognitive impairment.During an interview on 2/4/26 at 12:22 p.m. with Resident 2, Resident 2 stated she had been in the facility for a few months. Resident 2 stated part of her plan of care included teeth brushing and grooming which was not offered in the facility. Resident 2 stated she did not get her teeth brushed often as the staff had mentioned in the past that they did not have time. Resident 2 stated she would like to be able to brush her teeth every morning and night as part of her daily routine. Resident 2 stated she felt dirty and felt the lack of tooth brushing had caused her to experience tooth pain as her teeth were dirty.During a review of Resident 3's admission Record, the AR indicated, Resident 3 was admitted to the facility on [DATE] with diagnosis for spastic hemiplegia (chronic stiffness, muscle weakness, and poor motor control on one side of the body) affecting left nondominant side, arthritis (swelling and tenderness of one or more joints), muscle weakness, dependance on wheelchair.During a review of Resident 3's Minimum Data Set dated 1/21/2026, the MDS indicated, Resident 3's Brief Interview for Mental Status score was 12 out of 15 which indicated Resident 3 had moderate cognitive impairment.During an observation and interview on 2/4/26 at 12:43 p.m. with Resident 3 in Resident 3's room, Resident 3's teeth were observed with white and yellow buildup and breath had foul odor. Resident 3 stated he had not been offered supplies and staff had not offered to assist in brushing his teeth daily. Resident 3 stated brushing his teeth were part of his care that should have been completed without having to request it from the facility staff. Resident 3 stated he should not have to request basic care such as grooming or brushing teeth because the facility staff should have been completing that task. Resident 3 stated he felt dirty and could smell there was a foul odor on himself. Resident 3 stated he would like help and assistance in brushing his teeth every day.During an interview on 2/4/26 at 12:56 p.m. with (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	licensed vocational nurse (LVN) 1, LVN 1 stated the facility expectation was for the CNAs to ensure resident activities of daily living were completed. LVN 1 stated activities of daily living included grooming, teeth brushing, showering, shaving and nail cutting. LVN 1 stated teeth brushing should have been completed daily for each resident as part of their plan of care. LVN 1 stated, Residents should not have been asking for assistance with brushing their teeth but instead the CNAs should have completed the task as part of their care. LVN 1 stated when residents' teeth were not brushed there was a potential for buildup of decay, tooth pain and possible infections. LVN 1 stated personal hygiene was important for the residents to feel clean and to avoid preventable infections, skin breakdown and respiratory issues.During a concurrent observation and interview on 2/4/26 at 1:05 p.m. with CNA 1, in the hallway with Resident 2, Resident 2 stated she had not had her teeth brushed but was unable to open her mouth due to oral pain experienced. CNA 1 stated the facility process for resident personal care was for the CNA to assist each resident with bathing, grooming including brushing hair, shaving and tooth brushing. CNA 1 stated personal care should be completed before breakfast or as requested by each resident. CNA 1 stated Resident 1, Resident 2, and Resident 3 had not been offered to brush their teeth. CNA 1 stated it was important to complete oral hygiene to prevent infections. CNA 1 stated personal hygiene was important for each resident to ensure the residents felt clean and to prevent skin breakdown.During a record review of Resident 2's document titled, Activities of Daily Living, dated 2/2026, the document indicated that Resident 2's oral hygiene was completed 2/3/26 and 2/4/26.During a review of Resident 3's document titled, Activities of Daily Living, dated 2/26, the document indicated there was no documentation for Resident 3's oral hygiene since admission on [DATE].During a concurrent interview and record review on 2/4/26 at 1:26 p.m. with LVN 1, Resident 2's document titled, Activities of Daily Living, dated 2/2026 and Resident 3's document titled, Activities of Daily Living, dated 2/26 were reviewed. Resident 2's document indicated that Resident 2's oral hygiene was completed 2/3/26 and 2/4/26. Resident 3's document indicated there was no documentation for oral hygiene since admission on [DATE]. LVN 1 stated there should have been documentation for Resident 3 to ensure Resident 3's oral hygiene was completed daily.During an interview on 2/4/26 at 2:00 p.m. with the director of nursing (DON), the DON stated the facility expectation was for the CNAs to complete all personal hygiene for each resident. The DON stated personal hygiene should have been completed in the morning unless the residents requested a different time. The DON stated it was important to ensure oral hygiene was completed to prevent tooth decay or infections.During an interview on 2/4/26 at 2:16 p.m. with the administrator (ADM), the ADM stated the facility expectation was for the facility staff to provide all personal care needed to all residents in the facility. During an interview on 2/11/26 at 1:30 p.m. with the director of staff development (DSD), the DSD stated the facility expectation was for the CNAs to complete all activities of daily living for each resident daily including teeth brushing, bathing and grooming. The DSD stated the expectation was for the CNAs to complete personal hygiene tasks before breakfast for each resident, unless the resident requested a different time. The DSD stated it was the facility staff's responsibility including CNAs, Restorative Nurse Aide (RNA)s or nurses to ensure the activities of daily living task were completed. The DSD stated it was important for personal hygiene task to be completed to ensure residents were clean and groomed.During a review of the facility's policy and procedure (P&P) titled, Resident Rights, dated 1/1/12, the P&P indicated, .Purpose: To promote and protect the rights of all residents at the Facility. Residents of skilled nursing facilities have a number of rights under state and federal law. The Facility will promote and protect those rights. Residents have freedom of choice, as much as possible, about how they wish to live their everyday lives and receive care, subject to (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the Facility's rules and regulations and applicable state and federal laws governing the protection of resident health and safety. Employees are to treat all residents with kindness, respect, and dignity and honor the exercise of residents' rights. Procedure. The Facility makes every effort to assist each resident in exercising his/her rights by providing the following services: The Facility's Staff encourages residents to participate in planning their daily care routines. Each resident is allowed to choose activities, schedules and health care that are consistent with his or her interests, assessments and plans of care, including: Sleeping, eating, exercise and bathing schedules; Personal care needs, such as bathing methods, grooming styles and dress. Residents are provided assistance as needed to engage in their preferred activities on a routine basis.During a review of the facility's P&P titled, Oral Care, dated 1/1/12, the P&P indicated, .Purpose: All residents receive appropriate oral care, including denture care if applicable, daily. Policy: It is the responsibility of each staff member within the nursing department is to ensure good oral care for each resident. Each toothbrush of a resident must be labeled with resident's name, unless kept in the resident's bedside drawer.During a review of the facility's P&P titled, Grooming Care of Fingernails and Toenails, dated 10/21/21, the P&P indicated, .Purpose: Nail care is given to clean the nail bed and keep the nails trimmed. Fingernails are trimmed by Certified Nursing Assistants (CNAs), except for Residents with diabetes or circulatory impairments, this includes all toenails except for high-risk Residents.During a review of the facility's P&P titled, Showering and Bathing, dated 1/1/12, the P&P indicated, Purpose: A tub or shower bath is given to the residents to provide cleanliness, comfort and to prevent body odors. Policy: Residents are given tub or shower baths unless contraindicated. Observe the skin is performed during bath.