

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055626	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/25/2026
NAME OF PROVIDER OR SUPPLIER  Healthcare Centre of Fresno		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and record review the facility failed to meet professional standards of practice and follow the policy and procedure titled, Referrals to Outside Services, Resident Rights and NP04 Comprehensive Person-Centered Care Planning for two of five sampled residents (Residents 2 and Resident 3) when: 1. Licensed Nurse (LN) did not develop a care plan when Resident 2 refused all showers from 1/26/26-2/19/26.This failure had the potential to result in Resident 2 developing wounds and infections.2. Social Service department did not provide Resident 3 with transportation to his urology [a specialized branch of medicine that focus on diseases of the male and female urinary tract (the body's drainage system for removing waste and extra fluid, acting as a filter to produce, transport, store, and release urine)] appointment to assess removing his urinary catheter (a hollow tube inserted into the bladder to drain or collect urine) for discharge and Resident 3 missed his appointment.This failure had the potential to result in Resident 3 discomfort, developing an infection, and delayed discharge.Findings:1.During a review of Resident 2'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), indicated, Resident 2 was admitted to the facility on [DATE] with diagnosis that included progressive neuropathy (disease or dysfunction of one or more nerves, typically causing numbness or weakness in the hands and feet), type 2 Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), Congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling).During a review of Resident 2's Minimum Data Set [MDS a resident assessment tool used to identify cognitive (mental processes) and physical functional level assessment] dated 2/4/26, the MDS indicated, Resident 2'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 2 had moderate cognitive impairment.During a concurrent observation and interview on 2/25/26 at 11:50 a.m., in Resident 2's room, Resident 2 was sitting on the side of his bed and Licensed Vocational Nurse (LVN) 1 and Certified Nurse Assistant (CNA) 5 were providing care to Resident 2. LVN 1 stated Resident 2 refused showers and bed baths a lot. LVN 1 confirmed Resident 2 did not have a care plan for refusing showers. LVN 1 stated all residents should get two showers or baths in a week and if a resident was refusing, they should have started a care plan.During a concurrent interview and record review on 2/25/26 at 12:26 p.m. with RN 1, RN 1 stated Resident 2 refused showers a lot. RN 1 confirmed there was no care plan created for Resident 2 refusing showers. RN 1 stated a care plan should have been developed for Resident 2 refusing showers because repeated missed showers can lead to skin infections and other problems.During a concurrent interview and record review on 2/25/26 at 3:26 p.m., with Director of Nursing (DON), Resident</p> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 055626
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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2's care plans and Skin Monitoring Comprehensive CNA Shower Review forms dated 1/27/26-2/24/26 were reviewed. DON stated Resident 2 refused showers and bed baths repeatedly. DON reviewed Resident 2's medical record of care plans and stated Resident 2 had no care plan for refusing showers past or present. Shower documentation from 1/27/26 through 2/24/26 indicated Resident 2 had refused all nine offered showers and consented to three bed baths (2/3, 2/13, and 2/24). DON confirmed the forms dated 1/26/26, 2/2/26, and 2/5/26 indicated Resident 2 had refused showers and bed baths three times but the areas on the form for charge nurse assessment, intervention, and forwarded to DON were all left blank. DON confirmed Resident 2 had partial bed bath documented on 2/12/26, 2/16/26, and 2/19/26 due to refusing shower. The areas on the form for charge nurse assessment, intervention, and forwarded to DON were all left blank. DON stated her expectation was for all residents to be bathed at least two times a week and if a resident refused to be bathed, a care plan should be created after the first refusal. DON stated possible outcomes from not bathing included infection, wounds, and other complications.2. During a review of Resident 3's AR, dated 2/25/2026, indicated, Resident 3 was admitted to the facility on [DATE] with diagnosis including Cerebral Infarction (brain tissue dies due to lack of oxygen) with hemiplegia (paralysis of one side of the body) and hemiparesis (partial weakness on one side of the body), type 2 Diabetes Mellitus, major depressive disorder, retention of urine, anxiety disorder, and urinary tract infection (UTI- an infection in the bladder and urinary tract).During a review of Resident 3's MDS, dated [DATE], indicated, Resident 3 had a BIMS score of 12 out of 15 which indicated Resident 22 had moderate cognitive impairment.During a concurrent observation and interview on 2/25/26 at 2 p.m., in the facility smoking area, Resident 3 was sitting in his wheelchair, smoking, and talking to a visitor. Resident 3 stated he was upset because he still had his urinary catheter. Resident 3 stated he was supposed to see a urologist (a medical doctor who specializes in treating urinary tract diseases) to take out his catheter so that he could go home but the facility did not have a ride for him, so he missed his appointment. Resident 3 stated the soonest his wife could get him another appointment was for almost in a month.During a concurrent interview and record review on 2/25/26 at 2:15 p.m., with Social Service Director (SSD) 2, Resident 3's social service notes were reviewed. SSD 2 stated the process for getting transportation for residents to outside appointments was for the nurses to put the appointment in the calendar and send the calendar to SSD each morning to set up transportation for that day. SSD 2 stated that Resident 3 had a follow up urology appointment on 2/13/26 at 10:45 a.m. that he missed due to not having transportation. SSD 2 stated he did not receive notice that Resident 3 had an appointment or needed a ride until it was too late to get Resident 3 to his appointment.During an interview on 2/25/26 at 2:25 p.m., with SSD 1, SSD 1 stated Resident 3's missed appointment was her fault. SSD 1 stated when Resident 3 was being admitted , she was made aware of his Urology appointment and told the nurse she would put it on the calendar but forgot to. SSD 1 stated the facility provided residents with transportation to appointments for services not provided in the facility. SSD 1 confirmed the facility did not have a Urologist. SSD 1 stated there was no written process for setting up transportation for the residents to reference.During a concurrent interview and record review on 2/25/26 at 3:26 p.m., with DON, Resident 3's social service and nursing notes dated 2/13/26 were reviewed. DON stated Resident 3 had missed his urology appointment on 2/13/26 because the facility had not provided transportation. DON stated Resident 3 was supposed to be assessed to have his urinary catheter removed so that he could return to his home in an Assisted Living Facility (ALF). DON stated Resident 3's ALF would not let him return with a urinary catheter. DON stated Resident 3 missing his urology appointment could result in delayed discontinuation of his urinary catheter and delayed discharge for Resident 3. DON confirmed</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident 3 did not have a care plan for providing transportation to outside appointments or for ensuring Resident 3 made it to those appointments. The facility Policy and Procedure (P&amp;P) titled NP04 Comprehensive Person-Centered Care Planning dated 9/7/23 indicated, . a. a. The facility must develop and implement a comprehensive person-centered care plan for each resident consistent with the resident rights, that includes measurable objectives, and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following: i. The services that are to be furnished to attain or maintain the resident's highest practical physical, mental, and psychosocial well-being. ii. Any services that would otherwise be required under, but are not provided due to resident's exercise of rights, including the right to refuse treatment. iv. In consultation with the resident and the resident's representative: 1. The resident goals for admission and desired outcomes. 2. The resident's preference and potential for future discharge. The facility P&amp;P titled Referrals to Outside Services dated 8/31/22, indicated, . The Director of Social Services coordinates the referral of residents to outside agencies/programs to fulfill resident needs for services not offered by the Facility. The facility P&amp;P titled Resident Rights dated 1/1/12, indicated, . I. State and federal laws guarantee certain basic rights to all residents of the Facility. These rights include, but are not limited to, a resident's right to . C. Choose a physician and treatment and participate in decisions and care planning; II. The Facility makes every effort to assist each resident in exercising his/her rights by providing. C. Transportation to community activities can be arranged (when possible) through the Activity or Social Service Departments. III. 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: Personal care needs, such as bathing methods, grooming styles and dress. During a professional reference review retrieve from <a href="https://www.nursingworld.org/practice-policy/workforce/what-is-nursing/the-nursing-process/">https://www.nursingworld.org/practice-policy/workforce/what-is-nursing/the-nursing-process/</a> the professional reference indicated, . Nursing care is implemented according to the care plan, so continuity of care for the patient during hospitalization and in preparation for discharge needs to be assured. Both the patient's status and the effectiveness of the nursing care must be continuously evaluated, and the care plan modified as needed .</p>		