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	05/08/2026

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Individual Narcotic Record (INR) for Controlled Drugs (medications that are highly regulated by the government because of the significant risk of abuse and dependence they pose) were maintained accurately for five of six sampled residents (Resident 26, Resident 74, Resident 139, Resident 158 and Resident 159) when:1. The Licensed Nurse (LN)s transferred controlled medications for Resident 26 and Resident 158 from one medication cart to another, and the INR was not accurately completed by two required witnesses as indicated on the INR. This failure had the potential for Resident 26 and Resident 158 controlled medications to be diverted (illegal transfer or use of prescription medication) and Resident 26 and Resident 158's pain not to be met.2. Resident 74, Resident 139 and Resident 159 were administered controlled medications, and the INR was not signed by the LNs for each of the residents according to the facility's policy and procedure (P&P) titled, Medication Administration- IIA7: CONTROLLED MEDICATIONS.This failure had the potential for lost, misuse or abuse of medications for Resident 74, Resident 139 and Resident 159's medication3. Controlled medications were not reconciled by LNs at the beginning and end of shift according to the facility's policy and procedure.This failure had the potential for controlled drugs to be diverted and documentation to be inaccurate, which could bring about LNs administering the wrong dosage or type of medication, thus putting residents at risk of severe adverse effects or fatal complications.Findings:1. During a concurrent record review and interview on 5/6/26 at 11:16 a.m., with Licensed Vocational Nurse (LVN) 7 on Station 3 medication cart 1, Resident 26's INR was reviewed, the INR indicated Resident 26 had 30 capsules of Pregabalin (Schedule V controlled medication that calms overactive nerves in your body)100mg which was received on 3/22/26. The INR indicated moved to other cart No.2. There was no date of transfer or signature of giving or receiving LN for the controlled medication. There was no information on the disposition of unused drug section at the bottom of the INR page for Resident 26. LVN 7 stated there should be double signature on the INR indicating the giving or receiving LN, and the amount of Pregabalin 100mg capsules transferred to Cart 2 should have been indicated.During a review of Resident 26's admission Record (AR- a summary of important information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 5/8/26, the AR indicated Resident 26 was admitted to the facility on [DATE] with a diagnosis which included mononeuropathy of bilateral lower limbs (specific nerve in both legs is damaged, compressed, or inflamed).During a review of Resident 26's Order Summary Report (OSR), dated 3/20/26, the OSR indicated, Resident 26 had an active order for . Pregabalin oral capsule 100 mg (milligrams- unit of measurement) - give one capsule by mouth three times a day During a review of Resident 26's Minimum Data Set (MDS - a resident assessment tool used to identify resident cognitive and physical function) assessment dated [DATE], Resident 26's MDS assessment indicated Resident 26's Brief Interview for Mental Status (BIMS -assessment of cognitive status for memory and judgment) assessment score was 12 out of 15 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07 indicates severe (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	impairment). The BIMS assessment indicated Resident 26 was moderately impaired.During a review of Resident 26's INR,, the INR indicated the Pregabalin Cap 100mg -Take 1 cap po TID was moved to other cart No. 2 and was not signed off by the LNs.During a concurrent Interview and record review with LVN 5 on 5/6/26 at 3:47 p.m., on Station 1 medication cart 1, Resident 158's INR was reviewed, the INR indicated there were 24 capsules of Pregabalin 50mg left on 11/6/25 and the medication was given to ALF (Assisted Living Facility- residential senior living option that provides support for older adults who need help with daily tasks but do not require the intensive care). The INR indicated there was only one signature appended on the INR, which was the receiving LN's signature. LVN 5 stated whenever a controlled medication was transferred, the INR should be signed by two LNs, the receiving LN and the LN giving the medication. LVN 5 stated Resident 158 had 24 medications left on 11/6/25 and the medication was given to ALF because Resident 158 transferred to ALF. LVN 5 stated it was important that the controlled medication should be signed by 2 LNs because it was a controlled substance and had the potential for diversion.During a review of Resident 158's AR, dated 5/8/26, the AR indicated Resident 158 was admitted to the facility from an acute care hospital on [DATE] with diagnoses which included . Neuropathy (damage to the nerves outside the brain and spinal cord, which act as the body's wiring system) .During a review of Resident 158's MDS, dated [DATE], the MDS section C indicated Resident 158 had a BIMS score of 13, which indicated Resident 158 was cognitively intact.During a review of Resident 158's OSR dated 9/20/25, the OSR indicated Resident 158 had physician orders . Pregabalin oral capsule 50 mg - give one capsule by mouth three times a day.During a review of Resident 158's INR,, the INR indicated the Pregabalin Cap 50mg -Take 1 cap po TID was given to ALF and was signed by only one LN with no date indicating when the medication was transferred to ALFDuring an interview on 5/8/26 at 8:25 a.m. with LVN 4, LVN 4 stated the expectation was for two LNs to sign for the transfer of the controlled drug from one medication cart to another medication cart.During an interview on 5/8/26 at 1:36 p.m. with LVN 2, LVN 2 stated the expectation was for the LNs to sign at the bottom of the page, there is designated spot for who was receiving and giving the medication. LVN 2 stated this was important because the medications are controlled medication, and to ensure they were safely transported from one area to another.During an interview on 5/8/26 at 4:19 p.m. with the Director of Nursing (DON), the DON stated at the bottom page of the INR, there was the disposition section and the expectation was the section should be completed by the receiver and the giver, so it keeps a trail of where the narcotics went2. During a concurrent record review and interview with LVN 7 on 5/6/26 at 11:01 a.m., on Station 3 medication cart 1, Resident 139's INR was reviewed, the INR indicated after medication administration on 11/13/25 there were 3 tablets of Phenobarbital (used to treat seizures and as a sedative)30mg tablets left. LVN 7 stated she did not know where the remaining medication was and would find out.During a review of Resident 139's AR, dated 5/8/26, the AR indicated Resident 139 was admitted to the facility on [DATE] with diagnoses which included . Epilepsy unspecified (a long-term brain condition that causes repeated seizures[sudden, uncontrolled burst of abnormal electrical activity in the brain]), .During a review of Resident 139's MDS, dated [DATE], the MDS section C indicated Resident 139 had a BIMS score of 2, which indicated Resident 139 was severely cognitively impaired.During a review of Resident 139's OSR dated 4/18/25, the OSR indicated Resident 139 had physician orders . Phenobarbital oral tablet 30 mg give 45 mg by mouth at bedtime for unspecified convulsion given 1-1/2 tab (total 45 mg) .During a review of Resident 139's INR,, the INR indicated Phenobarbital 30 mg tab with no direction for administration, no date received, and no information on who received the medication. The INR indicated Resident 139 received 3 doses of Phenobarbital 30 mg tab (total-30x3=90mg) for each administration at 2100 on 11/5/25, 11/6/25, 11/7/25, 11/8/25, 11/9/25, 11/10/25, 11/11/25, 11/12/25 and 11/13/25 though the OSR indicated phenobarbital oral tablet 30 mg give 45 mg by mouth at bedtime for unspecified convulsion given 1-1/2 tab (total 45 mg). The INR indicated the medication was last documented as administered 11/13/25 and there were three tablets left. The INR indicated there was no documentation of the medications administered or (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	wasted and there was no documentation of the medications returned to the DON. During a review of Resident 139's MAR, the MAR indicated Phenobarbital 30 mg tab phenobarbital oral tablet 30 MG (Phenobarbital)-Give 45 mg by mouth at bedtime for unspecified convulsion given 1-1/2 tab (total 45 mg) . and was checked off as administered to Resident 139 on 11/13/25 and on 11/14/25.During an interview on 5/6/26 at 1:48 p.m. with LVN 4 in the conference room, LVN 4 stated Resident 139's Phenobarbital 30 mg tab was administered in the MAR on 11/14/25 but the LN forgot to sign the medication in the INR.During a concurrent record review and interview on 5/6/26 at 11:03 a.m., with LVN 7 on Station 3 medication cart 1, Resident 74's INR was reviewed, the INR indicated Morphine sulfate ((a Schedule II controlled medication used for relief of moderate to severe acute and chronic pain) 30mg ER- last administered 12/7/25 showing 1-tab remaining. LVN 7 stated she would assume the medication was administered but was not signed off.During a review of Resident 74's AR, dated 5/8/26, the AR indicated Resident 74 was admitted to the facility from an acute care hospital on 3/13/20 with diagnoses which included . Encounter for orthopedic aftercare following surgical amputation, polyneuropathy (condition where multiple nerves outside the brain and spinal cord become damaged, causing widespread numbness, tingling, or weakness), generalized osteoarthritis (a degenerative joint disease, in which the tissues in the joint break down over time), .During a review of Resident 74's MDS, dated [DATE], the MDS section C indicated Resident 74 had a BIMS score of 11, which indicated Resident 74 was moderately impaired.During a review of Resident 74's OSR dated 9/19/24, the OSR indicated Resident 74 had physician orders . Morphine Sulfate ER 30mg tablet extended release- take one tablet by mouth twice a day for chronic pain.During a review of Resident 74's INR,, the INR indicated Morphine Sul tab 30mg ER -Take 1 po BID was last documented as administered 12/17/25 and there was one tablet remaining. The INR indicated there was no documentation of the medication administered or wasted and there was no documentation of the medication returned to the DONDuring a review of Resident 74's MAR, the MAR indicated Morphine Sulfate ER 30mg tablet extended release- take one tablet by mouth twice a day for chronic pain and was checked off as administered to Resident 74 on 12/17/25 and on 12/18/25.During a concurrent interview and record review on 5/6/26 at 11:10 a.m., with LVN 7 on Station 3 medication cart 1, Resident 159's INR was reviewed, the INR indicated Buprenorphine dis(used to treat opioid addiction) 5mg - patch- 1 patch remaining on 3/2/26. LVN 7 stated she would assume whoever gave the patch after that day did not sign the patch out, the last date the patch was administered was 3/2/26 and Resident 159 was discharged on 3/10/26.During a review of Resident 159's AR, dated 5/8/26, the AR indicated Resident 159 was admitted to the facility from an acute care hospital on 5/1/25 with diagnoses which included .generalized osteoarthritis, .During a review of Resident 159's MDS, dated [DATE], the MDS section C indicated Resident 159 had a BIMS score of 12, which indicated Resident 159 was cognitively intact.During a review of Resident 159's OSR dated 10/22/25, the OSR indicated Resident 159 had physician orders . Buprenorphine Transdermal patch weekly 5mg/hr- apply 1 patch trans dermally in the afternoon every Mon for chronic pain.During a review of Resident 159's INR,, the INR indicated Buprenorphine Dis 5mg/hr-apply 1 patch q Monday was last documented as administered 3/2/26 and there was one patch left. The INR indicated there was no documentation of the patch administered or wasted and there was no documentation of the patch returned to the DONDuring a review of Resident 159's MAR, the MAR indicated .Buprenorphine Transdermal Patch Weekly 5 MCG/HR (Buprenorphine) Apply 1 patch trans dermally in the afternoon every Mon for chronic pain. and was checked off as administered to Resident 159 on 3/2/26 and on 3/9/26.During an interview on 5/8/26 at 8:25 a.m. with LVN 4, LVN 4 stated there was the potential controlled medication had been diverted. LVN 4 stated if the controlled medications were administered in the MAR and were not documented in the INR, then it was not done.During an interview on 5/8/26 at 1:42 p.m. with LVN 2, LVN 2 stated there was missing documentation. LVN 2 stated the LNs were violating the rights of the resident to receive their medication.During an interview on 5/8/26 at 4:03 p.m. with the DON, the DON stated the facility would have to come up with a process where there was proper (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	audit of controlled medications. The DON stated the auditing of controlled medication was not done effectively.During an interview on 5/8/26 at 4:17 p.m. with the DON, the DON stated the failure to properly audit controlled medications could potentially lead to diversion of the controlled medications. 3. During a concurrent interview and record review on 5/6/26 at 11:19 a.m., with LVN 7 on Station 3 medication cart 1, the INR was reviewed with LVN 7. The INR indicated, there were 5 unsigned entries by LNs in the month of October 2025, 4 unsigned entries by LNs in the month of November 2025, 1 unsigned entries by LNs in the month of April 2026 and 2 unsigned entries by LNs in the month of May 2026. The INR indicated there were uncompleted entries (such as dates, comments indicating how many controlled medications were in the medication cart) 16 times from October 2025 to May 2026. LVN 7 stated the expectation was for two LNs to count the number of controlled medications on every shift and both LNs should sign. LVN 7 stated it was important to follow the process of counting controlled medications at the beginning and end of each shift because controlled substances are very important to be documented correctly, if any of them got lost it could be dangerous for other residents and it could get into a resident or staff's hands who the controlled medication was not prescribed to. LVN 7 stated the affected person could die from taking a medication not prescribed to them or overdose on the medication. LVN 7 stated this failure had the potential to also affect the resident who was prescribed the controlled medication because they would not receive their medication. LVN 7 stated this could potentially lead to unmanaged pain, or residents could have withdrawals symptoms.During a concurrent record review and interview on 5/6/26 at 3:47 p.m., with LVN 5 on Station 1 medication cart 1, the INR was reviewed with LVN 5. The INR indicated, there was 1 unsigned entries by LNs in the month of November 2025. LVN 5 stated the oncoming and the off going LNs were expected to sign the Controlled log. LVN 5 stated this was important because it was the accounting of the medication, once the LNs counts the controlled medications they are responsible for the medications.During an interview on 5/8/26 at 11:39 a.m. with LVN 2, LVN 2 stated when a LN is taking over a medication cart, they are taking responsibility for those controlled medications in the cart, hence the need to ensure accuracy of the count of the controlled medications. LVN 2 stated the expectation from the LN was they should be counting properly and signing the logs right away. LVN 2 stated the failure to count controlled medications at the beginning and end of each shift could create conflict at shift change. During an interview on 5/8/26 at 4:17 p.m. with the DON, the DON stated expectation was both LNs should sign the controlled log at the beginning and at the end of each shift. The DON stated this was important because the LNs are counting controlled medication and passing the information onto the next shift to prove the count was accurate.During a review of professional reference Diversion of Drugs Within Health Care Facilities, a Multiple-Victim Crime: Patterns of Diversion, Scope, Consequences, Detection, and Prevention, dated July 2012, (found at https://pmc.ncbi.nlm.nih.gov/articles/PMC3538481/) indicated, .Healthcare workers who are diverting drugs from the health care facility workplace pose a risk to their patients, their employers, their co-workers, and themselves. It is essential that all health care institutions have a robust system in place to identify and investigate suspected diversion as rapidly and efficiently as possible and that they implement policies and procedures that enable a standardized and effective response to confirmed diversion. Drug diversion by healthcare workers violates the core value that the needs of the patient come first. Clearly, if we are to optimize our approach to inpatient drug diversion and its consequences, we must look at such diversion not as a victimless act but as a multiple-victim crime.During a review of the facility's Policy and Procedure (P & P) titled, Medication Administration-IIA7: CONTROLLED MEDICATIONS, dated 3/26, the P&P indicated, .Policy- Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal, and recordkeeping in the facility, in accordance with federal and state laws and regulations. Procedures-A. The Director of Nursing and the consultant pharmacist maintain the facility's compliance with federal and state laws and regulations in the handling of controlled medications. Only authorized licensed nursing and pharmacy personnel have access to (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	controlled medications. a) Medications are obtained from the locked medication cart (if a Schedule III, IV, or V medication). b) Preparation of the dosage form occurs according to the medication administration policy. c) When a controlled medication is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record and the medication administration record (MAR): Date and time of administration, Amount administered, Signature of the nurse administering the dose, completed after the medication is actually administered. d) When a dose of a controlled medication is removed from the container for administration but refused by the resident or not given for any reason, it is not placed back in the container. It must be destroyed according to facility policy. and the disposal documented on the accountability record on the line representing that dose. f) Discrepancies of controlled medication counts. Count discrepancies shall be reported to the Consultant Pharmacist, Medical Director, Administrator and Director of Nursing. Director of Nursing shall conduct a review and determine cause of the discrepancy and take appropriate actions per facility policy. g) Theft of controlled medications. When a theft of a controlled medications from patient supply is discovered, Director of Nursing shall conduct a review and report her findings to the appropriate law enforcement authorities. Facility Administrator / Director of Nurses will notify the Consultant Pharmacist, Medical Director and appropriate local law enforcement authorities of her findings.During a review of the facility's P & P titled, Medication Administration- ID 3: CONTROLLED MEDICATIONS STORAGE, dated 3/26, the P&P indicated, .Policy Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal and recordkeeping in the facility in accordance with federal, state and other applicable laws and regulations. Procedures A. The director of nursing and the consultant pharmacist maintain the facility's compliance with federal and state laws and regulations in the handling of controlled medications. Only authorized licensed nursing and pharmacy personnel have access to controlled medications. C. A controlled medication accountability record is prepared by the pharmacy for all Schedule II, III, and IV, medications (see Form 12: INDIVIDUAL RESIDENT'S CONTROLLED SUBSTANCE RECORD), including those in the emergency supply. The following information is completed: a. Name of resident .b. Prescription number. c. Name, strength, and dosage form of medication d. Date received e. Quantity received f. Name of person receiving medication supply D. At each shift change, a physical inventory of all controlled medications in Scheduled II-IV, including the emergency supply, is conducted by two licensed nurses and is documented on the controlled medication accountability record.F. Any discrepancy in controlled substance medication counts schedule II-IV is reported to the director of nursing immediately. The director or designee investigates and makes every reasonable effort to reconcile all reported discrepancies. The director of nursing documents irreconcilable discrepancies in a report to the administrator. a. If a major discrepancy or a pattern of discrepancies occurs or if there is apparent criminal activity, the director of nursing notifies the administrator and consultant pharmacist immediately. b. The administrator, the consultant pharmacist, and/or the director of nursing determine whether other action(s) are needed, e.g., notification of police, licensing, nursing board, or other enforcement personnel. c. The medication regimen of residents using medications that have such discrepancies are reviewed to assure the resident has received all medications ordered and the goal of therapy is met (example: a resident receiving a pain medication complains of unrelieved pain) . J. The consultant pharmacist or designee routinely monitors controlled medication storage, records, and expiration dates during routine scheduled medication storage inspections.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to follow professional standards and ensure for five of eight sampled residents (Resident 18, Resident 86, Resident 92, Resident 119 and Resident 131) were free from significant medication errors, when Resident 86, Resident 119 and Resident 131's insulin (insulin lispro/ insulin aspart: fast-acting with a quick onset of 5-15 minutes injectable medication that lowers blood glucose (BG- sugar)) and Resident 18 and Resident 92's insulin (regular insulin: short-acting with a slower onset of 30-60 minutes injectable medication) were administered more than an hour before meal.This failure had the potential to result in hypoglycemic (condition where sugar levels in the blood drop too low) episodes for Resident 18, Resident 86, Resident 92, Resident 119 and Resident 131 which could lead to confusion, dizziness, blurred vision, seizures, and loss of consciousness.Findings:During an interview with Licensed Vocational Nurse (LVN) 3 on 5/7/26 at 12:25 p.m. in Nursing station 3, LVN 3 stated she had six residents who received insulin medication. LVN 3 stated only 4 of the residents were in the facility and she had already checked their BG level. LVN 3 stated 3 of the 4 residents refused insulin administration and only 1 resident (Resident 119) was administered insulin.During a concurrent interview and record review on 5/7/26 at 12:26 p.m. with LVN 3 and LVN 4 in Nursing station 3 , Resident 119's Medication Administration Record (MAR) was reviewed with LVN 4, the MAR indicated Resident 119's BG level was checked, and 1 unit of insulin lispro was administered at 11: 47 a.m. LVN 3 stated she checked Resident 119's BG level at 11:30 a.m. LVN 3 stated when the lunch tray was announced, the Certified Nursing Assistants would bring the lunch trays up. LVN 3 stated lunch was usually between 12:30 p.m. and 1:30 p.m.During a review of Resident 119's admission Record (AR- a summary of important information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 5/8/26, the AR indicated Resident 119 was admitted to the facility on [DATE] with a diagnosis which included type 2 diabetes mellitus (DM-chronic condition where the body does not use insulin properly or make enough insulin, leading to high blood sugar levels), hyperlipidemia (abnormally high fat levels, or lipids, in the blood), chronic kidney disease (a long-term condition where the kidneys are damaged and gradually lose their ability to filter waste, toxins, and excess water from the blood), essential hypertension (high blood pressure) and history of falling.During a review of Resident 119's Order Summary Report (OSR), dated 5/1/26, the OSR indicated, Resident 119 had an active order for . Insulin Lispro (1 Unit Dial) Subcutaneous Solution Pen-injector 100 UNIT/ML [milliliters- metric unit used to measure the volume of a liquid] (Insulin Lispro) Inject as per sliding scale.subcutaneously (administered beneath all the layers of the skin)two times a day for DM During an interview on 5/7/26 at 12:29 p.m. with LVN 5 in Nursing station 3 , LVN 5 stated she had three residents (Resident 18, Resident 86 and Resident 92) who received insulin medication. LVN 5 stated all three residents BG level were checked between 11.15 a.m. and 11:30 a.m. LVN 5 stated Insulin was administered to the three residents after their BG levels were checked.During a record review on 5/7/26 at 12:30 p.m. LVN 4 in Nursing station 3 , Resident 18, Resident 86 and Resident 92's MAR were reviewed, the MAR indicated Resident 18's BG level was checked, and 14 units of regular insulin were administered at 11: 22 a.m. Resident 86's BG level was checked, and 2 units of insulin lispro were administered at 11: 18 a.m. and Resident 92's BG level was checked, and 4 units of regular insulin were administered at 10: 54 a.m.During a review of Resident 18's AR dated 5/8/26, the AR indicated Resident 18 was admitted to the facility on [DATE] with a diagnosis which included type 2 diabetes mellitus, hyperlipidemia, and essential hypertension.During a review of Resident 18's OSR, dated 5/8/26, the OSR indicated, Resident 18 had an active order for . Insulin Regular Human Injection Solution 100 UNIT/ML (Insulin Regular (Human)) Inject 14 unit subcutaneously three times a day for DM. Take with food During a review of Resident 86's AR dated 5/8/26, the AR indicated Resident 86 was admitted to the facility (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	on [DATE] with a diagnosis which included type 2 diabetes mellitus, hyperlipidemia, chronic kidney disease and essential hypertension.During a review of Resident 86's OSR, dated 5/5/26, the OSR indicated, Resident 86 had an active order for . Insulin Lispro injection Solution 100 UNIT/ML (Insulin Lispro) Inject as per sliding scale.subcutaneously before meals for DM .During a review of Resident 92's AR dated 5/8/26, the AR indicated Resident 18 was admitted to the facility on [DATE] with a diagnosis which included type 2 diabetes mellitus, hyperlipidemia, chronic kidney disease and essential hypertension.During a review of Resident 92's OSR, dated 2/3/26 and 5/4/26, the OSR dated 2/3/26 indicated, Resident 92 had an active order for . Insulin Regular HUMULIN R INJ U-100 Inject as per sliding scale., subcutaneously before meals and at bedtime for DM. The OSR dated 5/4/26 indicated, Resident 92 had an active order for . Insulin Regular Human Inject 4 unit subcutaneously three times a day for DM WITH MEALS During an observation on 5/7/26 at 12:57 p.m. on the third floor, the food trays arrived on floor and were served to residents.During a concurrent interview and record review on 5/8/26 at 7:42 a.m. with LVN 6 in Nursing station 1 , Resident 131's MAR was reviewed. LVN 6 stated she had checked BG level and administered Insulin to one resident (Resident 131). The MAR indicated Resident 131's BG level was checked, and 16 units of insulin aspart were administered at 7: 33 a.m. LVN 6 stated breakfast was served between 8 a.m. and 8:30 a.m. LVN 6 stated nurses should follow the physician's order. LVN 6 stated Resident 131's order indicated with meals. LVN 6 stated Resident 131 had not gotten his meal, and she should not have administered the insulin. LVN 6 stated she was not following physician's order and Resident 131's BG level could go down, and he would be hypoglycemic which could lead to an emergency.During a review of Resident 131's AR dated 5/8/26, the AR indicated Resident 131 was admitted to the facility on [DATE] with a diagnosis which included type 2 diabetes mellitus, hyperlipidemia, and essential hypertension.During a review of Resident 131's OSR, dated 5/8/26, the OSR indicated, Resident 131 had an active order for . Insulin Aspart Solution 100 UNIT/ML, inject 16 unit subcutaneously three times a day for Diabetes, Take with food .During an interview on 5/8/26 at 7:52 a.m. with LVN 1 in Nursing station 1 , LVN 1 stated insulin aspart and lispro were fast acting insulin with onset between 15- -30 mins. LVN 1 stated the insulin should be given when the breakfast tray was available. LVN 1 stated this was important because Resident 131's BG level could drop. LVN 1 stated breakfast was at 8: 30 a.m. LVN1 stated the nurses should follow the physician's orders. LVN 1 reviewed the physician's order in Resident 131's MAR and validated the insulin order. LVN 1 stated the nurse did not follow the physician's order for Resident 131 and that administering the insulin with the meal was not the same as administering insulin with a snack.During an interview on 5/8/26 at 8:20 a.m. with LVN 4, LVN 4 stated insulin lispro/aspart should be administered 30 -45 min before meals or with meals. LVN 4 stated administering insulin at the wrong time could result in side effects of low BG and the resident could become hypoglycemicDuring an interview on 5/8/26 at 4:27 p.m. with the Director of Nursing (DON), the DON stated she expected the nurses to follow the physician's order. The DON stated if the physician's order indicated with meals, then it should be given with meal. The DON stated resident could have hypoglycemia, and abnormal BG level. During a professional reference review retrieved from National Library of Medicine/National Institute of Health- Daily Med found at https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=2be14cbb-197a-4da8-82c8-2443594e7f6f, titled, INSULIN LISPRO injection, solution, undated, the professional reference indicated .2.2 Administration Instructions for the Approved Routes of Administration-Subcutaneous Injection-Administer the dose of Insulin Lispro within fifteen minutes before a meal or immediately after a meal by injection into the subcutaneous tissue of the abdominal wall, thigh, upper arm, or buttocks.During a professional reference review retrieved from National Library of Medicine/National Institute of Health- Daily Med found at https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=bee5b358-c863-420b-be73-ced2e920c499, titled, INSULIN ASPART injection, solution, undated, the professional reference indicated .2.2 Preparation and Administration Instructions for the Approved Routes of Administration- Subcutaneous (continued on next page)

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	055626	A. Building B. Wing	05/08/2026

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Injection-Inject Insulin Aspart subcutaneously within 5-10 minutes before a meal into the abdominal area, thigh, buttocks or upper arm.During a professional reference review retrieved from National Library of Medicine/National Institute of Health- Daily Med found at https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=b519bd83-038c-4ec5-a231-a51ec5cc291f, titled, HUMULIN R- insulin human injection, solution, undated, the professional reference indicated .2.2 Route of Administration- Subcutaneous Injection-Inject HUMULIN R subcutaneously approximately 30 minutes before meals into the thigh, upper arm, abdomen, or buttocks.During a review of the facility's Policy and Procedure (P & P) titled, Medication Administration, dated 8/19/25, the P&P indicated, .Policy: All medications shall be administered by licensed nursing staff according to physician orders, current best practices, and federal and state regulations. The facility shall ensure residents receive the correct medications in a timely, safe, and documented manner. Purpose- To establish standardized procedures for the safe, effective, and accurate administration of medications in compliance with state and federal regulations and best practice standards.Process- iii. Medications must be administered within one hour before or one hour after the scheduled time, unless a specific clinical reason requires a more rigid schedule (e.g., insulin.) . v. Right Time: Administer within ordered time window.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a safe, clean, comfortable, homelike environment for two of nine sampled residents (Resident 11 and Resident 69) when:1. Resident 11's bedside table had the plastic strip pulled away from the edge of the table with jagged rough edges on the bedside table.2. Resident 69's overhead bed light did not have a string attached that allowed Resident 69 to turn the light on and off.These failures had the potential to create a non-homelike environment for Resident 11 and Resident 69 and placed Resident 11 and Resident 69 at risk of injury and harm.Findings:1. During a concurrent observation and interview on 5/5/2026 at 9:52 a.m. with Resident 11 in Resident 11's room, Resident 11 was observed dressed, standing by her wheelchair. Resident 11 stated she had been at the facility since February 2026 due to having a stroke (cerebral infarction - damage to tissues in the brain due to a loss of oxygen to the area). Resident's bedside table observed with the side strip coming off the edge of the table with jagged, rough edges.During a review of Resident 11'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), dated 5/8/26, the AR indicated Resident 11 was admitted to the facility from an acute care hospital on 2/12/26 with diagnoses of intracerebral hemorrhage (bleeding in the brain caused by a ruptured blood vessel), dysphagia (difficulty swallowing), hemiplegia (paralysis [the loss of the ability to move and sometimes to feel anything] of one side of the body) and hemiparesis (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles) affecting left non-dominant side, morbid severe obesity (a serious health condition that results from an abnormally high body mass) due to excess calories, encephalopathy (damage or disease that affects the brain), abnormalities of gait (walking) and mobility (movement), and muscle weakness.During a review of Resident 11's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 2/19/26, the MDS section C indicated Resident 11 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive (involving the process of thinking, learning and understanding) understanding on a scale of 1-15) score of 13 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 11 was cognitively intact.During a concurrent observation and interview on 5/7/2026 at 11:15 a.m. with Certified Nursing Assistant (CNA) 1, in Resident 11's room, Resident 11's broken bedside table was observed. CNA 1 stated Resident 11's bed side table had the siding coming off and the wood was chipped by the edge. CNA 1 stated Resident 11 could get hurt or pinched by the broken bedside table. CNA 1 stated a broken table was not a homelike environment for Resident 11. CNA 1 stated staff informed maintenance through an electronic system and a maintenance binder if something needed repair.During an interview on 5/8/26 at 9:19 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated residents notified staff, or staff informed the nurses if something was broken and needed repair. LVN 1 stated there was a binder at the nurses' station where staff entered repair requests. LVN 1 stated staff also entered repair requests into an electronic system or notified the maintenance department verbally.During an interview on 5/8/26 at 10:39 a.m. with the Maintenance Director (MAIND), the MAIND stated it was important for Maintenance to know if repairs were needed. The MAIND stated staff logged requests into a binder and through the computer. The MAIND stated the department managers inspected resident rooms during their rounds, and the MAIND stated he depended on staff to inform him and his department if repairs were needed. The MAIND stated Resident 11's broken table was a risk for Resident 11 to sustain an injury and needed to be repaired for her safety. The MAIND stated Resident 11's broken table did not create a homelike environment (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for Resident 11.During an interview on 5/8/26 at 5:18 p.m. with the Director of Nursing (DON), the DON stated any staff member should have informed Maintenance if something needed to be repaired. The DON stated her expectation was to replace Resident 11's broken table. The DON stated a broken table was a safety risk to Resident 11 and was not a homelike environment.2. During a concurrent observation and interview on 5/5/2026 at 9:14 a.m. with Resident 69 in Resident 69's room, Resident 69 was observed dressed, lying in bed. Resident 69 stated she had been at the facility since January 2026 due to a bad fall. Resident 69 stated her right arm was weak and she was unable to move her right leg. Resident 69 stated she had physical therapy and could do some things on her own but needed assistance. Resident 69 stated her light above her bed did not have a string for her to turn the light on and off. Resident 69 stated she needed a CNA or staff to turn her overhead bed light on and off.During a review of Resident 69's AR, dated 5/8/26, the AR indicated Resident 69 was admitted to the facility from an acute care hospital on 1/26/26 with diagnoses of fall from or off toilet with subsequent striking against an object, abnormalities of gait (walking) or mobility (movement), dysphagia (difficulty swallowing), peripheral vascular disease (the reduced circulation of blood to the arms or legs), peripheral autonomic neuropathy (damage to nerves that manage normally automatic body functions), morbid obesity (a serious health condition that results from an abnormally high body mass) due to excess calories, muscle weakness, and need for assistance with personal care.During a review of Resident 69's MDS, dated [DATE], the MDS section C indicated Resident 69 had a BIMS score of 14, which indicated Resident 69 was cognitively intact.During a review of Resident 69's MDS, dated 2/2/26, section GG (Functional Abilities) indicated, Resident 69 had impairment (diminishment or loss of function or ability) in the right and left upper extremities (shoulder, elbow, wrist, hand) and impairment on right and left lower extremities (hip, knee, ankle, foot). Section GG indicated, .substantial/maximal assistance - helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.oral hygiene.dependent - helper does all of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.toileting hygiene: the ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement.shower/bathe self.upper body dressing.lower body dressing.putting on/taking off footwear.personal hygiene: the ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands.roll left and right.sit to lying.lying to sitting on side of bed.tub/shower transfer: the ability to get in and out of a tub/shower.During a concurrent observation and interview on 5/07/2026 at 11:15 a.m. with CNA 1 in Resident 69's room, Resident 69's overhead bed light was observed without a pull string for Resident 69 to turn her light on and off. CNA 1 stated Resident 69 should have an overhead bed light. CNA 1 stated if Resident 69 was unable to turn her overhead bed light on, she called the CNA to turn it on for her. CNA 1 stated calling for assistance was difficult for Resident 69 since her call light was broken.CNA 1 stated if repairs were needed, staff informed maintenance through an electronic system or a Maintenance log in a binder at the nurses' station.During a concurrent interview and record review on 5/8/26 at 9:24 a.m. with LVN 1 at the nurses' station, the Maintenance binder was reviewed. The Maintenance binder log indicated there was no documentation of repairs needed for Resident 69's room. LVN 1 stated Resident's notified staff if something was not working or needed repair, and staff notified the nurses. LVN 1 stated staff notified the Maintenance department of needed repairs by logging requests into the maintenance binder, or staff notified the Maintenance department verbally. LVN 1 stated Resident 69 should have been able to turn her light on and off for Resident 69's safety and for her needs.During an interview on 5/8/26 at 10:39 a.m. with the Maintenance Director (MAIND), the MAIND stated it was important for Maintenance to know if repairs were needed. The MAIND stated staff logged requests into a binder and through the computer. The MAIND stated the department managers inspected residents' rooms. The MAIND stated he depended on staff to inform him and his department if repairs were needed. The MAIND stated Resident 69 should have been able to turn her overhead bed lights on and off. The MAIND stated (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 69's room was not a homelike environment.During an interview on 5/8/26 at 5:18 p.m. with the DON, the DON stated her expectation was for Resident 69's overhead bed light should have had a string allowing Resident 69 to turn her light on and off and not have to ask staff to do it for her. The DON stated Resident 69's room was not a homelike environment. The DON stated any staff member should have been informing Maintenance of repairs.During a review of the facility's policy and procedure (P&P) titled, Resident Rooms and Environment, dated 1/1/2012, the P&P indicated, .The Facility provides residents with a safe, clean, comfortable, and homelike environment. Facility Staff will provide residents with a pleasant environment and person-centered care that emphasizes the residents' comfort, independence and personal needs and preferences.Facility Staff aim to create a personalized, homelike atmosphere, paying close attention to the following.lighting that is comfortable [minimum glare] yet adequate.personalized furniture.Facility Staff work to minimize.the characteristics of the Facility that reflect a depersonalized, institutional setting.generic, mas produced bedding, drapes and furniture.the Facility provides comfortable and adequate lighting throughout the Facility to promote a safe, comfortable and homelike environment.During a review of the facility's P&P titled, Maintenance - Work Orders, dated 1/1/2012, the P&P indicated, .to protect the health and safety of residents, visitors, and Facility Staff.maintenance work orders shall be completed in an effort to sustain maintenance services as a priority.department directors/supervisors are responsible for completing such work orders and forwarding them to the Director of Maintenance.a supply of workorder forms is maintained at each nurses' station.work order requests are to be placed in a designated location at the nurses' station.work orders are picked up daily by Maintenance Staff.emergency requests are given priority.emergency requests should be delivered directly to the Director of Maintenance.the director of Maintenance will maintain completed Work Orders chronologically in a binder in the Director of Maintenance's office.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for two of 13 sampled residents (Resident 5 and Resident 125) when:1. License Nurses (LN)s did not develop a detailed and person-centered care plan for Resident 5's pain. 2. LNs did not develop a care plan for Resident 125 indicating family preferences to not having the bedside table within reach due to safety concerns.These failures created the risk of inadequate care, potentially compromising Resident 5 and Resident125's safety and negatively affecting the overall quality of care and services provided.Findings:1. During a concurrent observation and interview on 5/5/25 at 3:50 p.m. with Resident 5 in Resident 5's room, Resident 5 was sitting in his wheelchair looking out the window. During a review of Resident 5'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), dated 5/8/26, the AR indicated Resident 5 admitted to the facility on [DATE] with diagnosis of Diabetes Mellitus Type II (chronic condition where the body cannot effectively use insulin (insulin resistance) or make enough of it, causing sugar (glucose) to build up in the blood instead of powering cells), Malignant neoplasm of the bone (an abnormal, uncontrolled growth of cells that forms a lump or tumor. Unlike harmless (benign) growths, malignant cells are aggressive-they can destroy healthy nearby tissue and spread to other parts of the body), generalized Osteo Arthritis (is a condition that cause an inflammation, pain, stiffness, and swelling in one or more joints), and depression (a common, serious mental health condition characterized by persistent sadness, low mood, and a loss of interest in activities that lasts for at least two weeks).During a review of Resident 5's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 3/25/26, the MDS section C indicated Resident 5 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive (involving the process of thinking, learning and understanding) understanding on a scale of 1-15) score of 14 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which indicated Resident 5 was cognitively intact.During a concurrent interview and record review on 5/7/26 at 2:20 p.m. with Licensed Vocational Nurse (LVN) 5, Resident 5's Care Plan (CP) dated 5/7/26 was reviewed. The CP indicated that a person centered, detailed CP for the resident's pain medication was not created. LVN 5 stated, . a specific care plan for the resident's pain medication was not present, the generic pain medication care plan in the resident's chart does not indicate which medication to give when the resident was experiencing 7 out of 10 pain. It is important for the medication that is to be given be clearly indicated in the care plan to prevent the wrong medication from being given and possibly delaying the pain relief for the resident .During a concurrent interview and record review on 5/8/26 at 4:45 p.m. with the Director of Nursing (DON), Resident 5's CP dated 5/7/26 was reviewed. The CP indicated that a person centered, detailed CP for the resident's pain medication was not created. The DON stated it was her expectation for the resident's pain medication to be Care Planned. If a care plan is not created, the staff will not know how to effectively treat the resident.During a review of the facility's policy and procedure (P&P) titled, Person-Centered Care Planning, dated 4/24/25, the P&P indicated, .the facility focuses on the resident as the center of control and supports each resident in making his or her own choices. Person-centered care includes making an effort to understand what is important to each resident with regard to daily routines and preferred activities.The facility must develop and implement a comprehensive person-centered care plan for each resident consistent with the resident rights.The comprehensive care plan must describe.services that are to be furnished to attain or maintain the resident's highest practical physical, mental, and psychosocial well-being.Any services that would (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	otherwise be required under, but are not provided due to resident's exercise of rights, including the right to refuse treatment.2. During a concurrent observation and interview on 5/5/2026 at 9:55 a.m. with Resident 125 in Resident 125's room, Resident 125 was observed lying in bed with bedside table and water pitcher off to the side and not within Resident 125's reach. Resident stated she could not get out of bed independently and was not able to reach her water.During a review of Resident 125's AR dated 5/8/26, the AR indicated Resident 125 was admitted to the facility on [DATE] with diagnoses of central cord syndrome at unspecified level of cervical spinal cord (an incomplete neck spinal cord injury where the middle part of the cord is damaged), Alzheimer's disease unspecified (progressive brain disorder), encephalopathy (any disease, damage, or malfunction that causes the brain to stop working properly), muscle weakness, unspecified protein-calorie malnutrition (lack of both protein and total calories-the exact severity or specific cause not fully documented), and major depressive disorder.During a review of Resident 125's MDS dated 3/6/26, the MDS section C indicated Resident 125 had a BIMS score of 05 which indicated Resident 125 had severe cognitive impairment.During a concurrent observation and interview on 5/7/2026 at 3:37 p.m. with Certified Nursing Assistant (CNA) 5 in Resident 125's room, CNA 5 stated Resident 125 was able to follow simple commands, use pad-call light if needed, and was able to grab a cup with water in it and drink it independently if it was within reach. CNA 5 stated bedside table with water was not within reach. CNA 5 stated Resident 125 should have had bedside table with water within reach. CNA 5 stated all residents should have water within reach to drink when they are thirsty. CNA 5 stated Resident 125 swings her arms a lot and for safety concerns of items easily falling on her if resident 125 were to swing her arms, the bedside table was not within reach.During a concurrent observation and interview on 5/7/2026 at 3:47 p.m. with LVN 1 in Resident 125's room, LVN 1 stated bedside table was not within Resident 125's reach per family request. LVN 1 stated Resident 125 had frequent jerking/movement of arms and family requested for bedside table to be off to the side for safety concerns regarding the bedside table and items falling on top of the resident if she were to swing her arms. LVN 1 stated family is at the facility almost daily and voiced concerns about the bedside table and items falling on top of the resident due to Resident 125's frequent arm movements/swinging. LVN 1 stated the family verbally communicated to staff they did not want bedside table over the bed where Resident 125 could possibly get injured.During a concurrent interview and record review on 5/7/26 at 4:26 p.m. with LVN 1, LVN 1 stated communication with the family regarding the request to not have bedside table within Resident 125's reach for safety concerns, was a verbal and informal request and stated he was unable to locate a care plan that reflected families request and current services being provided to ensure resident received fluid intake. LVN 1 stated resident care plans should always be updated to reflect residents' needs.During an interview on 5/8/26 at 5:00 p.m. with the DON, the DON stated it was her expectation that the CPs be updated as needed whenever there is a change and stated CP should be centered to reflect individual resident needs, change of conditions, and preferences Including those preferences expressed by family. The DON stated the CP should have been updated at the time the family had the communication with the nurse regarding the bedside table being out of reach and stated the nurse should have care planned the preference at that time. The DON stated the care plan was not updated at the time and should have been. The DON stated it was important for CP to be updated so nurses know what the plan of care is, to provide proper care to residents, and to honor residents' wishes and preferences.During a concurrent interview and record review on 5/8/26 at 5:04 p.m. with the DON, the facility's policy and procedure (P&P) titled, Person-Centered Care Planning, dated 4/24/25 was reviewed. The DON stated the facility's P&P was not followed if a care plan was not implemented to reflect Resident 125's current preferences.During a review of the facility's policy and procedure (P&P) titled, Person-Centered Care Planning, dated 4/24/25, the P&P indicated, .the facility focuses on the resident as the center of control and supports each resident in making his or her own choices. Person-centered care includes making an effort to understand what is important to each resident with regard to daily routines and preferred (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	activities.The facility must develop and implement a comprehensive person-centered care plan for each resident consistent with the resident rights.The comprehensive care plan must describe.services that are to be furnished to attain or maintain the resident's highest practical physical, mental, and psychosocial well-being.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.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the safe storage, supervision, and control of smoking materials for one of five sampled residents (Resident 37) when Resident 37 had a box of cigarettes with cigarettes inside placed on top of Resident 37's nightstand, accessible without staff knowledge or supervision.This failure had the potential to result in significant safety hazards, including unsupervised smoking, burn injuries, accidental fires, flash fires if smoking materials were used near oxygen equipment, and access to cigarettes by other residents.During a concurrent observation and interview on 5/5/2026 at 9:59 a.m. with Resident 37 in Resident 37's room, Resident 37 was observed lying in bed with a box of cigarettes with cigarettes inside, placed on top of Resident 37's nightstand. Resident 37 stated staff was unaware that the cigarette box was in his room.During a concurrent observation and interview on 5/7/2026 at 1:17 p.m. with Resident 37 in Resident 37's room, Resident 37 was observed sitting in his wheelchair (WC) in his room with a box of cigarettes with cigarettes inside, placed on top of Resident 37's nightstand. Resident 37 stated he goes on a smoke break with staff supervision and has always kept his cigarettes at bedside. Resident 37 stated the nurses provide lighter when he needs to smoke and stated he used to have a lighter in his room, but he misplaced it.During a review of Resident 37'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), dated 5/8/26, the AR indicated Resident 37 was admitted to the facility on [DATE] with diagnoses of dysarthria (a motor speech disorder characterized by slurred, slow, or difficult-to-understand speech) following cerebral infarction (when a portion of the brain dies because it isn't receiving enough blood), type 2 diabetes mellitus with other specified complications (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), other asthma (a long-term lung condition that makes it difficult to breathe), muscle weakness-generalized, nicotine dependence-cigarettes-uncomplicated, extrapyramidal (uncontrollable, involuntary movements that occur as a side effect of certain medications) and movement disorder-unspecified, and paranoid schizophrenia (a chronic mental health condition where a person loses touch with reality through intense, irrational distrust).During a review of Resident 37's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 3/13/26, the MDS section C indicated Resident 37 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive (involving the process of thinking, learning and understanding) understanding on a scale of 1-15) score of 07 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which indicated Resident 37 had severe cognitive impairment.During an interview on 5/7/2026 at 4:15 p.m. with Certified Nursing Assistant (CNA) 5, CNA 5 stated residents are not allowed to smoke inside the building only outside. CNA 5 stated cigarettes and lighters were stored by the nurses and given to residents when requested. CNA 5 stated it was important for the nurse to store cigarettes and lighters for precaution and for resident safety. CNA 5 stated cigarettes being stored on top of Resident 37's nightstand were accessible to any resident and for safety reasons, the cigarettes should not have been in Resident 37's room. CNA 5 stated CNA's were to report to the nurses if they observed cigarettes in resident rooms. During a concurrent observation and interview on 5/7/2026 at 1:21 p.m. with Licensed Vocational Nurse (LVN) 1 in Resident 37's room, LVN 1 stated the process for residents who smoked was that nurses kept the cigarettes and lighters in the medication room. LVN 1 observed Resident 37's nightstand and stated there was a cigarette box with cigarettes inside the box. LVN 1 stated Resident 37's room was not a safe place to store the cigarettes and cigarettes should have been kept at the nurses' station in the medication room for safety reasons because it (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	could cause a fire and it was a safety hazard for other residents. During an interview on 5/8/2026 at 4:55 p.m. with the Director of Nursing (DON), the DON stated her expectations were that residents' cigarettes be kept by nurses at the nursing station. The DON stated residents should not have their own cigarettes at bedside to prevent injury and potential smoking in the room for safety reasons. The DON stated cigarettes on a resident's nightstand, was a safety concern for that resident as well as other residents that could gain access to the cigarettes. The DON stated Resident 37's nightstand was not a safe place to store cigarettes.During a review of the facility's policy and procedure (P&P) titled, Smoking Residents, dated 8/18/23, the P&P indicated, .Smoking by residents is allowed outside the facility in designated, marked smoking areas.The IDT will develop an individualized plan of care for safe storage, use of smoking materials.for residents who smoke.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure residents received food that was palatable, attractive and appetizing for three of five sampled residents (resident 43, resident 126, and resident 130) when the facility ran out of polenta (coarsely ground cornmeal (yellow or white) that is boiled in water or broth until it becomes a thick, creamy porridge), during the lunch meal service and it was replaced with mashed potatoes. The temperature of the potatoes had not been taken, and the potatoes had a water-like consistency with water visibly pooling in the corner of the pan. The potatoes were placed on the tray line and served to residents. This failure had the potential for resident choking, weight loss, and malnutrition due to residents not eating unpalatable mashed potatoes.Findings:During a concurrent observation and interview on 5/7/25 at 12:06 p.m. with the [NAME] (CK), in the facility's kitchen, a square metal pan of potatoes was placed on the tray line (an assembly line for food). The cook stated, . The potatoes are too runny, I can not tell my boss that he needs to make another batch of potatoes . I did not see anyone take the temperature . everyone was in a rush because we ran out of polenta . The cook continued to place the watery potatoes onto the plates, the potatoes spread to cover half the plate when placed on the plate.During an interview on 5/7/26 at 2:40 p.m. with Resident 130, in Resident 130's room. Resident 130 stated she did not eat the potatoes, the carrots, or the pork on her lunch tray. Resident 130 said the potatoes were runny, and she did not care for the taste of the carrots or the pork. Resident 130 stated she ate ice cream for her lunch. During a review of Resident 130's admission Record (AR), dated 5/8/26, the AR indicated Resident 130 was admitted on [DATE] from an acute care hospital with diagnosis of history of Cerebral Infarction (a type of [ischemic stroke] where a blockage in an artery interrupts blood flow to the brain, causing brain tissue to die from lack of oxygen and nutrients), Diabetes Mellitus (DM - a condition where your body either stops responding to insulin or doesn't make enough of it), and need for assistance with personal care.During a review of Resident 130's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 4/1/26, the MDS section C indicated Resident 130 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive (involving the process of thinking, learning and understanding) understanding on a scale of 1-15) score of 05 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which indicated Resident 130 had severe cognitive impairment.During an interview on 3/7/26 at 3:10 pm with Resident 43 in Resident 43's room. Resident 43 stated, he could not eat the food that was served to him for lunch it looked like runny dog food and called his wife to bring him food. Resident 43 stated he would talk to the Kitchen Manager when he comes to his room. During a record review of Resident 43's AR dated 5/8/26, the AR indicated Resident 43 was admitted to the facility on [DATE] with diagnosis of Quadriplegia (the partial or total paralysis of all four limbs and the torso, typically caused by a spinal cord injury or disease in the neck [cervical spine]), pressure ulcer (PU - damage to the skin and underlying tissue caused by constant, prolonged pressure on a specific area of the body) to right hip, right heel, left heel, and sacral (the area of your lower back, right between your hips and just above your tailbone) and protein calorie malnutrition.During a review of Resident 43's MDS section C dated 4/23/26 indicated Resident 43 had a BIMS score of 13 which indicated Resident 43 was cognitively intact.During an interview on 3/7/26 at 3:30 p.m. with Resident 126 in Resident 126's room. Resident stated the food often served to her was cold, the texture was too watered down, and the food was strange. 43 residents stated she hoped with the new kitchen manager there would be changes, but the lunch was horrible. She stopped complaining because she felt no one would listen to her.During a review of Resident 126's MDS section C dated 4/8/26 indicated Resident 126 had a BIMS score of 13 which indicated Resident 126 was cognitively intact.During a record review of Resident 126's AR dated 5/8/26, the AR indicated Resident 126 was (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	admitted to the facility on [DATE] with diagnosis of Quadriplegia, DM, and depression (a serious mood disorder that causes persistent feelings of sadness, emptiness, and a loss of interest in activities you usually enjoy).During an interview on 5/7/26 at 4:06 p.m. with the Regional Certified Dietary Manager (RCDM), in the facility's kitchen, the RCDM stated there was not enough polenta to finish serving the residents. The RCDM stated mashed potatoes were an acceptable replacement and the Certified Dietary Manager (CDM) made mashed potatoes and placed them on the tray line. The RCDM stated the staff did not take the temperature of the potatoes before serving the residents and the texture and consistency was not acceptable. RCDM stated the potatoes should not have been served to the residents with the thin watery texture. Having thin consistency could cause choking, weight loss and malnutritionDuring an interview on 5/7/26 at 4:30 p.m. with the CDM, the CDM stated he should not have placed the potatoes on the tray line to be served to the residents. The potatoes were runny, and he had forgotten to take the temperature prior to placing on the tray line. The CDM stated all food needed to have the temperature checked prior to placing it on the tray line. CDM stated if the food was not at the correct temperature, it provided an opportunity for bacteria to grow. Having the food at the wrong consistency or texture could cause a choking hazard to the residents.During a review of the Good for Your Health Menus dated 5/7/26, the Good for your Health Menus indicated, the lunch menu for 5/7/26 was Hawaiian Pork, Polenta, Ginger Carrots, Wheat Roll and Ice Cream.During a review of the facility's policy and procedure (P&P) titled, DD05 Dining Program dated 2/20/25, P&P indicated, . Dining program is a service organized, staffed and equipped to assure that food service to residents is safe, appetizing and provides for their nutritional needs .

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to accommodate residents' preferences and allergies and to follow the meal ticket (list of food dislikes, allergies, and texture of food), for one of eight sampled residents (Resident 69), when Resident 69 was allergic to orange juice and was served orange juice for her lunch time meal. This failure had the potential for undesired side effects including weight loss, rash, hives, and anaphylaxis shock (a severe, rapidly progressing, and potentially life-threatening systemic allergic reaction that affects multiple body systems simultaneously, such as the skin, breathing, and blood pressure).Findings:During a concurrent observation and interview on 5/7/26 at 11:00 a.m. with Resident 69 in Resident 69's room, a container of orange juice was sitting on Resident 69's bedside table. Resident 69 stated she was allergic to orange juice and had to put the orange juice to the side. Resident 69 stated, . the kitchen is aware of my allergy, I do not want to drink it and die .During an interview on 5/8/26 at 9:09 a.m. with Licensed Vocational Nurse (LVN 4), LVN 4 stated, if an item on the resident's meal tray was an item on the Resident's allergy list, he would remove the item from the meal tray. If the resident ate or drank that item they could get an allergic reaction resulting in hives, rashes, or swelling of the throat leading to death. During a review of Resident 69's admission Record (AR), dated 5/8/26, the AR indicated, Resident 69 was admitted to the facility on [DATE] from an acute care hospital with the following diagnosis: Type II Diabetes Mellitus (DM II - a chronic condition where the body cannot effectively use insulin (insulin resistance) or make enough of it, causing sugar (glucose) to build up in the blood instead of powering cells), Peripheral Vascular Disease (PVD - is a slow, progressive circulation disorder caused by the narrowing, blockage, or spasms of blood vessels (arteries or veins) outside of the heart and brain, most commonly affecting the legs), and dysphagia (difficulty swallowing).During a review of Resident 69's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 2/2/26, the MDS section C indicated Resident 69 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15) score of 14 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which indicated Resident 69 was cognitively intact. During a concurrent interview and record review on 5/8/26 at 3:07 p.m. with the Certified Dietary Manager (CDM), Resident 69's meal ticket, dated 5/8/26 was reviewed. The meal ticket indicated in large font and capital letters with exclamation points, .!!!! NO ORANGES!!!! .Allergies: Oranges . Dislikes: Orange Juice .). The CDM stated, I am not sure if it was carelessness or an oversight but it is important that allergies listed get noted, some allergies can cause harm such as death . resident (Resident 69) should not have had orange juice or any citrus on her meal tray . During a review of Resident 69's Care Plan (CP), dated 1/27/26, the CP indicated, .The Resident has altered respiratory status r/t allergies . oranges . During a review of the facility's policy and procedure (P&P) titled, Dietary Profile and Resident Preference Interview dated 11/11/25, the P&P indicated, . The Dietary Department will provide residents with meals consistent with their preferences and Physician order as indicated on the tray card . if a preferred item is not available, a suitable substitute shall be provided .

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure medical records were complete and accurately documented in accordance with accepted professional standards of practice for two of nine sampled residents (Resident 6 and Resident 83), when Resident 6 and Resident 83's copy of the Physician Orders for Life-Sustaining Treatment (POLST - a medical order signed by both the patient and medical provider that specifies the types of medical treatment a patient wishes to receive toward the end of life) were incomplete.This failure had the potential for Resident 6 and Resident 83's decisions regarding lifesaving treatment options and end of life wishes to not be honored.Findings:During a concurrent observation and interview on [DATE] at 1:20 p.m. with Resident 6 in Resident 6's room, Resident 6 was observed dressed and lying in bed. Resident 6 stated she did not know how long she was in the facility or why she was there. During a review of Resident 6'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), dated [DATE], the AR indicated Resident 6 was admitted to the facility from an acute care hospital on [DATE] with diagnoses of hemiplegia (paralysis [the loss of the ability to move and sometimes to feel anything] of one side of the body) and hemiparesis (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles) affecting the left non-dominant side, type 2 Diabetes Mellitus (when the blood sugar levels in the body are too high), contracture (a permanent tightening of the muscles, tendons, skin, and nearby tissues that causes the joints to shorten and become very stiff) of muscle left thigh, acquired absence (surgical removal of finger, toe, hand, foot, arm or leg) of left leg above the knee, acute kidney failure (a condition when the kidneys suddenly are unable to filter waste products from the blood), dysphagia (difficulty swallowing), and cognitive communication deficit (difficulty with thinking and how someone uses language).During a review of Resident 6's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated [DATE], the MDS section C indicated Resident 6 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive (involving the process of thinking, learning and understanding) understanding on a scale of 1-15) score of 9 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 6 was moderately impaired.During a concurrent interview and record review on [DATE] at 9:02 a.m. with Licensed Vocational Nurse (LVN) 1, Resident 6's POLST, dated [DATE] was reviewed. The POLST indicated, Section C .Artificially Administered Nutrition.no artificial means of nutrition, including feeding tubes.trial period of artificial nutrition, including feeding tubes.long-term artificial nutrition, including feeding tubes. was not marked. LVN 1 stated a POLST was an Advanced Directive (a legal document indicating resident preference on end-of-life treatment decisions) that guided the nurse on what to do if a resident's heart stopped beating. LVN 1 stated the POLST was sent with residents if they were transferred to another facility or to the hospital. LVN 1 stated if the POLST was not complete, staff could do the wrong thing for the residents' end-of-life wishes. LVN 1 stated all sections of Resident 6's POLST should have been completed.During a concurrent interview and record review on [DATE] at 11:39 a.m. with the Medical Records Coordinator (MR), Resident 6's POLST, dated [DATE] was reviewed. Resident 6's POLST indicated Section C was not complete. The MR stated Section C of Resident 6's POLST was not filled in. The MR stated Section C determined if the resident would use artificial nutrition during end-of-life care. The MR stated it was important for resident's POLSTs to be complete. The MR stated the POLST indicated what a resident's code status (the type of emergent treatment a person would or would not receive if their heart or breathing were to stop) was so the (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nurse would know to do cardiopulmonary resuscitation (CPR - an emergency lifesaving procedure performed when the heart stops beating) or not. The MR stated all sections of the POLST should be completed.During an observation on [DATE] at 11:16 a.m. in Resident 83's room, Resident 83 was observed wearing a gown, lying in bed, awake. Resident 83 did not respond to any questions.During a review of Resident 83's AR, dated [DATE], the AR indicated Resident 83 was initially admitted to the facility from an acute care hospital on [DATE] and re-admitted to the facility on [DATE] with diagnoses of dysphagia following cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area), aphasia (a disorder that makes it difficult to speak) dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills, and eventually, the ability to carry out the simplest tasks), major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities), acute kidney failure, quadriplegia (a form of paralysis [the loss of the ability to move and sometimes to feel anything] that affects all of a person's limbs and body from the neck down), contracture of right and left shoulder, right and left elbow, right hand, right and left hip, right and left ankle, and adult failure to thrive (a gradual, ongoing decline in physical and mental health).During a review of Resident 83's MDS, dated [DATE], the MDS section C indicated Resident 83 had a BIMS score of 1, which suggested Resident 83 was severely cognitively impaired.During a review of Resident 83's Order Summary Report (OSR), dated [DATE], the OSR indicated, .CPR with full treatment.order status.active.order date.XXX[DATE].During a concurrent interview and record review on [DATE] at 9:02 a.m. with LVN 1, Resident 83's POLST, undated was reviewed. The POLST indicated there was no signature from Resident 83, or Resident 83's Responsible Party (RP - individual authorized to act on a resident's behalf regarding care), which was an appointed Conservator (a judge appointed person to act or make decisions for the person who needs help) on the POLST or date the POLST form was completed. LVN 1 stated a signed copy of Resident 83's POLST was not in the computer or in Resident 83's hardcopy (paper) file. LVN 1 stated there should have been a copy of Resident 83's POLST in the computer or hardcopy file, signed by Resident 83 or by Resident 83's RP. LVN 1 stated a POLST was an advanced directive, which guided the nurse on what to do if Resident 83's heart stopped beating. LVN 1 stated if a resident's POLST was not complete, staff could do the wrong thing for Resident 83's end-of-life wishes. LVN 1 stated all sections of the POLST should have been completed.During a concurrent interview and record review on [DATE] at 11:39 a.m. with the MR coordinator, Resident 83's POLST, undated was reviewed. Resident 83's POLST indicated there was no date the POLST form was prepared and section D (Information and Signatures) did not have a signature from the Resident or Conservator. The MR stated the POLST was completed by the physician or Nurse Practitioner (NP) after discussing with the resident or the resident's RP. The MR stated once the POLST form was complete, the Medical Records Department tracked the form to confirm it was uploaded into the resident's chart. The MR stated Resident 83's POLST had a notation to see a copy with Resident 83's Conservator's signature, but the MR stated she was unable to find the copy. The MR stated someone needed to call the Conservator to see if they had a signed copy of Resident 83's POLST. The MR stated it was important for Resident 83's POLSTs to be complete. The MR stated the POLST indicated what a resident's code status was so the nurse would know to do CPR or not. The MR stated all sections of the POLST should be complete.During an interview on [DATE] at 5:18 p.m. with the Director of Nursing (DON), the DON stated a POLST was a physician's order that informed staff with the residents' or RP's wishes were for life sustaining treatment, to do CPR or not. The DON stated all sections of a resident's POLST should have been completed. The DON stated if a resident's POLST was not complete, staff might not be able to follow the residents' or RP's wishes. The DON stated the physician completed the POLST form with the resident or RP and signed the form with the resident or RP to verify their wishes. The DON stated the nurse reviewed the POLST form for completeness. The DON stated her expectation was for Medical Records to do (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	auditing of the POLST forms before scanning into the resident's chart.During a review of the facility's policy and procedure (P&P) titled, Advance Directive, dated [DATE], the P&P indicated, .Upon admission, the Admissions Staff or Designee will provide written information to the resident concerning his or her right to make decisions concerning medical care; including the right to accept or refuse medical or surgical treatment, and the right to formulate advance directives.the Interdisciplinary Team will periodically review the Advance Directive, if applicable, with the resident or resident representative, to ensure that it still reflects the resident's wishes.During a review of the facility's P&P titled, Physician Orders, dated [DATE], the P&P indicated, .Physician orders will include the following.name of the ordering provider.resident's name.the date and time the order was received.treatment orders will include the following.a description of the treatment-the condition or diagnosis for which the treatment is ordered.other orders will include a clear and complete description to provide clarity on the physician's plan of care.documentation pertaining to physician orders will be maintained [in] the Resident's medical record.During a review of the facility job description document titled, Health Record Coordinator, undated indicated, .Assists in developing and maintaining an appropriate health record service and system for the facility.maintains Health Record System according to Federal, State and Community requirements.performs audits.coordinates physician documentation.During a review of the professional reference document titled, Physician Orders for Life-Sustaining Treatment Forms & Instructions (POLST), dated 2026, retrieved at: https://www.[NAME]-[NAME].org/programs/support-services/services/healthcare-ethics/polst.html, the document indicated, .The POLST form is completed by a patient ' s physician (or by someone who has undergone special training about POLST and who works with the patient ' s physician) in conjunction with thorough conversation with the patient regarding the patient ' s current and future health conditions and treatment preferences. Both the physician and patient must sign the POLST. If the patient lacks capacity to make medical decisions, the patient ' s legally recognized decision-maker can participate in both completing and signing the POLST form .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to establish and maintain an effective infection prevention and control program to help prevent the development and transmission of infections for four of 14 sampled residents (Resident 58, Resident 17, Resident 31, and Resident 59) when:1. Resident 58's foley catheter drainage tubing (a tube that is inserted into the urinary bladder to collect urine into a bag) was touching the floor and Resident 58's urine drainage bag (a bag that collects urine from a urinary catheter) was on the floor.2. The connector end of the feeding bag tubing for Resident 17 was left open to air and did not have a tube cover cap.3. The appropriate Personal Protective Equipment (PPE) was not worn during care for Resident 31 who was on contact precaution.4. Resident 59's Peripherally Inserted Central Catheter (PICC line, tube inserted into a vein for medications, fluids, or nutrition to be delivered over weeks or months) dressing change was not completed within 7 days according to physician orders. This failure placed Resident 58, Resident 17, Resident 31, and Resident 59 at risk for cross-contamination (the process when germs are unintentionally transferred from one substance or object to another, which causes a harmful effect) and infection (an invasion of the body by germs that cause disease).Findings: 1. During a concurrent observation and interview on 5/05/2026 at 3:57 p.m. with Resident 58, in Resident 58's room, Resident 58 was observed wearing a gown in bed. Resident 58 stated she was not feeling well since yesterday, and today she felt worse with a fever. Resident 58's urinary catheter bag and tubing were observed on the floor on the right side of Resident 58's bed. During a review of resident 58's admission Record (AR - a summary of information regarding a patient), dated 5/8/26, the AR indicated Resident 58 was initially admitted to the facility from an acute care hospital on 7/27/21 and readmitted on [DATE] with diagnoses of traumatic brain injury (a brain dysfunction caused by an outside force, usually a violent blow to the head), contracture (a permanent tightening of the muscles, tendons, skin, and nearby tissues that causes the joints to shorten and become very stiff) of muscles or the right forearm (the part of the arm extending from the elbow to the wrist) and left forearm, contracture of right hand and left hand, contracture of muscles of the right lower leg and left lower leg, quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury), obstructive and reflux uropathy (when urine cannot drain and backs up into the kidney), resistance to vancomycin (a medication used to treat bacterial infections), and artificial openings of the urinary tract (the organs that make urine and remove it from the body). During a review of Resident 58's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 4/16/26, the MDS section C indicated Resident 58 had a Brief Interview for Mental Status (BIMS, a test given to determine thinking, learning, and understanding), score of four (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which indicated Resident 58 was severely cognitively impaired. During an interview on 5/07/2026 at 11:15 a.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated Resident 58's urinary catheter tubing and bag should not have touched or been on the floor. CNA 1 stated Resident 58's drainage bag should have been inside a dignity bag (a cover that conceals urinary drainage bags from public view to protect a resident's dignity) and the dignity bag should have been tied to the bed and off the floor. CNA 1 stated Resident 58's urinary catheter tubing should not have been on the floor. CNA 1 stated if the urinary drainage bag and drainage tubing were on the floor, (continued on next page)

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	it could have caused cross-contamination from the floor. CNA 1 stated the ground was dirty and Resident 58 could get an infection. During a concurrent interview and record review on 5/8/26 at 8:50 a.m. with Licensed Vocational Nurse (LVN) 1, Resident 58's Order Summary Report (OSR), dated 5/8/26 was reviewed. The OSR indicated, .Levofloxacin tablet 500 milligrams (MG) give 1 tablet by mouth .for urinary tract infection (UTI).order date.05/07/2026. LVN 1 stated Resident 58's urinary catheter should not have been on the floor, it should have been hung on the bed railing off the floor for infection control. LVN 1 stated Resident 58's urine was observed to be cloudy on 5/5/26 and Resident 58 was started on an antibiotic yesterday for a UTI. LVN 1 stated his expectation was for the CNAs to drain the urinary drainage bag and place the bag and tubing back in the dignity bag and hang it on the bed rail. During an interview on 5/8/26 at 10:58 p.m. with the Infection Preventionist (IP), the IP stated residents' catheter tubing and bag should not be on the floor as there was a risk of cross contamination and infection to residents. During an interview on 5/8/26 at 5:18 p.m. with the Director of Nursing (DON), the DON stated her expectation was for residents' urinary catheter tubing and drainage bag to not touch the floor. The DON stated there was a risk of infection for the residents if the catheter tubing and bag were on the floor. The DON stated her expectation was for CNAs to put the drainage tubing and drainage bag inside the dignity bag and put the bags up off the floor after the CNAs completed draining the bag of urine. During a review of the facility's P&P titled, Infection Control – Policies & Procedures, dated 1/1/2012, the P&P indicated, .to provide infection control policies and procedures required for a safe and sanitary environment.and to help prevent and manage transmission of diseases and infections.prevent, detect, investigate, and control infections in the facility.staff are trained on the infection control policies and procedures upon hire and periodically thereafter, including where and how to find and use pertinent procedures and equipment related to infection control. During a review of the facility's policy and procedure (P&P) titled, Indwelling Catheter, dated 7/22/2025, the P&P indicated, .only properly trained licensed and care staff who know the correct technique of aseptic catheter insertion and maintenance will be responsible for the insertion and care of indwelling catheters. During a review of the facility's training plan (TP) titled, Catheter and Perineal Care, dated 2022, the TP indicated, .following proper perineal and catheter care procedures can prevent contamination that can lead to urinary tract infections.ensure that the catheter bag is secured to a non-movable part of a bed or chair, the tubing is not dragging on the floor.following correct procedures for peri care and catheter care can prevent infections. 2. During an observation on 5/6/26 at 9:44 a.m. in Resident 17's room, there was a feeding pump with feeding formula set up. The tubing was hanging on the feeding pump and the pole. The connector end of the feeding bag tubing for Resident 17 did not have a tube cover cap and was left open to air. During a review of Resident 17's AR, dated 5/8/26, the AR indicated, Resident 17, was admitted to the facility on [DATE] from acute care hospital and had diagnoses that included .dysphagia (difficulty or discomfort in swallowing), . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 17's MDS, dated [DATE], the MDS section C indicated Resident 17 had a BIMS score of 13 out of 15. The BIMS indicated Resident 17 was cognitively intact. During a review of Resident 17's OSR, the OSR indicated .Enteral Feed Order two times a day [named brand] feeding formula 1.8 at 85 mL (milliliter- unit of measure)/hour x 20 hours, = 1700 ml/24h 3060 calories (calorie- a unit of energy used to measure the amount of energy provided by food and drinks) /24h via g-tube for dx(diagnosis) of dysphagia . order start date 5/5/25. During an interview on 5/8/26 at 10:28 a.m. with Registered Nurse (RN) 1, RN 1 stated there should be a cap at the end of the feeding tube. RN 1 stated this was important because Resident 17 could get gastrointestinal infection (GI- an infection/inflammation of the stomach and intestines caused by viruses, bacteria, or parasites) During an interview on 5/8/26 at 1:46 p.m. with LVN 2, LVN 2 stated there should have been a cap or the end of the tubing should have been bagged to prevent getting the tube dirty. LVN 2 stated Resident 17 could get infection if the tubing was left open, LVN 2 stated the tubing should be replaced During an interview on 5/8/26 at 2:30 p.m. with the IP, the IP stated the tubing should have been capped to prevent infection. The IP stated Resident 17 could get GI infection. During an interview on 5/8/26 at 4:34 p.m. with the DON, the DON stated if feeding bag tubing is not connected to the resident it should be covered with a cap. The DON stated the expectation from the nurses was that the tube should be covered with a cap or the feeding bag should be discarded. The DON stated this was to prevent GI infection for Resident 17. 3. During an observation on 5/5/26 at 11:09 a.m. outside Resident 31's room, a contact precaution signage was posted on the wall outside Resident 31's room. CNA 3 was observed in Resident 31's room with no PPE gown on. CNA 3 packed dirty linen into a plastic bag, brought the bag outside the room and put the bag into the linen basket. CNA 3 went back into Resident 31's room then proceeded to wheel the shower gurney (shower stretcher- is a mobile, water-resistant device designed for transporting and bathing individuals with limited mobility who cannot sit upright) out of Resident 31's room into the hallway. While in the hallway, brown colored substances were noted on the shower gurney and water from the gurney was dripping onto the hallway floor. CNA 3 stated the brown substance was fecal matter, that Resident 31 had diarrhea. CNA 3 was observed using two medium sized towels to clean the water from the shower gurney on the hallway floor. CNA 3 cleaned the hallway floor in a continuous motion all the way back into Resident 31's room. CNA 3 stated Resident 31 had diarrhea. During a review of Resident 31's AR, dated 5/8/26, the AR indicated, Resident 31, was admitted to the facility on [DATE] from acute care hospital and had diagnoses that included .infection and inflammatory reaction due to cystostomy catheter (suprapubic catheter- a tube placed directly into the bladder through a small opening in the lower abdomen to drain urine), resistance to multiple antimicrobial drugs (germs such as bacteria, viruses, or fungi have developed the ability to survive and thrive despite being treated with several different types of medications), sepsis due to methicillin susceptible staphylococcus aureus (MSSA- a life-threatening, whole-body emergency caused by common staph bacteria entering the bloodstream), urinary tract infection (UTI-an infection caused by bacteria entering the urinary system [bladder, urethra, or kidneys], leading to inflammation and discomfort), unspecified Escherichia coli (E.coli- a type of bacteria found in the intestines of healthy humans which can cause food poisoning, diarrhea, or urinary tract infections), pseudomonas (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, Resident Isolation- Initiating Transmission- Based Precaution dated 4/22/2016, the P&P indicated, .V. When transmission-based precautions are implemented, the Infection Control Coordinator (or designee): A. Ensures that protective equipment (i.e., gloves, gowns, masks, etc.) is maintained near the resident's room so that everyone entering the room can access what they need; B. Posts the appropriate notice on the room entrance door and on the front of the resident's chart so that all personnel are aware of precautions, or aware that they must first see a nurse to obtain additional information about the situation before entering the room. C. Ensures that an appropriate linen barrel/hamper and waste container with a liner, is placed within reasonable distance of the resident's room; D. Places necessary treatment equipment and supplies in the room that are needed during the period of transmission-based precautions; E. Ensures there is an adequate supply of antiseptic soap and paper towels maintained in the room during the isolation period; . 4. During a concurrent observation and interview on 5/5/26 at 10:52 a.m. in Resident 59's room, Resident 59 stated she had a PICC line on her right upper extremity (RUE). The PICC line was observed to be dated 4/27/26. Resident 59 stated she was informed by hospital nurses that the PICC line dressing should be changed every seven days. Resident 59 stated the dressing was changed in the hospital on 4/14/26 and she was discharged from the hospital on 4/16/26. Resident 59 stated she was concerned the PICC line would get infected because since she came to the facility the dressing was not changed as expected. Resident 59 stated the PICC line dressing was changed by the nurses only once on 4/27/26 since she was admitted to the facility on [DATE]. During a review of Resident 59's AR, dated 5/8/26, the AR indicated, Resident 59, was admitted to the facility on [DATE] from acute care hospital and had diagnoses that included .methicillin resistant staphylococcus aureus infection (MRSA infection- caused by a type of staph bacteria that become resistant to many of the antibiotics used to treat ordinary staph infections), infection of amputation stump, left lower extremity, . During a review of Resident 59's MDS, dated [DATE], the MDS section C indicated Resident 59 had a BIMS score of 14 out of 15. The BIMS indicated Resident 59 was cognitively intact. During a review of Resident 59's OSR, the OSR indicated .Change dressing and cap to PICC line to right upper arm every Sunday noc (Night) shift as needed (PRN) for PICC Care. order start date 4/16/26. Change dressing and cap to PICC line to right upper arm every Sunday noc shift every day shift every 7day(s). order start date 4/16/26. During a concurrent interview and record review on 5/8/26 at 10:43 a.m. with RN 1, Resident 59's Treatment Administration Record (TAR) was reviewed, the TAR indicated Resident 59 had orders for PICC line dressing once a week every sun and PRN dated 4/16/26. RN 1 stated the TAR indicated there was a PICC line dressing change on 4/17/26 at 4:56 p.m., on 4/24/26 at 1:40 p.m. and on 5/1/26 at 10:15 a.m. During a concurrent observation, interview and record review on 5/8/26 at 11:11 a.m. with RN 1, Resident 59's PICC line dressing to her RUE was noted to be changed and dated 5/5/26 with no time of change indicated. Resident 59 stated the dressing was changed yesterday 5/7/26. Resident 59's Electronic Health record (EHR) was reviewed, the EHR indicated there was no record of the dressing change on 4/27/26 and on 5/5/26 as observed on Resident 59's RUE. RN 1 stated on 5/5/26 when the initial observation was made, the dressing to Resident59's RUE should have indicated 5/1/26 and not 4/27/26 if there was a dressing change on 5/1/26 as documented in the TAR. RN 1 stated (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 59's PICC dressing was not changed as indicated in the MAR but was documented as changed. RN 1 stated the Licensed Nurse (LN)s were putting Resident 59 at risk for infection when the PICC line dressing was not changed according to the physician's orders. During a concurrent interview and record review on 5/8/26 at 1:48 p.m. with LVN 2, a picture of the PICC line dressing to resident 59's RUE was reviewed. The picture indicated the RUE was dated 4/27/26. LVN 2 stated the expectation with respect to a PICC line, the LNs should monitor the site, proper dressing changing, and ensure there was no infiltration. LVN 2 stated dressing change was expected to be completed every week or prn if soiled. During the record review, LVN 2 stated the order indicated . change dressing and cap to PICC line to right upper arm every sun, noc shift. LVN 2 stated since Resident 59 was admitted on [DATE], the first dressing change should have been on the Sunday 4/19/26. LVN 2 stated if the dressing was changed on 5/1/26, the date should have been reflected on the resident's dressing on 5/5/26. LVN 2 stated the picture indicated the dressing was changed on 4/27/26. LVN 2 stated the LN that changed the dressing on 4/27/26 did not document the dressing change. LVN 2 stated the dressing was never completed 5/1/26 as indicated in the charting because there was no evidence of that based on the picture of Resident 59's RUE taken on 5/5/26 at 10: 52 a.m. LVN 2 stated there are discrepancies in the documentation and the actual observations. LVN 2 stated when Resident 59's PICC line dressing was not changed as expected it could get infected and affect the resident. During concurrent interview and picture review on 5/8/26 at 2:30 p.m. with the IP, the IP stated the expectation was for the LN to monitor the PICC line site, wear the appropriate PPE during resident care and the PICC line dressing change to be done. The IP stated the dressing changes should have been completed as per the physician's orders. The IP stated the dressing change should have been completed on the 4/19/26. The IP stated as at 5/5/26 at 10:52a.m., the dressing change on resident arm should have indicated 5/1/26 if the dressing change was completed on 5/1/26. The IP stated the dressing change was dated 4/27/26 in the picture review. The IP stated the dressing was not changed on 5/1/26. The IP stated there were more than 7 days from 4/27/26 to 5/5/26 and the dressing change should have been completed within 7 days. The IP stated it was important to change the PICC line dressing to ensure Resident 59 did not get infection. The IP stated Resident 59 could get blood infection and sepsis (body's extreme, life-threatening response to an infection) which could possibly be fatal for the resident. During concurrent interview and picture review on 5/8/26 at 4:38 p.m. with the DON, the DON stated Resident 59's dressing change should be completed every 7 days and prn. The DON stated the dates on the PICC line dressing and the EHR were different. The DON stated the dressing change was not done every 7 days according to the physician's order. The DON stated PICC line dressings are important to be changed timely to prevent infection since it was an open site. During a review of the facility's P&P titled, Vascular Access Device Assessment, Care, and Dressing Changes no date, the P&P indicated, Policy- A post insertion care bundle in conjunction with a culture of safety and quality is implemented to reduce the risk of catheter-related infection during daily care and management. Site care is performed at established intervals, including skin antisepsis and dressing changes, and immediately if the dressing integrity becomes compromised (e.g., lifted/detached on any border edge or within transparent portion of dressing; visibly soiled; presence of moisture, drainage, or blood) or compromised skin integrity is present under the dressing.Dressing and Securement Change Frequency- Transparent semipermeable membrane (TSM) dressings and TSM dressings with an integrated securement device (ISD) should be changed at least every 7 days or immediately if dressing integrity is disrupted (e.g., lifted/detached on any border edge or within (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	transparent portion of dressing; visibly soiled; presence of moisture, drainage, or blood) or compromised skin integrity is present under the dressing. 24. Label dressing with date performed. Documentation- Document in the patient's health record: Site assessment findings, Performance of procedure, including type of antiseptic solution, and dressing type, Patient response to the procedure, Patient education. During a review of the facility's P&P titled, Infection Control – Policies & Procedures, dated 1/1/2012, the P&P indicated, .to provide infection control policies and procedures required for a safe and sanitary environment.and to help prevent and manage transmission of diseases and infections.prevent, detect, investigate, and control infections in the facility.staff are trained on the infection control policies and procedures upon hire and periodically thereafter, including where and how to find and use pertinent procedures and equipment related to infection control.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure two of 14 residents (Resident 69 and Resident 93) had the ability to call for staff assistance through the call system (a communication system which relays the call directly to a staff member or to a centralized staff work area) when:1. Resident 69's call system was not working.2. Resident 93 was unable to reach her call button to access the call system while in their bed. These failures had the potential for Resident 69 and Resident 93 to not receive assistance or help from staff when needed and put Resident 69 and Resident 93 at risk of injury, harm and not having their needs met.Findings: 1. During a concurrent observation and interview on 5/5/2026 at 9:14 a.m. with Resident 69 in Resident 69's room, Resident 69 was observed dressed, lying in bed. Resident 69 stated she had been at the facility since January 2026 due to a bad fall. Resident 69 stated her right arm was weak and she was unable to move her right leg. Resident 69 stated she had physical therapy and could do some things on her own but needed assistance. Resident 69 stated it could take a while to get help since her call light did not work. Resident 69 stated she already pressed the call button and was waiting for assistance. Observed a red light lit on the wall with the outside light above the door not lit up. During a review of Resident 69'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), dated 5/8/26, the AR indicated Resident 69 was admitted to the facility from an acute care hospital on 1/26/26 with diagnoses of fall from or off toilet with subsequent striking against an object, abnormalities of gait (walking) or mobility (movement), dysphagia (difficulty swallowing), peripheral vascular disease (the reduced circulation of blood to the arms or legs), peripheral autonomic neuropathy (damage to nerves that manage normally automatic body functions), morbid obesity (a serious health condition that results from an abnormally high body mass) due to excess calories, muscle weakness, and need for assistance with personal care. During a review of Resident 69's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 2/2/26, the MDS section C indicated Resident 69 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive (involving the process of thinking, learning and understanding) understanding on a scale of 1-15) score of 14 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which indicated Resident 69 was cognitively intact. During a review of Resident 69's MDS, dated 2/2/26, section GG (Functional Abilities) indicated, Resident 69 had impairment (diminishment or loss of function or ability) in the right and left upper extremities (shoulder, elbow, wrist, hand) and impairment on right and left lower extremities (hip, knee, ankle, foot). Section GG indicated, .substantial/maximal assistance – helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.oral hygiene.dependent – helper does all of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.toileting hygiene: the ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement.shower/bathe self.upper body dressing.lower body dressing.putting on/taking off footwear.personal hygiene: the ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands.roll left and right.sit to lying.lying to sitting on side of bed.tub/shower transfer: the ability to get in and out of a (continued on next page)

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	055626	A. Building B. Wing	05/08/2026

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.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	tub/shower. During a review of Resident 69's Care Plan Report (CP), undated, the CP indicated, .the resident is [high] risk for falls related to [r/t] history of [h/o] fall, muscle weakness, gait/balance problems. date initiated: 1/27/2026.be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance.date initiated: 1/27/2026. During an interview on 5/07/2026 at 11:15 a.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated the CNAs received report from the night shift if a resident was totally dependent and needed assistance. CNA 1 stated if she saw a resident struggling, she helped them. CNA 1 stated if a resident needed assistance with repositioning, she checked on them every hour. CNA 1 stated she was aware of Resident 69's call light not working, and if Resident 69 needed assistance, her roommate pressed her call light to notify staff Resident 69 needed assistance. CNA 1 stated staff informed maintenance through an electronic system and a maintenance binder if something needed repair. During an interview on 5/8/26 at 9:24 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated residents notified staff if their call lights were not working, or staff informed the nurse. LVN 1 stated there was a maintenance binder the staff wrote in if something needed to be fixed, an electronic system they could put a request in, or verbally informed maintenance of repairs. LVN 1 stated there was a monitor at the nurses' station that lit up if a call light was pressed, but no noise was made from the monitor to alert staff of a resident requesting assistance. LVN 1 stated the call light was used for residents to ask for help, for staff requesting assistance to change the resident, for staff to report a change in resident's condition, and for resident safety such as a resident about to fall. LVN 1 stated Resident 69 should have had a functioning call light for the residents' safety and the residents' needs. LVN 1 stated residents should have some way of notifying staff of their needs. During a concurrent interview and record review on 5/8/26 at 10:39 a.m. with the Maintenance Director (MAIND), the MAIND stated he was not aware Resident 69's call light was not working. The MAIND stated staff used an electronic system to inform him if anything needed repair. The MAIND reviewed the electronic system log of repairs and stated there was no documentation of Resident 69's broken call light system, or that it was repaired. The MAIND stated the call light was for resident communication with staff, for concerns, if they needed something such as water, or were unable to stand and needed assistance to get up. The MAIND stated the facility had a no pass rule which indicated if a resident's call light was on, staff needed to go into the room, even if it was not their assigned area, to check on the residents. The MAIND stated the call light system was important for the residents and it was important for maintenance to be informed if it was broken and needed to be repaired. During an interview on 5/8/26 at 5:18 p.m. with the Director of Nursing (DON), the DON stated her expectation was for resident's call light system to be working. The DON stated if a resident's call light was not working, the facility provided a bell for the resident to ring when they needed assistance. The DON stated it was important for residents to have a way to call staff when they needed assistance or to communicate any needs. The DON stated any staff member could inform maintenance of repairs that were needed. During a review of the facility's policy and procedure (P&P) titled, Communication-Call System, dated 8/24/2024, the P&P indicated, .The facility will maintain a communication system to allow residents to call for staff assistance from their rooms and toileting/bathing facilities.to ensure that residents (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	have a means of contacting facility staff for assistance.facility staff will answer call alerts promptly and in a courteous manner.if the call alert system is defective, it will be reported to maintenance for immediate repair, if the call system cannot be repaired immediately, an alternative call alert process will be put in place [i.e., tap bells, auxiliary aids, etc.]. During a review of the facility's P&P titled, Maintenance – Work Orders, dated1/1/2012, the P&P indicated, .To protect the health and safety of residents, visitors, and Facility Staff.maintenance work orders shall be completed in an effort to sustain maintenance services as a priority.department directors/supervisors are responsible for completing such work orders ad forwarding them to the Director of Maintenance.a supply of workorder forms is maintained at each nurses' station.work order requests are to be placed in a designated location at the nurses' station.work orders are picked up daily by Maintenance Staff.emergency requests are given priority.emergency requests should be delivered directly to the Director of Maintenance.the director of Maintenance will maintain completed Work Orders chronologically in a binder in the Director of Maintenance's office. 2. During a concurrent observation and interview on 5/5/2026 at 9:43 a.m. with Resident 93 in Resident 93's room, Resident 93 was observed lying in bed with call light on the floor and unable to reach or push the call light. Resident stated she was unable to reach her call light. Call light was observed clipped to the head of the bed and dangling under the bed mattress and on the floor. During a review of Resident 93's AR, dated 5/8/26, the AR indicated Resident 93 was admitted to the facility on [DATE] with diagnoses of unspecified combined systolic (congestive) and diastolic (congestive) heart failure (when the heart cannot pump blood efficiently [systolic] and cannot fill with enough blood between beats [diastolic]), unspecified atrial fibrillation (an irregular heart beat), hemiplegia (complete inability to move) and hemiparesis (partial weakness or reduced strength on one side) following unspecified cerebrovascular disease (a group of conditions that disrupt blood flow to the brain starving brain cells of oxygen and nutrients) affecting unspecified side, and muscle wasting and atrophy (the loss of muscle tissue causing muscles to become smaller, thinner, and weaker) not elsewhere classified-unspecified site. During a review of Resident 93's MDS, dated 2/25/26, the MDS section C indicated Resident 93 had a BIMS score of 8 , which indicated Resident 93 was moderately impaired. During a concurrent observation and interview on 5/5/2026 at 9:50 a.m. with the Nurse Consultant (NC) in Resident 93's room, The NC stated the call light was on the floor and not within Resident 93's reach. The NC asked Resident 93 if she needed help, and Resident 93 stated she needed to get changed. During a concurrent observation and interview on 5/08/2026 at 3:25 p.m. with CNA 6, outside of Resident 93's room, CNA 6 stated resident 93's call light was not within reach and should have been so that resident 93 could call staff if she needed assistance, she needed to be changed, or in case something fell and they needed help etc. CNA 6 stated call light should also be within resident reach for resident safety and communication between the resident and staff. During a concurrent observation and interview on 5/08/2026 at 3:31 p.m. with LVN 1, outside of Resident 93's room, LVN 1 stated residents' call lights should always be within reach and staff should ensure the call light is clipped in order for it to stay within reach and ensure that the call light is functional for resident safety. LVN 1 stated resident 93's call light was clipped onto the bed, was on the floor and not within resident 93's reach. LVN 1 stated it was important for the call light to be (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	within resident 93's reach so that resident 93 could call for assistance if she needed it and for safety reasons. LVN 1 stated call light should be within reach so that residents could communicate and express their needs and wants. During an interview on 5/08/2026 at 5:05 p.m. with the DON, The DON stated her expectation was that call lights should be clipped (call light clip is used to keep call light within reach) and within residents reach so that residents could call for assistance. The DON stated it was important for the call light to be within resident reach so that residents could communicate their needs and wants. DON stated call light should always be within residents reach for safety. During a review of the facility's P&P titled, Communication-Call System, dated 8/24/2024, the P&P indicated, .The facility will maintain a communication system to allow residents to call for staff assistance from their rooms and toileting/bathing facilities.to ensure that residents have a means of contacting facility staff for assistance.The call alert device will be placed within the resident's reach.