STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055846	A. Building B. Wing	04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Terraces at San Joaquin Gardens Village	5551 N. Fresno St Fresno, CA 93710

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42123 Based on interview and record review the facility failed to meet professional standards of practice for one of four sampled residents (Resident 1) when Resident 1 ' s family member reported Resident 1 ' s abuse allegation to a licensed nurse (LN) and the LN perform a resident assessment and document on an SBAR (situation, background, assessment, recommendation- a communication tool used by healthcare workers when there is a change of condition among the residents) note in the electronic medical record (EMR) according to the facility ' s policy and procedure (P&P). This failure placed Resident 1 ' s safety at risk by not assessing her for signs and symptoms of potential abuse. Findings: During a review of Resident 1 ' s Admission Record, undated, the admission record indicated, Resident 1 was admitted to the facility on [DATE] with diagnoses which included fracture (a break in a bone) of the shaft of right humerus (middle part of the upper arm bone), aphasia (language disorder resulting from brain damage) following cerebral infarction (disruption of blood flow to the brain), hypertensive heart (heart condition caused by high blood pressure) and chronic kidney disease (kidneys are damaged) and history of falling . During a review of Residents 1 ' s Minimum Data Set (MDS- a resident assessment tool used to identify resident cognitive and physical function) assessment dated [DATE], indicated Resident 1 ' s Brief Interview of Mental status assessment (BIMS - assessment of cognitive status for memory and judgement) scored 04 of 15 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07 indicates severe impairment). The BIMS assessment indicated Resident 1 ' s cognition was severely impaired. Resident 1 ' s Interdisciplinary [IDT] Notes (IDT-team from different healthcare disciplines who work together to provide compressive patient care), dated 3/29/25, was reviewed. The IDT note indicated, . On 3/29/25, this resident ' s daughter informed the Licensed Nurse that the resident had told her that someone was hitting her at night . A resident interview was conducted, during which the resident was unable to provide details of the alleged incident, including who may have hit her or any description of the person . (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/23/25 at 9:23 a.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated she was familiar with Resident 1. CNA 1 stated Resident 1 had never complained to her about hitting her at night. CNA 1 stated Resident 1 was confused. During an interview on 4/23/25 at 10:33 a.m. with Licensed Nurse (LN) 1, Resident 1 ' s Health Status Note, dated 3/29/25 at 4:23 p.m., was reviewed. The note indicated, . [name of police officer] arrived to facility, spoke with RN [registered nurse] and [name of family member], regarding report of abuse accusations. RN explained to [police officer] of accusations made today, interviewed and no new skin problems . LN 1 stated she was unable to locate documentation indicating Resident 1 was assessed at the time of the allegation on 3/29/25. LN 1 stated a licensed nurse should have performed a complete skin assessment on Resident 1 to rule out any signs of abuse and documented the details of the alleged abuse and skin assessment on an SBAR. LN 1 stated Resident 1 was confused, emotional and frequently cried, but she had never seen any signs or symptoms of abuse. During a concurrent interview and record review on 4/23/25 at 11:10 a.m. with the Director of Nursing (DON), Resident 1 ' s electronic medical record (EMR) was reviewed. The DON stated she was unable to locate an SBAR indicating Resident 1 had an assessment after the alleged abuse was reported. The DON stated her expectations after Resident 1 ' s family member reported the alleged abuse, was for the nurse to be sure the resident was safe, perform a complete skin assessment to rule out any signs or abuse and report the alleged abuse. The DON stated the nurse should have assessed Resident 1 and completed an SBAR with details of their findings. During an interview on 4/23/25 at 11:35 a.m., with the Administrator (ADM), the ADM stated his expectations after abuse allegations were for the nurse to perform a skin assessment to rule out signs of abuse and document the details of the assessment. The ADM reviewed Resident 1 ' s EMR and stated he was unable to locate documentation that a complete skin assessment was done. During a review of the facility ' s policy and procedure (P&P) titled, Change in a Resident ' s Condition or Status, dated 2/2021, the P&P indicated, . Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident ' s medical/mental condition and/or status . The nurse will notify the resident ' s attending physician or physician on call when there has been a(an) . accident or incident involving the resident . significant change in the resident ' s physical/emotional/mental condition . A significant change of condition is a major decline or improvement in the resident ' s stated that . requires interdisciplinary review and/or revision to the care plan . Prior to notifying the physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including (for example) information prompted by the Interact SBAR Communication Form . The nurse will record in the resident ' s medical record information relative to changes in the resident ' s medical/mental condition or status . Based on interview and record review the facility failed to meet professional standards of practice for one of four sampled residents (Resident 1) when Resident 1's family member reported Resident 1's abuse allegation to a licensed nurse (LN) and the LN perform a resident assessment and document on an SBAR (situation, background, assessment, recommendation- a communication tool used by healthcare workers when there is a change of condition among the residents) note in the electronic medical record (EMR) according to the facility's policy and procedure (P&P). (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This failure placed Resident 1's safety at risk by not assessing her for signs and symptoms of potential abuse. Findings: During a review of Resident 1's Admission Record, undated, the admission record indicated, Resident 1 was admitted to the facility on [DATE] with diagnoses which included fracture (a break in a bone) of the shaft of right humerus (middle part of the upper arm bone), aphasia (language disorder resulting from brain damage) following cerebral infarction (disruption of blood flow to the brain), hypertensive heart (heart condition caused by high blood pressure) and chronic kidney disease (kidneys are damaged) and history of falling . During a review of Residents 1's Minimum Data Set (MDS- a resident assessment tool used to identify resident cognitive and physical function) assessment dated [DATE], indicated Resident 1's Brief Interview of Mental status assessment (BIMS - assessment of cognitive status for memory and judgement) scored 04 of 15 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07 indicates severe impairment). The BIMS assessment indicated Resident 1's cognition was severely impaired. Resident 1's Interdisciplinary [IDT] Notes (IDT-team from different healthcare disciplines who work together to provide compressive patient care), dated 3/29/25, was reviewed. The IDT note indicated, . On 3/29/25, this resident's daughter informed the Licensed Nurse that the resident had told her that someone was hitting her at night . A resident interview was conducted, during which the resident was unable to provide details of the alleged incident, including who may have hit her or any description of the person . During an interview on 4/23/25 at 9:23 a.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated she was familiar with Resident 1. CNA 1 stated Resident 1 had never complained to her about hitting her at night. CNA 1 stated Resident 1 was confused. During an interview on 4/23/25 at 10:33 a.m. with Licensed Nurse (LN) 1, Resident 1's Health Status Note, dated 3/29/25 at 4:23 p.m., was reviewed. The note indicated, . [name of police officer] arrived to facility, spoke with RN [registered nurse] and [name of family member], regarding report of abuse accusations. RN explained to [police officer] of accusations made today, interviewed and no new skin problems . LN 1 stated she was unable to locate documentation indicating Resident 1 was assessed at the time of the allegation on 3/29/25. LN 1 stated a licensed nurse should have performed a complete skin assessment on Resident 1 to rule out any signs of abuse and documented the details of the alleged abuse and skin assessment on an SBAR. LN 1 stated Resident 1 was confused, emotional and frequently cried, but she had never seen any signs or symptoms of abuse. During a concurrent interview and record review on 4/23/25 at 11:10 a.m. with the Director of Nursing (DON), Resident 1's electronic medical record (EMR) was reviewed. The DON stated she was unable to locate an SBAR indicating Resident 1 had an assessment after the alleged abuse was reported. The DON stated her expectations after Resident 1's family member reported the alleged abuse, was for the nurse to be sure the resident was safe, perform a complete skin assessment to rule out any signs or abuse and report the alleged abuse. The DON stated the nurse should have assessed Resident 1 and completed an SBAR with details of their findings. (continued on next page)

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