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	03/21/2025

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

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40641 Based on observation, interview, and record review, the facility failed to ensure the Minimum Data Set assessment (MDS-assessment of physical and psychological functions and needs) accurately reflected resident's health and functional status of one of five sampled residents (Resident 98) when Resident 98's surgical wound was inaccurately coded on the MDS assessment. This failure had the potential to result in Resident 98's care needs to not be met. Findings: During a concurrent observation and interview on 3/17/25 at 4:15 p.m., with Resident 98 in her room, Resident 98 was laying in bed watching TV. Resident 98 had a surgical wound with scabs on her midchest (middle area of the chest). Resident 98 stated she had an open heart surgery. During a review of Resident 98's Admission Record (AR-a summary of information regarding a patient which includes patient identification, past medical history, family contact information and other pertinent information) dated 3/19/25, the AR indicated, Resident 98 was admitted to the facility on [DATE] with diagnoses which included encounter for surgical aftercare following surgery on the circulatory system and shortness of breath. During a review of Resident 98's MDS dated [DATE], indicated the Brief Interview for Mental Status (BIMS) score was 14 out of 15 (a BIMS score of 13-15 indicates cognitively intact, 8-12 indicates moderately impaired and 0-7 indicates severe impairment), which indicated Resident 98 was cognitively intact. During a concurrent interview and record review on 3/20/25 at 254 p.m. with the Minimum Data Set Coordinator (MDSC), the MDSC stated Resident 98 was admitted to the facility with surgical wound to her midchest. The MDSC stated Resident 98 had an open heart surgery prior to admission to the facility. The MDSC reviewed Resident 98's admission assessment dated [DATE] section M (Skin Conditions), Resident 98's surgical wound was not coded in the MDS assessment. The MDSC stated, she did not complete the assessment, It was the other nurse The MDSC stated, Assessment is incorrect, it should have indicated yes on the surgical wound. The MDSC stated Resident 98's surgical wound should have been coded on the MDS admission assessment. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/21/25 at 12:05 p.m. with the Administrator (ADM), the ADM stated, .My expectation was to make sure MDS assessments are accurate and on-time . The ADM stated it was important for the MDS assessment to be accurately captured. During a review of the facility's policy and procedure (P&P) titled, MDS Assessment Coordinator, dated 2001, the P&P indicated, . Each individual who completes a portion of the assessment (MDS) must certify the accuracy of that portion of the assessment . Any individual who willfully and knowingly certifies (or cause another individual to certify) a material and false statement in a resident assessment is subject to disciplinary action . During a review of professional reference titled, Long-Term Care Facility Resident Assessment Instrument 3. 0 User's Manual version 1.19.1 10/24, indicated. Definitions . Surgical Wounds Any healing and non-healing, open or closed surgical incisions, skin grafts or drainage sites . Steps for Assessment . Examine the resident and determine whether any ulcers, wounds, or skin problems are present .

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51271 Based on observation, interview and record review, the facility failed to develop and implement a baseline care plan for three of 10 sampled residents (Resident 17, 197, 247) when: 1. Resident 17 had broken teeth and visible signs of tooth decay and no specific care plan interventions were put in place to address Resident 17's dental needs. This failure had the potential to result in Resident 17's dental needs to not be met which placed Resident 17 at an increased to develop dental infection. 2. Resident 197 and 247's care plans did not include their physician prescribed oxygen therapy (the administration of oxygen at concentrations greater than that of ambient air (20.9%) with the intent of treating or preventing the symptoms and manifestations of hypoxia-decreased perfusion of oxygen to the tissues). This failure had the potential for Resident 197 and 247 to not receive oxygen therapy as prescribed by their physician which had the potential to result in hypoxia and respiratory failure (a condition where there is not enough oxygen or too much carbon dioxide in your body). Findings: 1. During a review of Resident 17's Admission Record (AR- a document that provides resident contact details, a brief medical history, level of functioning, preferences, and wishes), dated 11/22/24 , the AR indicated Resident 17 had the following diagnoses: Parkinson's Disease (condition which affects the body's movements), Malignant neoplasm (a cancerous growth that occurs when cells grow and divide uncontrollably, invading nearby tissues and spreading to distant parts of the body) of rectum (the final 6 to 8 inches of the large intestine), bronchus (passageways that connects your windpipe to your lungs) and lung (spongy bags inside your chest that help you breath), Dysphagia (difficulty swallowing food or liquids), and Major Depressive Disorder (persistent sadness, loss of interest in activities and difficulty with relationships impacting a person's thinking and behavior). During a review of Resident 17's Minimum Data Set (MDS- resident assessment tool which indicated physical and cognitive abilities), dated 11/22/24, the MDS indicated a Brief Interview for Metal Status (BIMS- an assessment of cognitive function) score of seven (0-7 severe cognitive impairment, 8-12 moderate cognitive impairment, 13-15 no cognitive impairment), indicating Resident 17 had severe cognitive impairment. During a concurrent observation and interview on 3/17/25 at 9:47 a.m. with Resident 17 in their room, Resident 17 stated she had bad teeth because of her past cancer treatments. Resident 17's teeth had been in poor condition; all had been dark brown in color, broken and chipped. Resident 17 stated the condition of her teeth made her feel embarrassed. During an interview on 3/19/25 at 9:38 a.m. with Certified Nursing Assistant 4 (CNA 4), CNA 4 stated if it was not in the care plan, she would not know what to do for the resident. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/19/25 at 3:12p.m. with Certified Nursing Assistant 6 (CNA 6), CNA 6 stated that she had been familiar with the condition of Resident 17's teeth. CNA 6 stated the care plan directed the treatment for the resident. CNA 6 stated she referred to the care plan for resident care. CNA 6 stated if it wasn't in the care plan, she wouldn't know what to do. During an interview on 3/20/25 at 3:23p.m. with Licensed Vocational Nurse 6 (LVN 6), LVN 6 stated care plans were based on physician orders, resident preferences and any area of concern. LVN 6 stated baseline care plans were to be completed within twenty-four hours of resident admission. LVN 6 stated she had been familiar with the condition of Resident 17's teeth. During a concurrent interview and record review on 3/20/25 at 2:23 p.m. with (LVN 6), Resident 17's care plan (CP), dated 12/3/24 was reviewed. The CP indicated Resident 17 had evidence of cavities. Interventions listed on the care plan were to encourage or assist Resident 17 in performing oral hygiene after each meal and as needed. LVN 6 stated a care plan that addressed the dental needs of the resident should have been created on 11/22/24 the day Resident 17 admitted to the facility. LVN 6 stated a care plan addressing the dental needs of Resident 17 should have been created. LVN 6 stated having teeth like Resident 17's could cause infection, open areas in the mouth, difficulty chewing and psychosocial issues as well. During an interview on 3/20/25 at 3:22p.m. with the Minimum Data Set Coordinator (MDSC), The MDSC stated baseline care plans were completed during the night shift on the day of admission. MDSC stated aspects such as wound care and dental care should have been included in the baseline care plan. MDSC stated care plans were to be resident-specific and tailored to their individual needs. MDSC stated she was familiar with the condition of Resident 17's teeth. The MDSC stated poor dentition had the potential to contribute to weight loss, oral pain and feelings of embarrassment and self-consciousness. During an interview on 3/21/25 at 8:26 a.m. with Director of Nursing (DON), the DON stated baseline care plans were to be completed within twenty-four hours of admission. The DON stated any dental issues should be included in the baseline care plan. The DON stated she was familiar with the condition of Resident 17's teeth. The DON stated Resident 17 was admitted to the facility on [DATE]. The DON stated she expected the care plan addressing Resident 17's cavities, which was created on 12/3/24, to have been completed upon admission. During a review of the facilities policy and procedure (P&P) titled, Care Plans-Baseline, dated 3/2022, the P&P indicated, A baseline plan of care to meet the residents immediate health and safety needs is developed for each resident within forty eight hours of admission .the baseline care plan includes instructions needed to provide effective person-centered care of the resident that meet professional standards of quality care and must include the minimum healthcare information necessary to properly care for the resident including, but not limited to the following: e. social services . 51223 (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a concurrent observation and interview on 3/17/25 at 12:07 p.m. with Resident 197 in their room, Resident 197 laid in bed with head of bed elevated wearing an oxygen nasal cannula (NC-a thin, flexible tube that wraps around your head, typically hooks around the ears). The oxygen tubing extended from the resident down the right side of the bed, curled into several loops that laid on the floor then connected to the oxygen concentrator (a medical device that continuously purifies the air around you to deliver 90% to 95% pure oxygen). Resident 197 was alert, oriented, able to state name, date, time, location, and able to understand and answer questions. Resident 197 stated he had been wearing oxygen since hospitalization . During a record review of Resident 197's Admission Record (AR-a summary of important information regarding a patient which include patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information) dated 3/20/25, the AR indicated, Resident 197 was admitted to the facility on [DATE] with diagnoses which included the following: encounter for surgical aftercare following surgery on the digestive system (the break down food and absorbs nutrients for energy and growth), unspecified ventral hernia (a weak spot in the abdomen enabling abdominal tissue or an organ to protrude through a cavity muscle area) with obstruction (something that blocks), acute respiratory failure with hypoxia, and colostomy (a surgical procedure that brings one end of the large intestine out through the abdominal wall to allow waste to leave the body) status. During a review of Resident 197's Minimum Data Set (MDS-a federally mandated resident assessment tool), dated 3/13/25, the MDS section C indicated, Resident 197 had a Brief Interview for Mental Status (BIMS-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 15 out of 15 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07 indicates severe impairment, 99 indicates unable to complete the interview), which indicated Resident 197 was cognitively intact. During a concurrent observation and interview on 3/17/25 at 12:17 p.m. with Resident 247 during the initial tour in Resident 247's room, Resident 247 was lying in bed with a nasal cannula (NC- thin plastic tube that delivers oxygen directly into the nose through two small prongs) in her nostril connected to an oxygen concentrator (device that produces oxygen for breathing). Resident validated daily use of O2. During a review of Resident 247's AR, dated 3/20/25, the AR indicated, Resident 247, a [AGE] year-old female was admitted to the facility on [DATE] from an acute care hospital with diagnoses which included the following: .dependence on supplemental oxygen, shortness of breath (SOB), wheezing, partially vaccinated for COVID-19 . During a review of Resident 247's MDS assessment, dated 3/17/25, the MDS indicated, Resident 247's BIMS assessment score was 15 out of 15 (0-6 severe cognitive (pertaining to reasoning memory and judgement) deficit, 7-12 moderate cognitive deficit, 13-15 cognitively intact). BIMS scores indicated Resident 247 was cognitively intact. During a review of Resident 247's Order Summary Report (OSR) dated 3/11/25 at 11:04 a.m. The OSR indicated .oxygen at 2 LPM (liters per minute-unit of measurement) via NC due to SOB every shift. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/19/25 at 10:04 a.m. with Certified Nurse Aide (CNA) 1 in the Wing 3 common area, CNA 1 stated the care plan provided staff with information on the resident's likes/dislikes, level of care needed, and preferences so staff can provide person-centered care. CNA 1 stated it is important to have a care plan, so staff know how to care for and improve care for the resident. During a concurrent interview and record review on 3/20/25 at 3:47 p.m. with the Minimum Data Set Coordinator (MDSC), Resident 247's AR and O2 care plan dated 3/17/25 were reviewed. The AR indicated Resident 247 was admitted on [DATE]. The O2 care plan indicated that the care plan was initiated on the 3/17/25. The MDSC stated the baseline care plan was done by night shift (NOC) nurse and should be completed by the following day. The MDSC stated the baseline care plan should consist of the resident's primary diagnosis (the process of identifying a disease, condition, or injury from its signs and symptoms), other diagnoses, and medications. The MDSC stated, I would expect oxygen use to be on the baseline care plan. The MDSC stated the care plan was a guide for staff to provide resident care and was resident specific. The MDSC stated the baseline care plan would have helped the nurses verify the resident was receiving O2. The MDSC stated Resident 247 needed O2 in place, so they would not become short of breath. The MDSC stated if Resident 247 did not receive O2 they could develop respiratory failure that could lead to death. The MDSC stated the baseline care plan should have been done within 48hrs. The MDSC stated the baseline care plan was not within the acceptable time frame. During an interview on 3/19/25 at 04:00 p.m. with Licensed Vocational Nurse (LVN) 5 in the Wing 3 hallway, LVN 5 stated care plans could be modified by nurses and should be individualized to resident's diagnoses, functional status and medications. LVN 5 stated the care plan would provide staff instructions on how to care for the resident. LVN 5 stated when a resident has oxygen therapy ordered, the nurse should monitor the oxygen flow rate every shift to ensure the physician orders were followed. LVN 5 stated the potential risk of a resident not receiving oxygen as ordered could lead to hypoxia. During a concurrent interview and record review on 3/20/25 at 03:22 p.m. with the Minimum Data Set (MDS) Coordinator in the MDS office, Resident 197's order summary and care plan were reviewed. The order summary, dated 3/12/25, indicated the physician ordered two liters of oxygen (L-liter flow is the flow of oxygen received from the oxygen delivery device) every shift. The care plan, dated 3/20/25, indicated oxygen was not entered on the baseline care plan. The MDS stated the nurse should have completed the baseline care plan within 48 hours of admission to include person-centered care based on the primary diagnosis, medications, and treatment (such as oxygen therapy) that the resident had upon admission. The MDS stated the risk of not having oxygen therapy on the care plan could result in the resident not having oxygen treatment which could lead to breathlessness, respiratory failure or death. During an interview on 3/21/25 at 8:26 a.m. and 11:15 a.m. with the Director of Nurses (DON) in the room (RM) 214 and DON office, DON stated the baseline care plan should be completed within 24 hours of admission. The DON stated the baseline care plan should provide staff instructions on how to provide individualized care based on the resident's diagnoses, the reason for admission, and physician ordered treatment. The DON stated oxygen therapy should be on a resident's care plan. The DON stated the baseline care plan would ensure staff monitor the resident's oxygen flow rate to prevent the development of hypoxia. The DON stated the risk of hypoxia could lead to respiratory distress or death. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 3/21/25 at 9:00 a.m. with Director of Nursing (DON), Resident 247's AR and O2 care plan dated 3/17/25 were reviewed. The DON stated Resident's 247's care plan was initiated on 3/17/25. The DON stated the resident's baseline care plan should be completed within 24 hours of admission. The DON stated that the expectation from the LNs would provide care as indicated on the care plan. The DON stated the O2 care plan was not initiated timely. During a review of Job Description: Director of Nursing, dated 8/2018, the Mission Essential indicated, understand and adhere to company .policies and procedures. During a review of Job Description: LVN/LPN (Skilled Nursing), dated 8/2018, the Mission Essential indicated, understand and adhere to company .policies and procedures. During a review of the facility's policy and procedure titled, Care Plans-Baseline, dated 3/1/22, indicated, 1. The baseline care plan includes instructions needed to provide effective, person-centered care of the resident that meet professional standards of quality care and must include the minimum healthcare information necessary to properly care for the resident including, but not limited to the following: a. Initial goals based on admission orders .b. Physician orders . The baseline care plan is used and updated as needed to meet the resident's needs . During a review of the facility's policy and procedure titled, Oxygen Administration, revision dated 6/2/22, indicated, the purpose of this procedure is to provide guidelines for safe oxygen administration. Preparation . 2. Review the resident's care plan to assess for any special needs of the resident .Assessment Before administering oxygen, and while the resident is receiving oxygen therapy, assess for the following: .2. Signs of symptoms of hypoxia (i.e. rapid breathing, rapid pulse rate, restlessness, confusion) . During a review of Nursing World.org Professional Reference titled, The American Nurses Association-Nursing: Scope and Standards of Practice, Third Edition, dated July 2015, (found at https://www.nursingworld.org/~4af71a/globalassets/catalog/book-toc/nssp3e-sample-chapter.pdf) the reference indicated, .The Standards of Practice describe a competent level of nursing care as demonstrated by the critical thinking model known as the nursing process. The nursing process includes the components of assessment, diagnosis, outcomes identification, planning, implementation, and evaluation. Accordingly, the nursing process encompasses significant actions taken by registered nurses and forms the foundation of the nurse's decision-making . Standard 1. Assessment The registered nurse collects pertinent data and information relative to the healthcare consumer's health or the situation . (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of National Library of Medicine.org Professional Reference titled, Nursing Process, dated 4/10/23, (found at https://www.ncbi.nlm.nih.gov/books/NBK499937/) the reference indicated, . Planning: The planning stage is where goals and outcomes are formulated that directly impact patient care based on guidelines. These patient-specific goals and the attainment [the level of knowledge, skills, or qualifications a learner has acquired at a specific point in time] of such assist in ensuring a positive outcome. Nursing care plans are essential in this phase of goal setting. Care plans provide a course of direction for personalized care tailored to an individual's unique needs. Overall condition and comorbid conditions play a role in the construction of a care plan. Care plans enhance communication, documentation, reimbursement, and continuity of care across the healthcare continuum . vital to positive patient outcomes . the nursing process to guide care is clinically significant going forward in this dynamic, complex world of patient care. Aging populations carry with them a multitude of health problems and inherent risks of missed opportunities to spot a life-altering condition .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 40641 Based on observation, interview, and record review, the facility failed to develop and implement a resident-centered comprehensive care plan for two of five sampled residents (Resident 347 and Resident 24) when: 1. Resident 347 did not have a care plan for the use of sling to left arm and splint to left foot. These failures placed Resident 347 at risk for complication from not having care plan needs planned by licensed nurses to determine if nursing interventions needed to be added, changed or completed. 2. Resident 24 did not have a care plan for the use of antibiotic for clostridium difficile (C-diff-germ that causes diarrhea and colitis [inflammation of the colon]). This failure placed Resident 24 at risk for care needs not met. Findings: 1. During a concurrent observation and interview on 3/17/25 at 9:16 a.m. with Resident 347 in his room, Resident 347 was lying in bed with eyes closed. Resident 347 was observed with sling to left arm and splint to left foot. Resident 347 stated he fell at home and dislocated his left shoulder and sustained three broken ribs. Resident 347 stated his left foot has foot drop and had to wear the splint. During a review of Resident 347's Admission Record (AR-document with personal identifiable and medical information), 3/19/25, the AR indicated, Resident 347 was admitted on [DATE] with diagnoses which included anterior dislocation of left humerus (long bone in the upper arm), multiple fractures of ribs, and history of falling. During a review of Resident 347's Minimum Data Set (MDS-a functional and cognitive abilities assessment) assessment, dated 3/13/25, indicated the Brief Interview for Mental Status (BIMS) score was 15 out of 15 (a BIMS score of 13-15 indicates cognitively intact, 8-12 indicates moderately impaired and 0-7 indicates severe impairment), which indicated Resident 347 was cognitively intact. During a review of Resident 347's Order Summary Report, undated, the the order summary report indicated, . created date: 3/10/25 . Orthopedic Precaution: Left Upper Extremity Sling on at all times . Created Date 3/13/25 . Monitor placement of 3/11/25 hospital applied ace wrapped LLE [left lower extremity] with exposed first and second digit(s)[toes] . During a concurrent interview on 3/19/25 at 8:30 a.m. with Certified Nursing Assistant (CNA) 10, CNA 10 stated he is familiar with Resident 347's care. CNA 10 stated he did not remember licensed nurse telling him how to take care of Resident 347's sling to left shoulder and splint on the left foot. CNA 10 stated he only turn and reposition Resident 347 and had never done anything with the left arm sling and splint on his left foot. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/19/25 at 9:30 a.m. with CNA 8, she stated she is taking care of Resident 347. CNA 8 stated Resident 347 was admitted in the facility with a sling to his left shoulder because of broken ribs. CNA 8 stated, . I am not sure why he has it and I do not Resident 347 was sent out to the hospital and when he returned he had the splint on his left foot and did not remember licensed nurses telling CNAs' why Resident 347 had the splint on his left foot. CNA 8 stated, .I do not touched or removed the splint on his left foot, I just made sure he was comfortable. During a concurrent interview and record review on 3/19/25 at 2:20 p.m. with Infection Preventionist (IP), Resident 347's care plans were reviewed. IP stated Resident 347's use of left arm sling and left foot splint's care plan was initiated today (3/19/25). IP stated Resident 347 was admitted to the facility on [DATE] wearing left arm sling and care plan should have been initiated immediately within 24 hours of admission. IP stated Resident 347 had the splint on his left foot since 3/11/25 and care plan was not initiated until 3/19/25. The IP stated care plan should have been initiated right away and it was the responsibility of licensed nurses to ensure care plans were initiated right away. During a concurrent interview and record review on 3/20/25 at 2:58 p.m. with the Minimum Data Set Coordinator (MDSC), Resident 347's care plans was reviewed. The MDSC stated Resident 347 did not have a care plan for the use of left arm sling and left foot splint and it should have been care planned. The MDSC stated it was the responsibility of licensed nurse to create care plans on admissions and for new orders in order to better care for Resident 347. The MDSC stated she was responsible in updating care plans after completing resident assessments. 2. During a concurrent observation and interview on 3/17/25 at 10:10 a.m. with Resident 24 in her room, Resident 20 was lying in bed watching TV and appropriately dressed. Resident 20 stated she had been in the facility sine 4/24 due to an infection. During a review of Resident 24's Admission Record, dated 3/19/25, the AR indicated, Resident 20 was readmitted to the facility on [DATE] with diagnoses which included unspecified protein-calorie malnutrition (lack of sufficient protein and energy to meet the body;s needs) muscle weakness and pressure ulcer (localized injury to the skin and underlying tissue caused by prolonged pressure). During a review of Resident 20's Order Summary Report undated, the order summary indicated, . Order Date: 3/5/25 . Vancomycin HCl [hydrochloride] Oral Suspension . four times a day for C diff . During a concurrent interview and record review on 3/19/25 at 2:05 p.m. with the IP, Resident 24's care plans were reviewed. The IP stated Resident 24 was started on Vancomycin for C-diff on 3/5/25. The IP stated there was no care plan developed for the use of antibiotic and there should have been. The IP stated it was the licensed nurses responsibility to create a care plan but ultimately it was my responsibility since I am the IP. The IP stated, There should have been a care plan initiated immediately when the antibiotic medication was initiated . The IP stated care plan is important because it is used for continuity of care and used as communication between nursing staff taking care of residents. (continued on next page)

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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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/21/25 at 8:30 a.m. with the Director of Staff Development (DSD), the DSD stated care plan directs the care of residents. The DSD stated the practice was for care plan to be initiated on admission by the admission nurse and followed up by the Director of Nursing (DON) and the MDSC. During an interview on 3/21/25 at 8:30 a.m. with the DON, the DON stated her expectation was for care plans to be initiated immediately upon admission to the facility. The DON stated it was the licensed nurse's responsibly to initiate a care plan when residents are admitted to the facility within 48 hours. During an interview on 3/21/25 at 12:05 p.m. with the Administrator (ADM), the ADM stated the DON was responsible in ensuring nursing staff are following facility's policy and procedure on care planning. The ADM stated the medical Records person audits resident records and DON follows up and making sure audits are completed. During a review of the facility's policy and procedure (P&P) titled, Care plans, Comprehensive Person-Centered dated 2001, the P&P indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident . reflects currently recognized standards of practice for problem areas and conditions .

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40641 Based on observation, interview and record review, the facility failed to meet professional standards of practice for two of five sampled residents (Residents' 98 and 247) when: 1. Resident 98's oxygen (a colorless, odorless, tasteless gas essential to living organism) flow rate (the amount of oxygen being delivered to the body) was not administered according to the physician order. This failure resulted in Resident 98 to not receive the ordered amount of oxygen via oxygen concentrator (a machine that pulls in oxygen from the surrounding air) which could lead to breathing problems which includes shortness of breath, headache and confusion. 2. Resident 247's oxygen flow rate was set to 1.5L (liters-a unit of measurement) instead of the physician prescribed 2L/minute. This failure resulted in Resident 247 not receiving the correct amount of oxygen as ordered by the provider could have resulted in shortness of breath (SOB) and respiratory distress (difficulty breathing). 3. Licensed Nurses (LN)s did not clarify provider's note and failed to obtain an order to turn/ reposition Resident 247 every two hours. This failure had the potential to result in resident 247's pressure ulcer (injury to the skin and underlying tissues caused by prolonged pressure) to worsen which could lead to infection. Findings: 1. During a concurrent observation and interview on 3/17/25 at 4 p.m. with Resident 98 in her room, Resident 98 was observed in semi sitting position in bed watching TV. Resident 98 stated she did not know how long she had been in the facility. Resident 98 stated she needed oxygen and used it everyday. Resident's oxygen flow rate on the oxygen concentrator indicated 1 liter (L-unit of measurement) per minute via (through) nasal cannula (a tube used to deliver supplemental oxygen through the nose). During a concurrent observation, interview and record review on 3/17/25 at 4:50 p.m. with Registered Nurse (RN) 3, she stated Resident 98's oxygen concentrator flow rate was set less than the ordered amount of oxygen. Resident 98's oxygen order was reviewed and RN 3 stated Resident 98's oxygen order was 2L/min. RN 3 stated, Resident 98 is receiving less than the ordered oxygen which could result to respiratory distress. RN 3 stated she did not remember checking the oxygen flow rate of Resident 98 when she administered her medications. RN 3 stated it was the responsibility of licensed nurses to ensure residents receiving oxygen are receiving the right amount of oxygen as ordered by the physician. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 3/19/25 at 10:10 a.m. with Licensed Vocational Nurse (LVN) 7, Resident 98's oxygen order was reviewed. LVN 7 stated Resident 98's oxygen order was continuous oxygen at 2L/minute via NC. LVN 7 stated it was the responsibility of licensed nurses to ensure physician orders for oxygen are followed. LVN 7 stated Resident 98's oxygen level could drop which could lead to respiratory distress. During an interview on 3/21/25 at 8:45 a.m. with the Director of Nursing (DON) the DON stated licensed nurses should be monitoring the flow rate of oxygen. The DON stated it was important for licensed nurses to check the flow rate was correct. The DON stated oxygen level could drop if resident not receiving the ordered oxygen which could lead to respiratory distress and potentially lead to death. During a review of facility's policy and procedure (P&P) titled, Medication Administration, dated 11/14, the P&P indicated, .to establish uniform guidelines in the receiving and recording of medication orders . Physician Orders/Progress Notes must be signed and dated .Oxygen Orders . specify the rate of flow, route and rationale . During a professional reference review retrieved from https://pubmed.ncbi.nlm.nih.gov/19377391/ titled, The use of medical orders in acute care oxygen therapy, dated 2009, the professional reference review indicated, . Oxygen is considered to be a drug requiring a medical prescription and is subject to any law that covers its use and prescription . authorized by a physician following legal written instruction to a qualified nurse . 50446 2. During a review of Resident 247's Admission Record (AR) (a document containing demographic information), dated 3/20/25, the AR indicated, Resident 247, a [AGE] year-old female was admitted to the facility on [DATE] from acute care hospital and had diagnoses that included .dependence on supplemental oxygen, shortness of breath, wheezing, partially vaccinated for COVID-19 . During a concurrent observation and interview on 3/17/25 at 12:17 p.m. with Resident 247 during the initial tour in Resident 247's Room, Resident 247 was lying in bed with a nasal cannula (NC- thin plastic tube that delivers oxygen directly into the nose through two small prongs) on, connected to a working oxygen concentrator (device that produces oxygen for breathing) and set to 1.5L flow rate. Resident 247 stated she uses the O2 daily. During a review of Resident 247's Minimum Data Set (MDS- a resident assessment tool used to identify resident cognitive (mental) and physical functional level) assessment, dated 3/17/25, the MDS indicated, Resident 247's Brief Interview for Mental Status (BIMS) assessment score was 15 out of 15 (0-6 severe cognitive (pertaining to reasoning memory and judgement) deficit, 7-12 moderate cognitive deficit, 13-15 cognitively intact). BIMS scores indicated Resident 247 was cognitively intact. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 3/19/25 at 3:59 p.m. with Licensed Vocational Nurse (LVN) 5 Resident 247's Order Summary Report (OSR) dated 3/11/25 at 11:04 a.m. and a picture of oxygen concentrator in Resident 247's room showing the flow rate set at 1.5L were reviewed. The OSR indicated, . oxygen at 2 LPM (Liters per minutes-unit of measurement) via NC due to SOB every shift. LVN 5 stated the floating ball should be on the line for checking the correct flow rate. LVN 5 validated the flow rate was at 1.5L but should have been at 2L. LVN 5 stated the nurse should check the oxygen flow meter every shift to ensure it is at the right flow rate. LVN 5 stated Resident 247 would be at risk of inadequate oxygenation if the provider's orders were not followed. During a concurrent interview and record review on 3/21/25 at 8:27 a.m. with the Director of Nursing (DON), Resident 247's OSR dated 3/11/25 @11:04 a.m. and a picture of oxygen concentrator in Resident 247's room showing the flow rate set at 1.5L were reviewed. The DON stated the flow rate was at 1.5L and the order was for 2L. The DON stated the nurses did not check the O2 order. The DON stated the nurse should be monitoring the flow rate of the O2. The DON stated it is important to check the setting is correct. The DON stated the nursing staff were not following the provider's orders. The DON stated the importance of monitoring is to prevent the resident from desaturating. The DON stated the flow rate should be appropriate to the resident to ensure oxygenation does not drop. The DON stated the potential risk to resident 247 was O2 levels could drop if not above 94%-95%, there could be respiratory destress, shortness of breath which could lead to death. During a review of the facility's policy and procedure (P&P) titled, Medication Orders revised 11/2014, the P&P indicated, Purpose- .To establish uniform guidelines in the receiving and recording of medication orders . Recording Orders . (3) oxygen orders- when recording orders for oxygen, specify the rate of flow, route and rationale . During a review of the facility's P&P titled, Oxygen Administration, revised 6/2/22, the P&P indicated, Purpose- .to provide guidelines for safe oxygen administration. Preparation (1) verify that there is a provider order for this procedure. Review the provider's order of facility protocol for oxygen administration . During a review of the facility's document titled, Job Description, LVN/LPN (Skilled Nursing), dated 08/2018, the document indicated .effectively plans and implements nursing services to provide quality care. Work duties . Provide residents care including administrating medications ., maintains communication with doctors . concerning resident care, .takes doctor's orders . Knowledge skills and abilities . Knowledge of . policies procedures, methods, and practices of the community ., use of medical supplies and equipment During a review of the facility's document titled, Job Description, Registered Nurse, dated 10/2019, the document indicated .Responsible for the total nursing needs of residents . Carries out provider orders and document the events ., accurately and completely performs direct nursing services such as medication administration, treatments, personal care and other nursing procedures. Accurately receives documents and transcribes provider orders with their appropriate follow through in a timely fashion specifically advocating resident's safety . Knowledge skills and abilities . Knowledge of . policies procedures, methods, and practices of the community , use of medical supplies and equipment . (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During a review of Resident 247's AR dated 3/20/25, the AR indicated, Resident 247 had diagnoses that included .spontaneous bacterial peritonitis (acute infection of ascites [an abnormal accumulation of fluid in the abdomen] without a distinct or identifiable source of infection), pressure ulcer of sacral region unspecified stage (medical condition characterized by skin and tissue damage in the sacral area [base of the spine] due to pressure, shear, or friction, where the stage of the ulcer is not specified), irritant contact dermatitis (a non-allergic inflammatory skin reaction caused by direct exposure to irritating substances) due to fecal, urinary or dual incontinence . During a concurrent observation and interview on 3/17/25 at 12:17 p.m. with Resident 247 during the initial tour in Resident 247's Room, Resident 247 was lying in bed. Resident 247 stated she was transferred to facility on 3/11/25 and had been in hospital for the last 2-3months. Resident 247 stated she had lost weight and was currently too weak in arms and legs. Resident 247 stated she was on the specialty bed (Low air loss [LAL] mattress) because . low back pain, had bedsore from laying while in the hospital . During a concurrent interview and record review on 3/19/25 at 3:59 p.m. with Licensed Vocational Nurse 5 (LVN 5), Resident 247's Provider's Note (PN) dated 3/12/25 and 3/13/25, Document survey report v2 (DSR) on task to monitor- turn/ reposition dated 3/21/25, MDS Functional limitation in range of motion (GG0115) assessment dated [DATE] were reviewed. The PN dated 3/12/25 at 2:56 p.m. indicated Resident 247 had a sacral ulcer (sore or wound that develops on the skin over the triangular bone at the base of the spine), which should be monitored closely, and resident should be turned every two hours to relieve pressure on her back. The PN dated 3/13/25 at 8:51 p.m. indicated Resident 247 had pressure ulcer and should be turned every two hours to relieve the pressure on her back. The DSR indicated the task to monitor- turn/ reposition was as needed (PRN), Resident 247 was turned/repositioned on 3/11/25 at 8:05 p.m., 3/18/25 at 7:59 p.m. and on 3/19/25 at 3:28 p.m. The GG0115 assessment score was 2 (0-No impairment, 1-impairment on one side, 2-impairment on both sides). The GG0115 score indicated Resident 247 had impairment on both sides to upper extremity (shoulder, elbow, wrist, hand). LVN 5 validated there was no written order to turn Resident 247 every two hours. LVN 5 stated there should be an order to turn/reposition Resident 247 every two hours. LVN 5 stated the provider's intent to turn/repositioned resident every two hours should have been identified and implemented. LVN 5 stated the expectation was for the nurse to read the provider's notes and follow up regarding interventions that were not ordered. LVN 5 stated the nurse should have called the provider to verify the instruction and confirm if the provider wanted an order placed. LVN 5 stated there was the risk of wound worsening if Resident 247 was not repositioned. During a concurrent interview and record review on 3/20/25 at 3:37 p.m. with Minimum Data Set Coordinator (MDSC), Resident 247's Provider's Note (PN) dated 3/12/25, Document survey report v2 (DSR) on task to monitor- turn/ reposition dated 3/21/25, MDS Functional limitation in range of motion (GG0115) assessment dated [DATE] were reviewed. The MDSC stated the LNs should read the provider's notes and follow through. The MDSC stated the presence of a LAL mattress should not negate the provider's note to turn resident every 2 hours. The MDSC stated the DSR on task to monitor- turn/ reposition should not be a PRN order. The MDSC stated the task should have been to reposition resident every 2 hours. The MDSC validated Resident 247 had impairment on both side to upper extremity and could not turn every two hours without assistance. The MDSC stated the risk of Resident 247 not getting turned every two hours would be that the pressure on back would not be eased, resident would not be comfortable, and the pressure ulcer could worsen. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 3/21/25 at 8:48 a.m. with Director of Nursing (DON), Resident 247's Provider's Note (PN) dated 3/12/25, Document survey report v2 (DSR) on task to monitor-turn/ reposition dated 3/21/25, MDS Functional limitation in range of motion (GG0115) assessment dated [DATE] were reviewed. The DON stated no provider's order is needed for turn every 2 hours because it is a standard of practice. The DON stated the standard is for the nurse to turn/reposition Resident 247 every two hours. The DON stated the nurse should review the provider's note to see if there are other interventions the provider indicated for the resident but did not communicate. The DON stated the provider wanted the resident turned every two hours. The DON stated according to the task, the facility did not follow the provider's instruction. The DON stated it is important to follow provider's instruction to prevent further decline of the wound. The DON stated the resident would need both arms to turn self and due to impairment to both sides, resident would need help to turn/ reposition. The DON stated the importance of having the documentation in place to turn Resident 247 every two hours was to ensure the staff implemented the task. The DON stated not turning the resident could result in the potential risk for infection, worsening of the wound, discomfort, resident staying in bed more, decline in level of function, and increased pain During the review of a professional reference titled, Quick Safety 25: Preventing pressure injuries, updated March 2022 from https://www.jointcommission.org/resources/news-and-multimedia/newsletters/newsletters/quick-safety/quick-safety-issue-25-preventing-pressure-injuries/preventing-pressure-injuries/. The reference indicated, .Pressure injury prevention and treatment requires multi-disciplinary collaborations, good organizational culture and operational practices that promote safety. Per the International Guideline, risk assessment is a central component of clinical practice and a necessary first step aimed at identifying individuals who are susceptible to pressure injuries. Other interventions that influence an individual's healing process may include identifying nutritional needs, repositioning and early mobilization, skin care, use of support surfaces, cleansing and debridement, pain assessment and management, psychological and spiritual support, and family support . Positioning and Mobilization: Immobility can be a big factor in causing pressure injuries. Immobility can be due to several factors, such as age, general poor health condition, sedation, paralysis, and coma. Turn and reposition at-risk patients, if not contraindicated. Plan a scheduled frequency of turning and repositioning the patient . Monitor the prevalence and incidence of pressure injuries. Educate and train all members of the interdisciplinary team. Make sure they are aware of the plan of care and that all care is documented in the patient's record .

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 41166 Based on observation, interview, and record review, the facility failed to ensure residents were free from unnecessary drugs for two of six randomly sampled residents when: 1. Resident 12 was administered ondansetron (a medication for nausea) and had active orders for both routine and as needed (prn) ondansetron, which exceeded the maximum daily dose (maximum dose in 24 hours). 2. Staff administered apixaban (a blood thinner) to Resident 24, but did not monitor for side effects of apixaban. These failures had the potential for Resident 12 to experience ondansetron toxicity including irregular heartbeat, and for Resident 24 to experience apixaban side effects including bleeding. Findings: 1. During a medication administration observation on 3/17/2025 at 8:06 a.m., in Resident 12's room, Registered Nurse (RN) 1 was observed administering one tablet of ondansetron to Resident 12. During a record review of Resident 12's Physician Orders (PO), Resident 12's PO indicated Resident 12 had two active orders for ondansetron. Resident 12's PO dated 1/7/2025, indicated an active routine order for ondansetron 4 milligram (mg, a unit of measure) tablet, Give 1 tablet by mouth three times a day for NAUSEA. Resident 12's PO dated 3/6/2024, indicated an active prn order for ondansetron 4 mg tablet, Give 1 tablet by mouth every 6 hours as needed for nausea. During a record review of ondansetron's manufacturer package insert (product labeling information for healthcare professionals and patients) provided by the facility, the package insert indicated, the maximum recommended human oral [by mouth] dose of 24 mg per day . During an interview on 3/18/2025 at 1:39 p.m., with RN 1 in the east wing, RN 1 stated Resident 12 had the prn ondansetron order before hospice (special care to person near end of life), but a routine ondansetron order was added after hospice for persistent nausea. RN 1 stated if Resident 12 took all her routine and prn ondansetron doses, she would get a total of 28 mg of ondansetron per day. RN 1 stated it was important for residents not to be on medications they did not need to prevent possible overdose. During an interview on 3/18/2025 at 2:10 p.m., with the Director of Staff Development (DSD) in DSD's office, DSD stated the two orders for ondansetron exceeded the maximum daily dose by 4 mg. DSD stated that when nursing take[s] [a] new order, they should discontinue the old order. During an interview on 3/18/2025 at 2:56 p.m., with the Director of Nursing (DON) in DON's office, DON stated the prn ondansetron order was not used, but if it had been used with the routine ondansetron order, it would've exceeded the max dose. DON stated that when nursing staff received a new order, they should get clarification on whether to continue or discontinue the old order. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 3/20/2025 at 10:00 a.m., with the facility's Consultant Pharmacist (CRPH), CRPH stated if Resident 12 had received all her routine and prn ondansetron doses, Resident 12 would have received 28 mg of ondansetron per day. CRPH stated the ondansetron drug manufacturer specified 24 mg as the maximum daily dose. CRPH stated that exceeding the ondansetron maximum daily dose could result in side effects listed by the manufacturer. During a review of ondansetron manufacturer package insert, the package insert listed the following side effects: headache, malaise/fatigue, constipation, diarrhea, hypoxia (low oxygen levels). The manufacturer package insert listed warnings and precautions, such as the following: hypersensitivity (allergic) reactions, QT interval prolongation and Torsade de Pointes (abnormal and potentially life-threatening heart rhythms). During a review of the facility's policy and procedure (P&P) titled, Tapering Medications and Gradual Drug Dose Reduction revised July 2022, the P&P indicated After medications are ordered for a resident, the staff and practitioner shall seek an appropriate dose and duration for each medication that also minimizes the risk of adverse consequences. 2. During a review of Resident 24's PO, Resident 24's PO, dated 4/19/2024, indicated an active order for apixaban 2.5 mg tablet, Give 1 tablet by mouth two times a day for PAROXYSMAL ATRIAL FIBRILLATION [a type of irregular heart rhythm]. During a review of Resident 24's care plan dated 4/19/2024, Resident 24's care plan indicated to monitor for side effects of apixaban every shift. Resident 24's care plan indicated to monitor/document/report side effects of apixaban, such as blood tinged or red blood in urine, black tarry stools, dark or bright red blood in stools, sudden severe headaches .bruising .[shortness of breath] .sudden changes in mental status, significant or sudden changes in . vital signs. Resident 24's care plan indicated a goal of not show[ing] . signs/symptoms of bleeding. Resident 24's care plan listed interventions, [E]valuate for blood in stools . [E]valuate for change in level of consciousness .[E]valuate for hematuria [blood in urine] During a concurrent interview and record review on 3/19/2025 at 2:12 p.m., in the south wing with RN 2, Resident 12's Medication Administration Record (MAR) was reviewed. RN 2 was unable to provide documentation that nursing staff was monitoring Resident 12 for apixaban side effects. RN 2 stated that side effect monitoring for apixaban should be there. RN 2 stated that monitoring side effects of apixaban was important because it is a blood thinner because if patients start bleeding, like in the stool, we should monitor for any bleeding. During an interview on 3/19/2025 at 3:38 p.m., with the DON in DON's office, DON stated that she couldn't find it [apixaban side effect monitoring in the MAR] either. DON stated it was important to monitor the side effects of apixaban in the MAR due to the bleeding risk. During a telephone interview with CRPH on 3/20/2025 at 10:09 a.m., CRPH stated apixaban could cause side effects such as bleeding, bruising and nose bleeds. CRPH stated it was important to monitor for side effects of apixaban because if the patient has any signs of that, they need to notify the doctor immediately and hold the drug. (continued on next page)

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	055846	A. Building B. Wing	03/21/2025

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The Terraces at San Joaquin Gardens Village	5551 N. Fresno St Fresno, CA 93710

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of apixaban manufacturer package insert, the package insert indicated apixaban .increases the risk of bleeding and can cause serious, potentially fatal, bleeding .be .aware of signs and symptoms of blood loss and .report them immediately .the most serious [side effects] .were related to bleeding .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 41166 During an observation, interview, and record review, the facility failed to ensure all medications used in the facility were properly labeled and discarded after the discontinued date when: 1. In the west wing medication cart, Resident 36's discontinued ondansetron (medication used for nausea and vomiting) was not separated from active medications 2. In the south wing medication cart, Resident 37's discontinued benzonatate (medication used for cough) was not separated from active medications and Resident 98's insulin lispro (medication used to lower blood sugar) multidose vial was stored in medication cart, partially used and not labeled with an open or discard date. These failures had the potential for medications to be administered incorrectly causing an underdosing or overdosing of medications, or to be administered to the wrong residents causing harm to the residents. Findings: 1. During a concurrent observation and interview on 3/17/25 at 3:58 p.m., with Licensed Vocation Nurse (LVN) 1 at the west wing medication cart, Resident 36's ondansetron 8 milligram (mg- unit of measure) blister card (card with medication pill sealed in individual bubbles) containing eight tablets was observed in the medication cart, not separated from medications that were in use for facility residents. Resident 36's ondansetron label indicated, 8 mg every 8 hours as needed for nausea for 14 days. LVN 1 stated Resident 36's ondansetron order was for 14 days, and was started on 2/21/25 and should have been discontinued on 3/7/25. LVN1 acknowledged discontinued medications should be separated from active medications. LVN 1 stated, If we complete order, we remove it because its no longer on the order . LVN 1 stated the expectation was for nurse to notify the doctor right away if resident was requesting medication and wanted it to be reordered. 2. During a concurrent observation and interview on 3/18/25 at 10:13 a.m., with LVN 3 at the south wing medication cart, Resident 37's benzonatate 100 mg blister card containing thirty capsules was observed in the medication cart, not separated from medications that were in use for facility residents. Resident 37's benzonatate label indicated, 100 mg every 6 hours as needed for cough for 14 days. LVN 3 stated Resident 37's benzonatate order was ordered on 2/26/25 until 3/2/25. LVN 3 acknowledged Resident 37's benzonatate medication should have separated from active medications. LVN 3 stated discontinued medications should be taken out to ensure medications were not accidentally given, causing medication errors. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 3/17/25 at 10:14 a.m., with LVN 3 at the south wing medication cart, Resident 98's insulin lispro 10 milliliters (ml- unit of measure) multidose vial was stored in medication cart, partially used and not labeled with an open or discard date. Resident 98's insulin lispro label indicated, inject subcutaneously (into the fat under skin) four times a day before meals and at bedtime according to sliding scale (insulin dose given according to level of blood sugar). LVN 3 acknowledged Resident 98's insulin lispro vial was partially used and did not have an open or discard date. LVN 3 stated the expectation was to date the vial with open or discard date because the vial was to be discarded after 28 days. LVN 3 stated, .after 28 days, insulin's not good, not want to give insulin that is expired. During an interview on 3/18/25 at 3 p.m., with Director of Nursing (DON), DON stated the expectation was for nursing staff to removed discontinued medications from the medication cart to prevent medication errors that can occur by administering medication when there was no order for it. Regarding medication labeling, DON stated it was important to have open and discontinued dates on insulin vials because the medication could be expired and not working appropriately when administered. During a telephone interview on 3/20/25 at 10:11 a.m., with facility's Consultant Pharmacist (CRPH), CRPH stated it was important to remove discontinued medications from current medications so nursing staff does not accidentally give medications to a resident without an order. CRPH stated multidose vials were to be dated by nursing staff with sticker provided by pharmacy, so they do not administer expired medications to residents. During a review of the facility's Policy and Procedure (P&P), titled, Administering Medications, revised 4/19, the P&P indicated, The expiration/beyond use date on the medication label is checked prior to administering. When opening a multi-dose container, the date opened is recorded on the container. During a review of the facility's P&P, titled, Medication Label and Storage, revised 2/23, the P&P indicated, If the facility has discontinued, outdated or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. 51271 Based on observation, interview and record review, the facility failed to assist residents in obtaining routine and 24-hour emergency dental care or referred to a dental hygienist to address dental needs for one of five sampled residents (Resident 17) when Resident 17 was admitted with poor dentition characterized by visible signs of decay and missing and broken teeth and the facility did not ensure Resident 17 was referred and assessed timely by a dental hygienist to address her dental needs This failure resulted in Resident 17 reporting feelings of embarrassment due to her dental condition and placed Resident 17 at an increased to develop dental infection. Findings: During a review of Resident 17's Admission Record (AR- a document that provides resident contact details, a brief medical history, level of functioning, preferences, and wishes), dated 11/22/24 , the AR indicated Resident 17 had the following diagnoses: Parkinson's Disease (condition which affects the body's movements), Malignant neoplasm (a cancerous growth that occurs when cells grow and divide uncontrollably, invading nearby tissues and spreading to distant parts of the body) of rectum (the final 6 to 8 inches of the large intestine), bronchus (passageways that connects your windpipe to your lungs) and lung (spongy bags inside your chest that help you breath), Dysphagia (difficulty swallowing food or liquids), and Major Depressive Disorder (persistent sadness, loss of interest in activities and difficulty with relationships impacting a person's thinking and behavior). During a review of Resident 17's Minimum Data Set (MDS- resident assessment tool which indicated physical and cognitive abilities), dated 11/22/24, the MDS indicated a Brief Interview for Metal Status (BIMS- an assessment of cognitive function) score of seven (0-7 severe cognitive impairment, 8-12 moderate cognitive impairment, 13-15 no cognitive impairment), indicating Resident 17 had severe cognitive impairment. During a concurrent observation and interview on 3/17/25 at 9:47 a.m. with Resident 17 in their room during initial pool, Resident 17 stated she had bad teeth because of her past cancer treatments. Resident 17's teeth had been in poor condition; all had been dark brown in color, broken and chipped. Resident 17 covered her mouth as she told the surveyor about her teeth. Resident 17 stated the condition of her teeth made her feel embarrassed. During an interview on 3/19/25 at 10:12 a.m. with Certified Nursing Assistant (CNA) 6, CNA 6 stated Resident 17 did not have dentures. CNA 6 stated Resident 17 did not complain of mouth pain, but she needed her food to be soft to ensure she could eat it. (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/19/25 at 1:51 p.m. with Social Services Director (SSD), The SSD stated she was familiar with the condition of Resident 17's teeth. The SSD stated Resident 17 informed them that the condition of her teeth had been caused by previous cancer treatments. The SSD stated that, upon admission, if a resident appeared to have potential dental issues, an evaluation would be conducted to assess their condition and determine the necessary course of action. The SSD stated the facility contracted with a dental hygienist to come out and perform cleanings and oral evaluations on residents. Based on the evaluation, they would make a recommendation if a resident needed to be seen by a dentist. The SSD reviewed the resident's chart and determined Resident 17 had not been evaluated by the hygienist or seen by a dentist since their admission on 11/22/24. The SSD stated Resident 17 could have fallen through the cracks during the transition from short-term to long-term care. SSD stated that something in the system should have triggered Resident 17 to be seen by a dentist, as there was documentation from speech therapy indicating pain with swallowing and dietary changes made to address her broken teeth. The SSD stated someone should have informed her of these findings so she could have arranged for Resident 17 to be seen or scheduled an appointment. The SSD stated Resident 17 should have received dental services. During a review of Resident 17's MDS Section L-Oral/Dental Status, dated 11/28/24, the MDS indicated, Resident 17 had obvious or likely cavity or broken natural teeth. During a review of Resident 17's Speech Therapy PDPM Resource (PDPM), dated 11/25/24, the PDPM indicated Resident 17 complained of difficulty or pain with swallowing. During an interview on 3/20/25 at 3:22p.m. with the Minimum Data Set Coordinator (MDSC), MDSC stated she was familiar with the condition of Resident 17's teeth. The MDSC stated Resident 17's teeth were an actual issue, not potential. MDSC stated if Resident 17 refused treatment, there should have been a care plan associated with that decision. During an interview on 3/20/25 at 4:03 p.m. with SSD, the SSD stated the facility did not have a process for residents to sign a refusal of treatment for dental issues. During an interview on 3/21/25 at 9:36 a.m. with the Director of Nurses (DON), the DON stated the process was the SSD conducted an evaluation to determine if any dental or vision needs were required for the resident. The SSD would proceed to obtain an order for a dental hygienist. The DON stated she was familiar with the condition of Resident 17's teeth. The DON stated Resident 17 should have been seen by the hygienist and offered dental services immediately. During a review of Resident 17's Progress Notes (PN), dated 3/4/25, the PN indicated, Resident 17 reported intermittent difficulty chewing tough meats .wanted to have her meats cut up in front of her at time of service. During a review of Resident 17's Diet Order (DO), dated 12/11/24, the DO indicated, Resident 17 prescribed diet was no salt added, with regular texture and regular/thin consistency. Resident 17 may have needed assistance with cutting food. (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facilities policy and procedure (P&P) titled, Dental Services, dated 12/2016, the P&P indicated, Routine and emergency dental services are available to meet the resident's oral health services in accordance with the resident's assessment and plan of care .Dental services are provided to our residents through a. contract agreement with a licensed dentist that comes to the facility monthly, b. referral to resident personal dentist, c. referral to a community dentist, d. referral to other health care organizations that provide dental services . social services representatives will assist residents with appointments, transportation arrangements. During a review of Job Description: Social Services Designee, dated unknown, the General Statement of Position indicated, assesses resident social service needs and ensures the identified needs are addressed.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51223 Based on observation, interview, and record review, the facility failed to ensure menus were followed for one of three sampled residents (Resident 198) when Resident 198 was served roasted red potatoes while on a mechanical soft-chopped diet. This failure placed Resident 198 at risk for choking. Findings: During a concurrent observation and interview on 3/17/25 at 11:43 a.m. with Resident 198 in the resident's room, the resident was sitting in her wheelchair next to her bed. Resident 198 wore a black sling that supported her right arm. Resident 198 stated she admitted to the facility for therapy after fracturing (a partial or complete break in a bone) her shoulder. Resident 198 stated she needed assistance with cutting her food and spreading butter on bread due to the limited motion of her right hand. During a record review of Resident 198's Admission Record (AR-a summary of important information regarding a patient which include patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information) dated 3/20/25, the AR indicated, Resident 198 was admitted to the facility on [DATE] with diagnoses: displaced fracture of surgical neck of right humerus (upper arm bone), moderate protein-calorie malnutrition (a nutritional status in which reduced availability of nutrients leads to changes in the body composition and function), Vitamin D Deficiency (the body is not getting enough vitamin D to stay healthy), Irritable Bowel Syndrome (a common condition that affects the stomach and intestines), Diverticulosis (a common condition in which pockets develop on the inside of your colon). During a review of Resident 198's Minimum Data Set (MDS-a federally mandated resident assessment tool), dated 3/18/25, the MDS section C indicated, Resident 198 had a Brief Interview for Mental Status (BIMS-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 15 out of 15 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07 indicates severe impairment, 99 indicates unable to complete the interview), which indicated Resident 198 was cognitively intact. During a concurrent observation and interview on 3/17/25 at 1:14 p.m. with Resident 198 in the resident's room, the resident was sitting in her wheelchair eating her lunch. The resident was served: red roasted potato wedges, a few shreds of meat and chunky pieces of meat with gristle, cup of vanilla pudding, glass iced water. The resident's meal ticket indicated: diet order-mechanical soft-chopped. During an interview on 3/18/25 at 11:43 a.m. with the Executive Chef (EC) in the Wing 3 common area, the EC stated the kitchen prepares the food and delivers to the satellite kitchen for plating by the nurses. The kitchen will deliver the different portion sized scoops and will notify the nurse staff of how many protein slices to serve based on weight. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/18/25 11:45 a.m. with the Certified Dietary Manger (CDM) in the Wing 3 common area, the CDM stated the Certified Nursing Assistant (CNA) plates the food. The CDM stated she facilitated the CNA therapeutic diet training. The CDM stated CNA receive different modules of therapeutic diet training throughout the year. During an observation on 3/18/25 at 11:59 a.m. in the Wing 3 common area, CNA 2 was plating the lunch meal for residents on Wing 3. The Director of Staff Development (DSD) would check the tray before approving CNA 1 to deliver the tray to the resident's room. During an interview on 3/19/25 with CNA 1 in the Wing 3 common area, CNA 1 stated the tray line process started with the kitchen delivering the food to the satellite kitchen on Wing 3, the kitchen staff check the food temperatures and place the portioned scoops next to each wrapped food. The CNA stated the CNA would review the resident's meal ticket for the lunch menu and then refer to the back the meal ticket for the resident's diet order. CNA 1 stated mechanical soft chopped diet is ordered when a resident has swallowing problems. CNA 1 stated mechanical soft chopped looked like regular diet but chopped small almost babylike. CNA 1 stated if a resident was not served the proper diet order there would be a risk for choking. CNA 1 stated the CDM manages the diet order as listed on the meal ticket. During an interview on 3/19/25 at 2:41 p.m. with the DSD in the Wing 3 hallway, the DSD stated tray line training is mainly performed by the kitchen staff. DSD stated the DSD's role in the tray line process was to review the meal ticket, check the allergies, diet order, room number and the menu preference for the day. The DSD stated her role was to ensure the facility served what the resident requested. The DSD stated the CNA received therapeutic diet training to know the difference between regular chopped and mechanical soft chopped diets. During an interview on 3/19/25 at 4:00 p.m. with Licensed Vocational Nurse (LVN) 5 in the Wing 3 hallway, LVN 5 stated the nurse would check the correct diet, portion sizes, liquids and textures are served correctly during meal tray before delivering to the resident. LVN 5 stated red potato wedges would not be mechanical soft chopped as the pieces should be smaller. During an interview on 3/19/25 at 5:28 p.m. with the CDM in RM 214, the CDM stated she trained staff on therapeutic diet textures. During an interview on 3/20/25 at 9:02 a.m. with the Registered Dietician (RD) over the telephone and the CDM in the DSD office, the RD stated the goal of a therapeutic diet was to minimize the risk of complication from a particular disease. RD stated the risk of not following the therapeutic diet could affect the resident's overall treatment. During a concurrent interview and record review on 3/20/25 at 3:22 p.m. with the CDM, a photo of Resident 198's lunch meal tray dated 3/17/25 and the Menu Works Diet Spread Report, dated 3/17/25 were reviewed. The photo indicated a plate with shreds of meat and wedged roasted red potatoes and a meal ticket with diet order: mechanical soft chopped. The diet spreadsheet indicated, mechanical soft chopped menu of corned beef same as base chopped and mashed potatoes. The CDM stated the facility did not follow the menu as the Resident 198 was not served mashed potatoes. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 3/21/25 at 8:26 a.m. with the Director of Nursing (DON) in room [ROOM NUMBER], a photo of Resident 198's lunch meal tray dated 3/17/25 and the Menu Works Diet Spread Report, dated 3/17/25 were reviewed. The photo indicated a plate with shreds of meat and wedged roasted red potatoes and a meal ticket with diet order: mechanical soft chopped. The diet spreadsheet indicated, mechanical soft chopped menu of corned beef same as base chopped and mashed potatoes. The DON stated the facility did not follow the menu for Resident 198 as the resident did not receive a mechanical soft chopped meal. The DON stated the risk to the resident when the menu was not followed may result in the resident not receiving the diet ordered by the physician which could result in choking. During a review of Job Description: Certified Nurse Assistant (CNA)/Nursing Assistant-Certified, dated 4/2022, Reports To indicated the CNA assigned to Skill Nursing-Director of Nursing/Assistant Director of Nursing or assigned Nursing Supervisor. The Essential Functions-Work Duties indicated the CNA will perform dining and light housekeeping tasks as required . During a review of Job Description: Director of Nursing, dated 8/2018, the General Statement of Position indicated .the Director of Nursing (DON) plans, directs, organizes, and evaluates nursing services to meet the total needs of the residents; ensures an efficient health facility operation in cooperation with other departments and in compliance with state and federal regulations. Provides care in accordance with our Philosophy for Person-Directed Care. The Scope indicated the DON supervisory responsibility included supervision of nursing and caregiving staff in assigned areas. During a review of Job Description: Director of Staff Development, dated 8/2018, General Statement of Position indicated .the Director of staff Development (DSD) effectively assesses training needs, plan, implements and provides in-service education and department specific new team member orientation. Ensures all medical staff is trained accordingly to provide care in accordance with our Philosophy for Person-Directed Care .In addition, the DSD assists in educating and treating residents . During a review of Job Description: Nutrition Care Manager II, dated 2019, the Summary indicated, Collaborating with a Registered Dietician, provides nutrition care such as .implementation of the Dietician's nutrition care plan. Supervises food services while ensuring resident satisfaction, quality care, regulatory compliance and good public relations are achieved through the safe and efficient use of resources . The Regulatory & Safety indicated Supervise and assist meal service to ensure meets resident dining standards. Supervisory indicated planning and supervision of resident dining and service . During a review of Job Description: RD Role: Remote Job Description, dated 1/1/25, Clinical Responsibilities indicated QAPI Audit Tools: Diet Order Accuracy. Menu Management: Menus & Extensions-Nutritional Adequacy . During a review of the facility's policy and procedure titled, Diet Orders House Policy, not dated, the Diet Textures indicated If This: Hospital Texture Diet Regular texture, Easy to Chew (IDDSI 7) then Use This: TSJG Terminology Regular; Description-No modification needed. If This: Hospital Texture Diet: Soft, Mech Soft Chopped, Dental soft, Chopped, mechanically altered, Dysphagia Advanced, Dysphagia 3, Soft & Bite Sized (IDDSI 6), Use This: TSJG: Terminology chopped, In PCC, order Chopped texture, add Mechanical Soft Chopped texture to additional directions in PCC, Description Meats chopped, and food modified when needed to assist those with difficulty chewing or swallowing. IF resident has inability to use utensils to cut own food, please indicate this in the directions . (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure titled, Mechanical Soft (Chopped), not dated, the Description indicated The diet is a modification of the Regular Diet for edentulous resident who has mild difficulty chewing or swallowing. All foods are fork tender (cooked until soft enough to be cut easily with a fork), meats are generally chopped, and gravies are typically added to the meats and most potatoes to allow for additional moisture and texture variation to assist with mastication. Examples of Food to Avoid indicated Avoid Hard or dry food-Nuts, raw vegetables, dry bread. Tough or fibrous foods-steak, pineapple. Bone or gristle-meat with gristle. During a review of the facility's policy and procedure titled, Resident Food Services, dated 1/2025, meal/tray assembly procedures indicated checks meals for accuracy . During a review of the facility's policy and procedure titled, Therapeutic Diets, dated 10/2017, the Policy Statement indicated Therapeutic diets are prescribed by the attending physician to support the resident's treatment and plan of care and in accordance with his or her goals and preferences.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51223 Based on observation, interview and record review, the facility failed to maintain a safe and sanitary environment to help prevent the development and transmission of communicable diseases and infections for four out of 10 sampled residents (Residents' 22, 98, 197, 247) when: 1. Resident 98, 197 and 247's nasal cannula (NC-tube used to deliver supplemental oxygen through the nose) was found on the floor in each resident's room. This failure had the potential for Resident 98, 197 and 247 to develop respiratory infections which could lead to serious health condition. 2. When the facility did not have an order for Enhanced Barrier Precautions (EBP-an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities) upon admission for two of five sampled residents (Resident 197 who had a colostomy (a surgical procedure that brings one end of the large intestine out through the abdominal wall to allow waste to leave the body) and Resident 247 who had a sacral (the triangular-shaped bone at the base of the back) wound. This failure had the potential to expose Resident 197 and 247 to the spread of multidrug resistant organisms (MDRO-bacteria that resist treatment with more than one antibiotic) if staff and visitors did not use proper protective equipment (PPE) during high-contact resident care activities (examples: dressing, bathing/showering, transferring, providing hygiene, changing linens, device care-colostomy, wound care.) 3. Resident 98's nasal cannula (NC-tube used to deliver supplemental oxygen through the nose) was found on the floor under a chair next to her bed. This failure had the potential for resident 98 to develop respiratory infection which could lead to serious health condition. 4. Staff did not follow enhanced barrier precaution procedures prior to providing care to one of six randomly sampled residents (Resident 22). These failures had the potential for the development and the spread of infection to all residents and/or staff in the facility. Findings: 1. During a concurrent observation and interview on 3/17/25 at 12:07 p.m. with Resident 197 in their room, Resident 197 was lying in bed with the head of bed elevated wearing an oxygen nasal cannula (NC-a thin, flexible tube that wraps around your head, typically hooks around the ears). The oxygen tubing hung from the resident down the right side of the bed, several loops laid curled on the floor and then connected to the oxygen concentrator. Resident 197 was alert, oriented, able to state name, date, time, location, and able to understand and answer questions. Resident 197 stated he had been wearing oxygen since hospitalization . (continued on next page)

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	055846	A. Building B. Wing	03/21/2025

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

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a record review of Resident 197's Admission Record (AR-a summary of important information regarding a patient which include patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information) dated 3/20/25, the AR indicated, Resident 197 was admitted to the facility on [DATE] with diagnoses: encounter for surgical aftercare following surgery on the digestive system (the break down food and absorbs nutrients for energy and growth), unspecified ventral hernia (a weak spot in the abdomen enabling abdominal tissue or an organ to protrude through a cavity muscle area) with obstruction (something that blocks), acute respiratory failure with hypoxia, and colostomy (a surgical procedure that brings one end of the large intestine out through the abdominal wall to allow waste to leave the body) status. During a review of Resident 197's Minimum Data Set (MDS-a federally mandated resident assessment tool), dated 3/13/25, the MDS section C indicated, Resident 197 had a Brief Interview for Mental Status (BIMS-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 15 out of 15 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07 indicates severe impairment, 99 indicates unable to complete the interview), which indicated Resident 197 was cognitively intact. During a concurrent observation and interview on 3/17/25 at 12:17 p.m. with Resident 247 in the resident's room, Resident 247 was lying in bed and had a nasal cannula (NC- thin plastic tube that delivers oxygen directly into the nose through two small prongs) in her nostrils that was connected to an oxygen (O2) concentrator (device that produces oxygen for breathing). O2 concentrator was at the left side of the bed and the O2 tubing was laying on the floor. Resident stated she used O2 daily. During a review of Resident 247's AR, dated 3/20/25, the AR indicated, Resident 247, a [AGE] year-old female was admitted to the facility on [DATE] from an acute care hospital and had diagnoses that included . dependence on supplemental oxygen, shortness of breath, wheezing, partially vaccinated for COVID-19 . During a review of Resident 247's MDS, dated [DATE], the MDS indicated, Resident 247's BIMS assessment score was 15 out of 15 (0-6 severe cognitive (pertaining to reasoning memory and judgement) deficit, 7-12 moderate cognitive deficit, 13-15 cognitively intact). BIMS scores indicated Resident 247 was cognitively intact. During a concurrent observation and interview on 3/17/25 at 4 p.m. with Resident 98 in her room, Resident 98 was in semi-sitting position in bed watching TV and stated she did not know how long she had been in the facility. Observed in the room next to Resident 98 bed was a nasal cannula on the floor under a bedside chair and connected to oxygen concentrator (device that produces oxygen for breathing). Resident 98 stated she used the oxygen every day and had difficulty breathing without the oxygen. During a review of Resident of Resident 98's Admission Record, (AR-document containing resident demographic information and medical diagnosis), dated 3/19/25, the AR indicated Resident 98 was admitted to the facility on [DATE] with diagnoses which included pulmonary edema (excess fluid accumulates in the lungs making it difficult to breath), shortness of breath and dependence on supplemental oxygen. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 98's Minimum Data Set (MDS-a functional and cognitive abilities assessment) assessment, dated 3/13/25, indicated the Brief Interview for Mental Status (BIMS) score was 14 out of 15 (a BIMS score of 13-15 indicates cognitively intact, 8-12 indicates moderately impaired and 0-7 indicates severe impairment), which indicated Resident 98 was cognitively intact. During a review of Resident 98's Order Summary Report, undated, the Order Summary Report indicated, . Order Date: 3/7/25 . Oxygen: Oxygen at 2LPM [liters (unit of measurement) per minute] via NC every shift . During a concurrent observation and interview on 3/17/25 at 4:40 p.m. with Certified Nursing Assistant (CNA) 11 in Resident 98's room, she stated Resident 98's oxygen tubing is on the floor. CNA 11 stated oxygen should be in her [Resident 98] nostrils and not on the floor. CNA 11 stated, . nasal cannula on the floor was an infection prevention and control issue because the floor was dirty and could cause resident to get sick . During an interview on 3/17/25 at 4:50p.m. with Registered Nurse (RN) 3, she stated Resident 98's nasal cannula should not had been on the floor because it was an infection control issue. RN 3 stated floor was dirty and full of bacteria and could make resident sick. RN 3 stated nursing staff are responsible in making sure oxygen tubing (NC) are not on the floor. During an observation on 3/18/25 at 2:58 p.m. in Resident 247's room, Resident 247 was lying in bed asleep and the O2 tubing was laying on the floor. During an observation on 3/18/25 at 3:01 p.m. in Resident 197's room, the resident was wearing his oxygen with the extended tubing laying on the floor curled under the bedside table. During an interview on 3/19/25 at 9:30 a.m. CNA 8, she stated CNAs are not to touch the setting of oxygen, we only make sure the NC is in resident nostrils and not on the floor. CNA 8 stated oxygen tubing should not be on the floor because it was an infection control issue, floor was dirty. During an interview on 3/19/25 at 10:04 a.m. with Certified Nursing Aide (CNA) 1 in the Wing 3 common area, CNA 1 stated oxygen tubing should not touch the floor due to sanitation (keeping things clean and safe) concerns. During an interview on 3/19/25 at 1:45 p.m. with the Infection preventionist (IP), the IP stated nursing staff are responsible in making sure NC or oxygen tubing are not on the floor. The IP stated, NC on the floor is not acceptable, it is infection control issue and should be replaced with a new one . During a concurrent interview and record review on 3/19/25 at 2:41 p.m. with the Director of Staff Development (DSD) in Wing 3 hallway, the picture of Resident 247's O2 tubing laying on the floor was reviewed. The DSD stated oxygen tubing should not be on the floor. DSD stated when oxygen tubing is found on the floor, the staff are expected to replace the tubing. The DSD stated keeping oxygen tubing off the floor is part of infection control to prevent the resident from being exposed to germs. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 3/19/25 at 3:02 p.m. with the Infection Preventionist (IP), the picture of Resident 247's O2 tubing laying on the floor was reviewed. The IP stated oxygen tubing should not be on the floor. The IP stated when oxygen tubing is found on the floor the staff should replace the tubing. The IP stated the resident would be at risk for cross contamination (the unintentional transfer of harmful bacteria or other contaminants from one surface or object to another, often leading to the growth of microorganisms) if they used oxygen tubing that was on the floor. During a concurrent interview and record review on 3/19/25 at 3:59 p.m. with Licensed Vocational Nurse (LVN) 5, the picture of Resident 247's oxygen concentrator and O2 tubing laying on the floor was reviewed. The LVN 5 stated oxygen tubing should not be on the floor. LVN 5 stated oxygen tubing on the floor would be an infection control issue as it would not be sanitary. LVN 5 stated the resident would be at risk for cross contamination if they used oxygen tubing that had been on the floor. During a review of Resident 197's Order Summary Report, dated 3/20/25, other indicated, Oxygen: Oxygen at 2LPM via NC every shift was ordered on 3/12/25. During an interview on 3/21/25 at 8:13 a.m. with the DSD, the DSD stated the oxygen nasal cannula should not be on the floor. The DSD stated if the oxygen tubing was on the floor, it would be an infection control issue as the floor is dirty. The DSD stated the nursing staff know oxygen tubing should not be on the floor as it was a common practice, and staff received a huddle (informal in-service) regarding oxygen equipment management. During an interview on 3/21/25 at 8:48 a.m. with the Director of Nursing (DON), the DON stated oxygen tubing should be in a bag coiled and not touch the floor. The DON stated if the oxygen tubing touched the floor, the resident would be at risk for cross contamination or infection. During a review of Job Description: Infection Preventionist, dated 7/8/20, the GENERAL STATEMENT OF POSITION, indicated, the Infection Preventionist (IP) is responsible for the facility infection prevention and control program (IPCP) which is designated to provide a safe, sanitary and comfortable environment, and to help prevent development and transmission of communicable diseases and infections. The ESSENTIAL FUNCTIONS, indicated Oversight of the IPCP, which includes at minimum the following elements: A system for preventing, identifying, reporting, investigation and controlling infections and communicable diseases for all residents .based upon the facility assessment and following accepted national standards .Standard and transmission-based precautions to be followed to prevent the spread of infection . The Work Duties indicated the IP will Assess the need for, develop and present or oversee presentation of IPCP related education .the following topics: .Cleaning, disinfection .and aseptic techniques during procedures; Specific practices in direct care and ancillary settings; Therapeutic and diagnostic procedures and devices; Use of isolation/barrier precautions when indicated .Environmental hazards; Use of patient care products and medical equipment . During a review of Job Description: Director of Nursing, dated 8/2018, the Mission Essential indicated, understand and adhere to company .policies and procedures. Knowledge indicated policies, procedures, methods and practices of the community. Most recent evidenced-based practices of nursing care. Knowledge and proficiency in state and federal survey regulations .Knowledge of applicable Federal, State and Local regulations as they pertain to Health Centers Facilities . Ability to direct and oversee the work of others. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Job Description: LVN/LPN (Skilled Nursing), dated 8/2018, the Mission Essential indicated, understand and adhere to company, community and department programs, policies and procedures .Keep current knowledge .for quality care and services mandated by federal and state law, and other regulating agencies. Knowledge of indicated, Policies, procedures, methods and practices of the community; Most recent evidenced-based practices in nursing care; Use of medical supplies and equipment . During a review of HomeCareMag.com Professional Reference titled, Don't Let an Oxygen Concentrator Lead to Infection, dated 1/29/20, (found https://www.homecaremag.com/february-2020/dont-let-oxygen-concentrator-lead-infection), the reference indicated, .The nasal cannula prongs often become contaminated when patients don't properly protect the cannula between uses (i.e., leaving the nasal cannula on the floor, furniture, bed linens, etc.). Then the patient puts the contaminated nasal cannula back in their nostrils and directly transfers potentially pathogenic organisms from these surfaces onto the mucous membranes inside their nasal passages, putting them at risk of developing a respiratory infection. Educate the patient on how to store the nasal cannula between uses in a manner that does not allow it to have direct contact with potentially contaminated surfaces. Either keep the in-use nasal cannula somewhere that does not allow contact with a surface or place it on a cleaned surface, inside an open clean container, or in an open plastic bag . 2. During a concurrent observation and interview on 3/17/25 at 12:07 p.m. with Resident 197 at the resident's room, the door or wall outside the resident's room did not indicate Enhanced Barrier Precautions (EBP-an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities) was required. Resident 197 laid in bed with head of bed elevated wearing an oxygen nasal cannula (NC-a thin, flexible tube that wraps around your head, typically hooks around the ears). Resident 197 was alert, oriented, able to state name, date, time, location, and able to understand and answer questions. Resident 197 stated he had a colostomy due to the removal of his intestines. During a record review of Resident 197's Admission Record (AR-a summary of important information regarding a patient which include patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information) dated 3/20/25, the AR indicated, Resident 197 was admitted to the facility on [DATE] with diagnoses: encounter for surgical aftercare following surgery on the digestive system (the break down food and absorbs nutrients for energy and growth), unspecified ventral hernia (a weak spot in the abdomen enabling abdominal tissue or an organ to protrude through a cavity muscle area) with obstruction, acute respiratory failure with hypoxia, and colostomy status. During a review of Resident 197's Minimum Data Set, dated dated [DATE], the MDS section C indicated, Resident 197 had a Brief Interview for Mental Status (BIMS-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 15 out of 15 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07 indicates severe impairment, 99 indicates unable to complete the interview), which indicated Resident 197 was cognitively intact. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 3/17/25 at 12:17 p.m. with Resident 247 during the initial tour in Resident 247's Room, there was no EBP sign posted on the door on the outside to Resident 247's room. Resident 247 was lying in bed. Resident 247 stated she had been in hospital for the last 2-3months and was transferred to facility on 3/11/25. Resident 247 stated she had developed bedsores while in the hospital from laying on the bed. Resident 247 stated the facility was treating the bedsore and the nurse was looking at the bedsore daily. During a review of Resident 247's AR dated 3/20/25, the AR indicated, Resident 247 had diagnoses that included .spontaneous bacterial peritonitis (acute infection of ascites [an abnormal accumulation of fluid in the abdomen] without a distinct or identifiable source of infection), pressure ulcer of sacral region unspecified stage (unstageable sacral ulcer-medical condition characterized by skin and tissue damage in the sacral area [base of the spine] due to pressure, shear, or friction, where the stage of the ulcer is not specified), irritant contact dermatitis (a non-allergic inflammatory skin reaction caused by direct exposure to irritating substances) due to fecal, urinary or dual incontinence . During a review of Resident 247's MDS, dated [DATE], the MDS indicated, Resident 247's BIMS assessment score was 15 out of 15 (0-6 severe cognitive (pertaining to reasoning memory and judgement) deficit, 7-12 moderate cognitive deficit, 13-15 cognitively intact). BIMS scores indicated Resident 247 was cognitively intact. During a review of Resident 247's Order Summary Report (OSR) dated 3/11/25 at 5:08 p.m. The OSR indicated Monitor unstageable to sacrum for s/s (signs and symptoms) of worsening. Notify MD of changes every shift, Treatment to unstageable PI (Pressure Injury- a localized area of skin damage and underlying tissue that develops when prolonged pressure is applied to the body) to sacrum. Cleanse with NS (Normal Saline), pat dry with gauze, apply Medi honey and cover with foam dressing as needed for displacement or soil dressing and every evening shift During an interview on 3/19/25 at 10:04 a.m. with Certified Nurse Aide (CNA) 1 in Wing 3 common area, CNA 1 stated EBP was followed when residents had an indwelling (relating to a device that is left inside the body) medical device such as an ostomy (surgery to create an opening (stoma) from an area inside the body to the outside). CNA 1 stated EBP was not triggered for residents with wounds. CNA 1 stated EBP alerted staff to perform hand hygiene and wear gowns, gloves, and masks to provide high contact care. CNA 1 stated EBP would be used to prevent cross contamination between staff and residents when performing high contact care. During an interview on 3/19/25 at 2:16 p.m. with LVN 4 outside of Resident 197's room, LVN 4 stated Resident 247 had an unstageable sacral ulcer. LVN 4 stated EBP would be indicated when a resident had a colostomy, wounds, foley catheter or was immunocompromised (weakened immune systems have lower defenses against infections). LVN 4 stated a wound would not be an indicator of EBP. LVN 4 stated staff should wear a gown and gloves when performing high contact care for a resident with EBP. LVN 4 stated residents on EBP should have a sign outside their door. LVN 4 stated the Infection Preventionist (IP) would be responsible for the identification, assessment and implementation of EBP. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/19/25 at 2:41 p.m. with the DSD in Wing 3 hallway, the DSD stated EBP would be indicated for a resident with any type of indwelling device or open wound. The DSD stated the IP would: initiate EBP, alert all staff which resident required EBP, hang an EBP sign on the resident's door and place personal protective equipment (PPE- clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) in the room. During a concurrent interview and record review on 3/19/25 at 3:02 p.m. with the IP, the facility's P&P titled Enhanced Barrier Precautions was reviewed. The IP stated EBPs is indicated for any indwelling devices, wounds, and MDRO. The IP stated the EBPs sign are posted on Resident's door upon admission to the facility. The IP stated the importance of having the EBPs sign posted is that it is a visual cue (a nonverbal signal or element that uses visual information, like pictures, symbols, or gestures, to convey information or guide behavior) for staff that they should practice EBPs when in the Resident's room. The IP validated Resident 247 had a wound. The IP stated, I missed it. The IP stated the EBPs sign on Resident 247's door was missing. The IP stated the standard is that there should have been an EBPs sign on the Resident 247's door. The IP stated if Resident 247 resident had a dressing order, there should have been an EBPs sign. The IP stated the facility failed to follow EBPs policy. During a concurrent interview and record review on 3/19/25 at 3:21 p.m. with the IP in the DSD office, Resident 197's Admission Record, Order Summary and Care Plan, dated 3/19/25 and the facility's policy and procedure titled Enhanced Barrier Precautions, dated 8/1/22, were reviewed. The AR indicated the resident admitted with a diagnosis of colostomy status. The Order Summary indicated colostomy treatment was ordered on the day of admission 3/11/25. The Care Plan indicated EBP was not initiated. The P&P indicated Enhanced barrier precautions are utilized to prevent the spread of multi-drug resistant organisms to residents .EBPs employ targeted gown and glove use during high contact resident care activity .Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: .device care or use .EBPs are indicated for residents with .indwelling medical devices regardless of MDRO colonization . EBPs remain in place for the duration of the resident's stay or until .discontinuation of the indwelling medical device that places them at increased risk .Signs are posted in the door or wall outside the resident room indicating the type of precautions and PPE required .Residents, families and visitors are notified of the implementation of EBPs throughout the facility. The IP stated EBP would be indicated when a resident had an indwelling device or wound. The IP stated EBP would be communicated to staff during huddle or review of the resident's care plan. The IP stated EBP signs are usually posted at the resident's room upon admission by the admission nurse, DSD or IP. The IP stated the presence of EBP signage would be confirmed by the IP or DSD during facility rounds. The IP stated the EBP sign would provide staff with visual queuing that EBP practice would be required when in the resident's room. The IP stated the EBP sign was not on Resident 197's door and stated, I missed one. IP stated the facility failed to follow the EBP P&P for Resident 197. During an interview on 3/19/25 at 4:00 p.m. with LVN 5 in Wing 3 hallway, LVN 5 stated EBP is used when a resident has an indwelling catheter such as an ostomy (surgery to create an opening (stoma) from an area inside the body to the outside), any medical device or wounds. LVN 5 stated EBP was usually identified upon admission, if not, the nurse would alert IP for assessment and initiation. LVN 5 stated IP would communicate with the staff when EBP was initiated. LVN 5 stated it was important to initiate EBP to improve infection control. LVN 5 stated the risk of not implementing EBP would place the resident at risk for cross contamination if provided care without the utilization of proper PPE. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 197's Order Summary Report, dated 3/20/25, other orders, dated 3/11/25, indicated, treatment to colostomy site Remove colotomy barrier with Adhesive wipes, cleanse area and stoma with NS, pat dry with gauze, apply sureprep to area around stoma, place wafer and then place barrier and attach pouch. As needed for displacement. Treatment to Colostomy site Remove colotomy barrier with Adhesive wipes, cleanse area and stoma with NS, pat dry with gauze, apply sureprep to area around stoma, place wafer and then place barrier and attach pouch. Every evening shift every Mon, Thu. During an interview on 3/21/25 at 8:26 a.m. with DON in room [ROOM NUMBER], the DON stated residents with wounds or indwelling devices should have EBP triggered to prevent infection/cross contamination. DON stated staff would be required to follow hand hygiene, wear gowns and gloves when providing care to the resident. The DON stated EBP signage should be outside of the room and PPE stored inside the room. The DON stated if EBP is not initiated staff would not follow the EBP for high-contact care which would place the resident at increased risk of infection, sepsis and further decline. During a review of Job Description: Director of Nursing, dated 8/2018, the Mission Essential indicated, understand and adhere to company .policies and procedures. Knowledge indicated policies, procedures, methods and practices of the community. Most recent evidenced-based practices of nursing care. Knowledge and proficiency in state and federal survey regulations .Knowledge of applicable Federal, State and Local regulations as they pertain to Health Centers Facilities . Ability to direct and oversee the work of others. During a review of Job Description: LVN/LPN (Skilled Nursing), dated 8/2018, the Mission Essential indicated, understand and adhere to company, community and department programs, policies and procedures .Keep current knowledge .for quality care and services mandated by federal and state law, and other regulating agencies. Knowledge of indicated, Policies, procedures, methods and practices of the community; Most recent evidenced-based practices in nursing care; Use of medical supplies and equipment . During a review of Job Description: Infection Preventionist, dated 7/8/20, the GENERAL STATEMENT OF POSITION, indicated, the Infection Preventionist (IP) is responsible for the facility infection prevention and control program (IPCP) which is designated to provide a safe, sanitary and comfortable environment, and to help prevent development and transmission of communicable diseases and infections. The ESSENTIAL FUNCTIONS, indicated Oversight of the IPCP, which includes at minimum the following elements: A system for preventing, identifying, reporting, investigation and controlling infections and communicable diseases for all residents .based upon the facility assessment and following accepted national standards .Standard and transmission-based precautions to be followed to prevent the spread of infection . The Work Duties indicated the IP will Assess the need for, develop and present or oversee presentation of IPCP related education .the following topics: .Cleaning, disinfection .and aseptic techniques during procedures; Specific practices in direct care and ancillary settings; Therapeutic and diagnostic procedures and devices; Use of isolation/barrier precautions when indicated .Environmental hazards; Use of patient care products and medical equipment . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure titled, Infection Prevention and Control Program, dated 10/2018, the Policy Interpretation and Implementation indicated 2. The program is based on accepted national infection prevention and control standards .11. Prevention of Infection a. Important facets of infection prevention include: . (7) implementing appropriate isolation precautions when necessary; and (8) following established general guidelines .such as those of the Centers for Disease Control (CDC) . During the review of a professional reference from CDC (Centers for Diseases Control and Prevention - an agency that works to protect people from health threats) titled, Consideration for Use of Enhanced Barrier Precautions in Skilled Nursing Facilities (https://www.cdc.gov/hicpac/media/pdfs/EnhancedBarrierPrecautions-508.pdf) dated 06/2021, the reference indicated . Resident-to-resident pathogen transmission in skilled nursing facilities occurs, in part, via healthcare personnel, who may transiently carry and spread MDROs on their hands or clothing during resident care activities. Residents who have complex medical needs involving wounds and indwelling medical devices are at higher risk of both acquisition and colonization by MDROs. Residents who are MDRO colonized are not often recognized by healthcare personnel based on available clinical cultures or medical history In 2019, CDC introduced a new approach to the use of personal protective equipment called Enhanced Barrier Precautions (EBP). This new approach recommends gown and glove use for certain residents during specific high-contact resident care activities associated with MDRO transmission Consideration for Use of Enhanced Barrier Precautions in Skilled Nursing Facilities- Enhanced Barrier Precautions can be applied (when Contact Precautions do not otherwise apply) to residents with any of the following: Wounds or indwelling medical devices, regardless of MDRO colonization status . examples of high contact resident care activities include dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, and wound care During a review of CDC.gov Professional Reference titled, Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), dated 7/12/22, (found at https://www.cdc.gov/long-term-care-facilities/media/pdfs/PPE-Nursing-Homes-508.pdf), the key points indicated, .2. Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. 3. EBP may be indicated .for residents with any of the following: wound or indwelling medical devices, regardless of MDRO colonization status . The Background indicated Residents in nursing homes are at increased risk of becoming colonized and developing infection with MDROs .more than 50% of nursing home residents may be colonized with an MDRO, nursing homes have been the setting for MDRO outbreaks, and when these MDROs result in resident infections, limited treatment options are available [1-9] . The Description of Precautions: Enhanced Barrier Precautions indicated, Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions include dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use .wound care . 40641 3. During a concurrent observation and interview on 3/17/25 at 4 p.m. with Resident 98 in her room, Resident 98 was in semi-sitting position in bed watching TV and stated she did not know how long she had been in the facility. Observed in the room next to Resident 98 bed was a nasal cannula on the floor under a bedside chair and connected to a oxygen concentrator (device that produces oxygen for breathing). Resident 98 stated she used the ox [TRUNCATED]

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	03/21/2025

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 51223 Based on observation, interview, and record review, the facility failed to maintain a safe and sanitary environment when the facility's three tumble dryers in the laundry room was not maintained per the manufacturer's recommendations and had a layer of gray and white debris collected on the back of the dryer's vent and pipes. This failure had the potential to create a fire hazard that could have placed 50 of 50 residents at risk for displacement. Findings: During an observation and interview on 3/19/25 at 11:15 a.m. with the Director of Buildings and Grounds (MAIN) and laundry (LAU) in the laundry room, a layer of small gray and white particles covered the back of the three dryer vents and the pipe that lead from the back of the dryer to the wall. The LAU stated maintenance cleans behind the dryers and keeps the air ducts clean. Laundry stated the dust to the pipes and grate look good it's not bad. LAU stated it was important to remove the lint to avoid a buildup of dust. MAIN stated the facility provides maintenance to the dryer vents annually or as needed. MAIN stated it was important to prevent excess build up as it becomes a fire hazard and may affect the efficiency and performance of the dryer. During an interview on 3/20/25 at 2:42 p.m. with MAIN in the administrative office, MAIN stated the dryer exhaust ductwork was cleaned semi-annually. MAIN stated he reviewed the manufacturer's guideline which indicated the dryer exhaust inspection should be scheduled for review and cleaning monthly. MAIN stated the facility was not following the manufacturer's recommendation. During an interview on 3/21/25 at 11:03 a.m. with the Administrator (ADM) in the ADM office, the ADM stated the laundry room should not have dust as there would be risk of contaminating the environment and resident clothes. ADM stated dust could compromise the dryer performance and fire. ADM stated the facility was not following the dryer's manufacturer's recommendation for monthly maintenance. During a review of Maintenance Work Order #131428, dated 10/16/24, the SQ, Dryer Exhaust Ductwork Cleaning-Semi-Annual indicated the main laundry dryer exhaust ductwork was cleaned to make sure it was free of blockages on 10/16/24. During a review of Tumble Dryers Installation/Operation/Maintenance, dated 7/2017, the maintenance on page 94 indicated Monthly 1. Remove lint and debris from inside exhaust duct to maintain proper airflow and avoid overheating. a. Remove external duct and duct access covers, if present. b. Clean inside the duct with a vacuum. c. Clean dampers and make sure they operate freely. d. Replace duct and all access covers before returning tumble dryer to operation .3. Carefully wipe any accumulated line off the cabinet high limit thermostat and thermistor, including perforated cover. 4. Clean lint and debris buildup from blower to maintain power airflow. Quarterly 1. Use a vacuum to clean air vents on drive motors . (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of the facility's policy and procedure titled, Homelike Environment, dated 2/2021, the P&P indicated Residents are provided with a safe, clean, comfortable and homelike environment . During a review of the facility's policy and procedure titled, Laundry and Bedding, Soiled, dated 9/2022, Onsite Laundry Processing indicated, 4. Laundry equipment (e.g. washing machines, dryers) is used and maintained according to the manufacturer's IFU to prevent microbial contamination of the system.