STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055955	A. Building B. Wing	08/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
California Home for the Aged	6720 E. Kings Canyon Fresno, CA 93727

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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents were free from accidents for one of five sampled residents (Resident 1), when Resident 1 was identified as being at risk for falls with a history of seven falls in the facility and the care planned intervention of a 1:1 (continuous observation and support provided by one qualified staff member to one resident) was not implemented and Resident fell on 7/18/25. This failure resulted in Resident 1 experiencing a witnessed fall, from the bed onto the floor on 7/18/25. After the fall Resident 1 experienced pain, discoloration and tenderness to the left shoulder and was sent to the general acute care hospital (GACH) for evaluation. Resident 1 was diagnosed with a non-displaced (a break where the broken pieces of bone remain in their proper alignment and position) clavicle (collarbone) fracture (a break or discontinuity in a bone), and her left shoulder was bruised. As a result of Resident 1's injury she now needs assistance with feeding and has limited mobility in her left arm. During a review of Resident 1's admission Record (document containing resident demographic information and medical diagnosis), dated 7/23/25, the admission Record indicated Resident 1 was admitted to the facility on [DATE]. Resident 1's diagnosis included but was not limited to .ALZHEIMER'S (progressive disease that destroys memory and other important mental functions).DEMENTIA (a chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning).MAJOR DEPRESSIVE DISORDER (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). DELIRIUM (Serious disturbance in mental abilities that results in confused thinking and reduced awareness of surroundings).MUSCLE WEAKNESS (age-related progressive loss of muscle mass and strength).HISTORY OF FALLING.ANXIETY (a feeling of worry, nervousness) .During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool used to identify resident cognitive (the mental processes of perception, thinking, learning, memory, reasoning, and judgment) and physical function) Assessment, dated 6/11/25, the MDS indicated Resident 1's Brief Interview for Mental Status (BIMS -an evaluation of attention, orientation and memory recall) score of 3 (0-7 severe cognitive impairment, 8-12 moderate cognitive impairment, 13-15 no cognitive impairment), indicating Resident 1 had severe cognitive impairment (a significant decline in mental functions like memory, thinking, and judgment, making it impossible for an individual to live independently and requiring significant assistance with daily tasks and self-care). During a review of Resident 1's facility Incident by Incident log, dated 7/23/25, the Incident by Incident log indicated Resident 1 had seven falls in the facility from 3/5/25 to 7/18/25. The first fall was unwitnessed on 3/5/25, the second fall was unwitnessed on 3/11/25, the third fall was unwitnessed on 4/15/25, the fourth fall was unwitnessed on 5/12/25, the fifth fall was witnessed on 7/5/25, the sixth fall was unwitnessed on 7/16/25 and the seventh fall on 7/18/25 was witnessed by staff. During a record review of Resident 1's Fall Risk Evaluation (evaluation of residents history, current status and predisposing conditions - a factor that increases a person's likelihood of developing a particular health condition, genetic trait, or other characteristic, but it is not the direct or immediate cause) assessments, with date ranges from 2/28/25 to 7/19/25, the Fall Risk Evaluation scores ranged from 17-22 points. The Fall Risk Evaluation of 10 points or higher indicated Resident 1 was a high risk (involving or exposed to a high level of danger) for falls. During a concurrent observation and interview on 8/19/25, at 1:30 p.m. with Resident 1 and her Granddaughter in Resident 1's room, Resident 1 was lying in bed watching television with her granddaughter. Resident 1 had a shoulder sling in place on her left shoulder. Resident 1 stated she wasn't doing too good and pointed in the direction of her sling. Resident 1 stated she did have pain at the time of her fall. Resident 1's granddaughter stated she now requires 1:1 (continuous observation and support by one qualified staff member to one resident) at all times due to her most recent fall on 7/18/25.During an interview on 8/19/25 at 2 p.m., with the Certified Nursing Assistant (CNA) 1, CNA 1 stated she is currently assigned to Resident 1 as a 1:1. CNA 1 stated she re-started the 1:1 care after Resident 1's return from the hospital on 7/19/25. CNA 1 stated 1:1 assignment consists of having a CNA observe, monitor, assist, and help prevent future incidents that could harm the resident. CNA 1 stated she has worked with Resident 1 multiple times prior to this 1:1 assignment and has noticed a change since her last fall. Resident 1 is not as mobile as she used to be. CNA 1 stated it is her responsibility to remain with the resident at all times, provide activities of daily living (ADL- routine tasks such as bathing, dressing and toileting a person performs daily to care for themselves) care including