| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055955 | A. Building<br>B. Wing | 03/20/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| California Home for the Aged | 6720 E. Kings Canyon<br>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 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>40141<br><br>Based on record review, interview, and facility policy review, the facility failed to ensure a psychotropic medication was addressed on the comprehensive care plan for 1 (Resident #5) of 5 sampled residents reviewed for unnecessary medications.<br><br>Findings included:<br><br>A facility policy titled, Care Plans, Comprehensive Person-Centered, revised 03/2022, 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. The policy indicated, 1. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident.<br><br>An Admission Record indicated the facility admitted Resident #5 on 11/11/2024. According to the Admission Record, the resident had a medical history that included diagnoses of major depressive disorder, anxiety disorder, and insomnia.<br><br>An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/18/2024, revealed Resident #5 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident had diagnoses of anxiety disorder, depression, and insomnia. The MDS revealed the resident received an antidepressant medication during the assessment's seven-day lookback period.<br><br>Resident #5's Order Summary Report, with active orders as of 03/19/2025, contained an order dated 11/11/2024 for duloxetine hydrochloride 30 milligrams (mg), with instructions to give two capsules by mouth one time a day related to anxiety disorder. The Order Summary Report also contained an order dated 02/19/2025 for trazodone hydrochloride 100 mg, with instructions to give one table by mouth at bedtime related to major depressive disorder.<br><br>Resident #5's Care Plan Report included a problem statement revised on 11/22/2024, that indicated the resident used antidepressant medication (trazodone) related to insomnia. The Care Plan Report revealed a problem statement revised 11/22/2024, that indicated the used anti-anxiety medications (buspirone) related to anxiety disorder. Further review revealed the Care Plan Report did not address duloxetine hydrochloride.<br><br>(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 |
|---|---|---|
| | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|
| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 03/18/2025 at 12:21 PM, Licensed Vocational Nurse (LVN) #1 stated the floor nurses were responsible for the care plans. LVN #1 stated the nurses also updated and revised the care plans with any changes. LVN #1 stated Resident #5 received duloxetine for depression. LVN #1 reviewed Resident #5's care plan and stated, The duloxetine is not addressed on [Resident #5's] care plan.<br><br>During an interview on 03/20/2025 at 8:16 AM, LVN #2 stated the care plans should match the physician orders. LVN #2 stated the care plans were there to let staff know how to implement the resident's care.<br><br>During an interview on 03/20/2025 at 8:56 AM, LVN #3 stated if the nurse obtained a new medication order they would address the order on the care plan and put interventions on the care plan. LVN #3 stated the admission nurse was responsible for addressing the care plan. LVN #3 stated the nurse who admitted Resident #5 back from the hospital in November (2024) would have been responsible to ensure the medications were addressed on the care plan. LVN #3 stated she did not know why the duloxetine would not be on the care plan. LVN #3 stated the duloxetine was an antidepressant, so it was important that it was on the care plan for behaviors and monitoring. LVN #3 stated the duloxetine was not addressed on Resident #5's care plan.<br><br>During an interview on 03/20/2025 at 10:34 AM, the Director of Nursing (DON) stated the admission nurse would initiate the baseline care plan and complete the nursing part. The DON stated the nurse would initiate the psychotropic medication nursing related care plan, then social services would complete the care plan specific to the medication and behaviors. The DON stated she expected the specific medication to be addressed on the care plan. The DON stated the duloxetine had been on the care plan previously and should have been on the care plan.<br><br>During an interview on 03/20/2025 at 10:51 AM, the Director of Social Services (DSS) stated nursing was responsible for initiating the care plan, then the interdisciplinary team (IDT) team between nursing and social services was responsible for making sure the medication was on the care plan.<br><br>During an interview on 03/20/2025 at 11:00 AM, the Administrator stated the IDT team was responsible for the comprehensive care plan. The Administrator stated she expected for the duloxetine to have been on the care plan for Resident #5. The Administrator stated the trazodone and duloxetine were the same classification but had different uses, so the duloxetine should have been on the care plan. |