

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  056207	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/26/2024
NAME OF PROVIDER OR SUPPLIER  Pacific Gardens Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  577 S. Peach Ave. 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)
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38961</p> <p>Based on interview and record review, the facility failed to provide services which meet professional standards of practice for one of three sampled residents (Resident 1) when License Vocational Nurse (LVN 1) did not perform necessary assessment of her assigned residents and continued to document on Resident 1's clinical record Resident 1's vital signs, pain assessment, feeding tube assessment, enteral feeding intake, and provided non-pharmacological pain interventions care she did not provide from 12/25/21 to 12/30/21 during the time Resident 1 was admitted in general acute care hospital (GACH) from 12/25/21 to 12/30/21.</p> <p>These failure resulted in an inaccurate Resident 1's clinical record which did not reflect Resident 1's current medical status and the lack of resident assessment could negatively impact the care of other residents residing in the facility.</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record (a document containing demographic information), dated, [DATE] the Admission Record indicated, Resident 1 was admitted to the facility on [DATE], with diagnoses that included Hemiplegia (paralysis in one side of the body) and Hemiparesis (partial paralysis) following unspecified Cerebrovascular Disease (a condition that affects the blood flow to the brain) affecting Right Non-Dominant side (Muscle weakness or partial paralysis on one side of the body). Type 2 Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). Morbid Obesity (a disorder that involves having too much body fat), Dysphagia (difficulty swallowing), Aphasia (disorder that makes it difficult to speak), Vascular Dementia (brain damage caused by multiple strokes), Sepsis (life-threatening blood infection), chronic kidney disease (kidneys stop filtering waste from your blood) .</p> <p>During a review of Resident 1's SNF (Skilled Nursing Facility/NF (Nursing Facility) to Hospital Transfer Form, dated 12/25/21, the document indicated, .Resident 1 was sent to hospital on 12/25/21 at 2:26 p.m. for SOB (shortness of breath) via ambulance.</p> <p>During a concurrent interview and record review on 11/26/24, at 11 a.m., with Assistant Director of Nursing (ADON), Resident 1's Weights and Vitals Summary dated 12/1/21-12/31/21 was reviewed. The Weights and Vitals Summary indicated, on 12/28/21 at 5:46 a.m. LVN 1 documented Resident 1's Blood Pressure 122/78, Temperature 98 degrees, Respiration 18 breaths per minute, Pulse 78 beats per minute, Pain Level was between 0-2 and Blood oxygen level was at 98%.</p> <p>(continued on next page)</p>

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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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>During a review of Resident 1's Medication Administration Record (MAR) dated 12/1/21-12/31/21. The MAR indicated, physician orders .Enteral Feed (a method of providing nutrition to the body through the stomach) Order every night shift Enteral-Change Syringe q [every] 24 hours . LVN 1 documented on the MAR on 12/29/21 and 12/30/21 the order was completed.</p> <p>During a review of Resident 1's MAR dated 12/1/21-12/31/21. The MAR indicated, physician orders .Enteral Feed Order every night shift every other day Enteral-Change tubing Q48 hrs.(hours) with each bottle/bag change . LVN 1 documented on the MAR on 12/29/21 the order was completed.</p> <p>During a review of Resident 1's MAR dated 12/1/21-12/31/2. The MAR indicated, physician orders .Enteral Feed Order every shift Enteral-Check Residuals before beginning a feeding administration. If Greater than 100 cc (unit of measure) HOLD feedings and Recheck in 1 HR [hour] if not resolved CALL MD . LVN 1 documented on the MAR on 12/29/21 and 12/30/21 the order was completed.</p> <p>During a review of Resident 1's MAR dated 12/1/21-12/31/21. The MAR indicated, physician orders .Enteral Feed Order every shift Enteral-Check Tube Placement before Feeding, flush and Meds, Choose methods and document 0 for no issue or 1 for issue when using Gastric Residual Volume &amp; visual methods Enter actual ph (measure of how acidic a solution is) reading when using ph method. Add progress notes prn (as needed) . LVN 1 documented on the MAR on 12/29/21 and 12/30/21 the order was completed.</p> <p>During a review of Resident 1's MAR dated 12/1/21-12/31/21. The MAR indicated, physician orders .Enteral Feed Order every shift Enteral-Elevate Head of bed at least 30 degrees during feeding, any medication administration and 30-minutes after feeding . LVN 1 documented on the MAR on 12/29/21 and 12/30/21 the order was completed.</p> <p>During a review of Resident 1's MAR dated 12/1/21-12/31/21. The MAR indicated, physician orders . Enteral Feed Order every shift Enteral-Medication Administration Flush-flush with minimum of 30 ml [milliliters-(unit of measurements)] water before giving medications, flush with at least 5 ml between medications, and flush with minimum of 30 ml after all medications given . LVN 1 documented on the MAR on 12/29/21 and 12/30/21 the order was completed.</p> <p>During a review of Resident 1's MAR dated 12/1/21-12/31/21. The MAR physician orders .Enteral Feed Order every shift Monitor for tube feeding complications including nausea, vomiting, diarrhea, complications, GI (referring to stomach) discomfort abdomen discomfort, coughing, congestion, choking, SOB, cyanosis (bluish discoloration of skin, nails, lips), frothy sputum, and unusual restlessness . LVN 1 documented on the MAR on 12/29/21 and 12/30/21 the order was completed.</p> <p>During a review of Resident 1's MAR dated 12/1/21-12/31/21. The MAR indicated, physician orders . Pain non-Rx [prescription], record any non-drug intervention used to prevent OR relieve Pain-Nondrug intervention . LVN 1 documented on the MAR on 12/29/21 and 12/30/21 the order was completed.</p> <p>During a review of Resident 1's MAR dated 12/1/21-12/31/21. The MAR indicated, physician orders . Pain-Record Highest Level of Pain Every Shift. LVN 1 documented on the MAR on 12/29/21 and 12/30/21 Resident 1's pain level was 0 and the order was completed.</p> <p>During a review of Resident 1's MAR dated 12/1/21-12/31/21. The MAR indicated, physician orders . Enteral Feed Order every 6 hours Enteral -Flush Tubing with 240 ml water Q 6 hrs [hours] . LVN 1 documented on the MAR on 12/28/21 and 12/30/21 the order was completed.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>During an interview on 11/26/24 at 11:30 a.m., with the ADON, the ADON stated, the documentation on the MAR for Resident 1 was completed by LVN 1. The ADON stated, Resident 1 was not in the facility and was admitted at the GACH when LVN 1 documented on the MAR from 12/25/21 through 12/30/21. The ADON stated, LVN 1 also documented Resident 1's vital signs and care the provided while Resident 1 was admitted at the GACH. The ADON stated, it was unacceptable for LVN 1 to document services provided while Resident 1 was out of the facility. The ADON stated, it was illegal to document in a resident's medical record and falsify services and treatment were provided when it was not.</p> <p>During an interview on 11/26/24 at 12:55 p.m., with the DON, the DON stated, LVN 1 documented in Resident 1's clinical record medical care and services provided while Resident 1 was at the GACH. The DON stated, LVN 1 did not follow the five rights of medication administration when LVN 1 documented in the MAR enteral feeding was administered to Resident while Resident 1 was not in the facility and was admitted at the GACH. The DON stated, this type of documentation could affect residents' safety and wellness. The DON stated, these was unacceptable and placed all residents on the facility at risk for their health and wellness.</p> <p>During a telephone interview on 12/3/24 at 11:20 a.m., with LVN 1, LVN 1 stated, she was familiar with Resident 1 and was assigned to care for Resident 1. LVN 1 stated, her electronic signature on the MAR was LF 37. LVN 1 stated, when treatment was provided to residents there would be a check mark and LF37 on the MAR indicated she was the LVN who provided the treatment and care on the specific date. LVN 1 stated, she made a mistake on her documentation. LVN1 stated, she documented on Resident 1's clinical record, care and treatment was provided while Resident 1 was admitted in the GACH. LVN 1 stated, I am responsible because my signature is on the MAR. LVN1 stated, Documenting is a very important part of my job and I failed to accurately document for Resident 1.</p> <p>During a review of the facility's Policy and Procedure (P&amp;P) titled, General Dose Preparation and Medication Administration dated 12/01/07 the P&amp;P indicated This Policy 6.0 sets forth the procedures relating to general dose preparation and medication administration. Facility staff should also refer to Facility policy regarding medication administration and should comply with Applicable Law and the State Operations Manual when administering medications . Verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time, for the correct resident .</p> <p>During a review of the facility's document titled Job Description/Performance Evaluation, dated 11/13/17, the job description indicated, job title LVN/LPN . provides accurate assessment, over-sight, and monitoring of patients for quality medical management and early detection of changes in condition . utilizes professional standards in performing basic assessment and clinical monitoring . implements and maintains established policies and procedures relative to skin care treatments . properly prepares and administers medications and treatments . complies with professional standards, policies &amp; procedures . principles for administering medications, treatments</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>During a review of the professional reference from <a href="https://nursingeducation.org/insights/documentation/#:~:text=Principle%20of%20Confidentiality%20in%20Nursing,compliance%2C%20and%20following%20ethical%20guidelines">https://nursingeducation.org/insights/documentation/#:~:text=Principle%20of%20Confidentiality%20in%20Nursing,compliance%2C%20and%20following%20ethical%20guidelines</a> titled Nurse Insights: What are the best practices for nursing documentation? dated 5/7/24, the professional reference indicated, Nursing documentation is an essential aspect of patient care and plays a pivotal role in enhancing communication between healthcare professionals, recording medical history accurately, and providing legal protection for registered nurses (RNs) . Importance of Accurate Nursing Documentation . Accurate nursing documentation significantly influences the quality of patient care. It not only provides a clear picture of the patient's medical history but also serves as a vital tool of communication among healthcare professionals. When filled accurately and systematically, it can also protect nurses legally if there's a complaint or lawsuit related to patient care . The Role in Patient Care Proper and precise nursing documentation forms the core of patient care. It documents the care plan and the patient's response to it. This includes medication administered, medical procedures performed, observations, and any significant changes in the patient's condition. Ineffective documentation could lead to medical errors or inappropriate care, which might harm the patient . Enhances Communication Among Healthcare Professionals . Documented nursing care enables a shared understanding of the patient's condition among all members of the healthcare team. It also aids in facilitating handovers between shifts, ensuring that all essential information is correctly relayed and continuity in patient care is maintained. Miscommunication or misunderstood information can put patient safety at risk . Legal Protection for Nurses . In the event of legal proceedings, the nursing documentation acts as tangible proof of the care provided and becomes a crucial part of the defense. Maintaining consistent, accurate, and factual narratives about patient care significantly bolsters a nurse's case in a court of law. Remember-all noted observations and actions have to be entered timely, concisely, and accurately. Follow your nursing program's guidelines and the legal and ethical requirements of your jurisdiction. Good documentation skills are integral to becoming a skilled and responsible nurse .</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38961</p> <p>Based on interview and record review, the facility failed to ensure license nurse perform residents assessment and document accurately according to the care provided when License Vocational Nurse (LVN 1) did not perform necessary assessment of her assigned residents and continued to document on Resident 1's clinical record Resident 1's vital signs, pain assessment, feeding tube assessment, enteral feeding intake, and provided non-pharmacological pain interventions care she did not provide from 12/25/21 to 12/30/21 during the time Resident 1 was admitted in general acute care hospital (GACH) from 12/25/21 to 12/30/21.</p> <p>These failure resulted in an inaccurate Resident 1's clinical record which did not reflect Resident 1's current medical status and the lack of resident assessment could negatively impact the care of other residents residing in the facility.</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record (a document containing demographic information), dated, [DATE] the Admission Record indicated, Resident 1 was admitted to the facility on [DATE], with diagnoses that included Hemiplegia (paralysis in one side of the body) and Hemiparesis (partial paralysis) following unspecified Cerebrovascular Disease (a condition that affects the blood flow to the brain) affecting Right Non-Dominant side (Muscle weakness or partial paralysis on one side of the body). Type 2 Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). Morbid Obesity (a disorder that involves having too much body fat), Dysphagia (difficulty swallowing), Aphasia (disorder that makes it difficult to speak), Vascular Dementia (brain damage caused by multiple strokes), Sepsis (life-threatening blood infection), chronic kidney disease (kidneys stop filtering waste from your blood) .</p> <p>During a review of Resident 1's SNF (Skilled Nursing Facility/NF (Nursing Facility) to Hospital Transfer Form, dated 12/25/21, the document indicated, .Resident 1 was sent to hospital on 12/25/21 at 2:26 p.m. for SOB (shortness of breath) via ambulance.</p> <p>During a concurrent interview and record review on 11/26/24, at 11 a.m., with Assistant Director of Nursing (ADON), Resident 1's Weights and Vitals Summary dated 12/1/21-12/31/21 was reviewed. The Weights and Vitals Summary indicated, on 12/28/21 at 5:46 a.m. LVN 1 documented Resident 1's Blood Pressure 122/78, Temperature 98 degrees, Respiration 18 breaths per minute, Pulse 78 beats per minute, Pain Level was between 0-2 and Blood oxygen level was at 98%.</p> <p>During a review of Resident 1's Medication Administration Record (MAR) dated 12/1/21-12/31/21. The MAR indicated, physician orders .Enteral Feed (a method of providing nutrition to the body through the stomach) Order every night shift Enteral-Change Syringe q [every] 24 hours . LVN 1 documented on the MAR on 12/29/21 and 12/30/21 the order was completed.</p> <p>During a review of Resident 1's MAR dated 12/1/21-12/31/21. The MAR indicated, physician orders .Enteral Feed Order every night shift every other day Enteral-Change tubing Q48 hrs.(hours) with each bottle/bag change . LVN 1 documented on the MAR on 12/29/21 the order was completed.</p> <p>(continued on next page)</p>		

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