STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056207	A. Building B. Wing	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pacific Gardens Nursing and Rehabilitation Center	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)
F 0621 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Treat residents equally regarding transfer, discharge, and provision of services for all residents, regardless of payment source (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0621 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow the policy and procedure (P&P) titled, Admission, Transfer, Discharge and Bed-Holds, for one of three sampled residents (Resident 1) when Resident 1 (a veteran - someone who has served in a nation's armed forces) was denied admission for rehabilitation services based on payment source. This failure had the potential to delay recovery for Resident 1 following an Esophagogastroduodenoscopy (EGD - a medical procedure used to examine the lining of the esophagus, stomach, and the first part of the small intestine), Robotic Ivor [NAME] Esophagectomy (a minimally invasive surgical procedure with the use of a surgical robot to remove a portion of the esophagus to treat cancer) and Exploratory Laparotomy (a surgical procedure involving a large incision in the abdomen to visually examine the abdominal organs to identify the cause of unexplained symptoms or injuries).During an interview on 8/26/25 at 11:01 a.m. with [Hospital A] Social Worker (SW), the SW stated Resident 1 was referred to the facility on 8/5/25 for rehabilitation services for 20 days. The SW stated on 8/5/25 he spoke with the facility's Business Office Manager (BOM) and the BOM informed him the facility was unable to admit Resident 1 because [Hospital A] did not bill Medicare (the federal health insurance program for U.S. citizens and permanent legal residents, age [AGE] and older, people with disabilities and End-Stage Renal Disease (a severe condition where the kidneys have permanently lost most of their function) for the required three midnight stay (a Medicare Part A regulation requiring a patient to have a minimum of three consecutive nights of inpatient hospital care before they are eligible for covered services). The SW stated [Hospital A] billed VA (United States Department of Veterans Affairs - a cabinet-level agency of the U.S. government responsible for providing comprehensive benefits, healthcare, and support services to military veterans and their families) directly for services, not Medicare. During a review of Resident 1's [Hospital A] Demographic (HD), undated, the HD indicated, [name of Resident 1]. POS (Period of Service): Vietnam ERA. admitted : 7/11/25. discharged : 8/6/25. Health Insurance Information: Medicare Part A Effective 2/1/13. Medicare Part B Effective 2/1/13. Tricare (the U.S. military's health insurance plan providing coverage to service members, retirees, and their families) Effective 1/1/25.During a review of Resident 1's [Hospital A] Discharge Summary (DS), dated 8/6/25, the DS indicated, THORACIC SURGERY (surgical procedures performed on the organs and structures within the chest cavity). DISCHARGE SUMMARY. DATE OF OPERATION: 7/11/25. PREOPERATIVE DIAGNOSIS: Esophageal cancer (a disease in which malignant cells form in the tissues lining the hollow muscular tube that transports food and liquids from the throat to the stomach). PROCEDURES PERFORMED: 1. EGD 2. Robotic Ivor [NAME] esophagectomy. 3. Exploratory laparotomy. Diagnoses/Active Problems Managed this Hospitalization: . (Resident 1) treated with the above procedure, which the patient tolerated well. He continued to do well and on POD#20 (post-operative day 20), he was transferred to the floor. Inpatient rehab recommendations are for SNF (skilled nursing facility - a place that offers medical and therapeutic services that can only be performed safely and effectively by or under the supervision of licensed, trained health professionals to address complex medical needs and facilitate recovery after an illness, injury, or surgery). A suitable facility has been found, all necessary arrangements have been made, and the patient will be discharged .During an interview on 8/27/25 at 9:28 a.m. with the admission Services Manager (ASM), the ASM stated when the facility received a referral for admission, the admission staff reviewed the referral to ensure the facility could provide the services required. The ASM stated the admission staff would verify the residents' primary insurance, secondary insurance and copay. The ASM stated a three midnight stay at a general acute care hospital with an inpatient status was required for Medicare to cover skilled nursing services (medical and therapeutic services that can only be performed safely and effectively by or under the supervision of licensed, trained health professionals to address complex medical needs and facilitate recovery after an illness, injury, or surgery). The ASM stated Medicare would not cover skilled nursing services if there was no record of the three midnight stay at a general acute care hospital. During an interview on 8/27/25 at 9:45 a.m. with the BOM, the BOM stated when the facility received a referral for admission, the referral was reviewed to verify payment source. If a resident had no payment source, the resident was given a private option to pay. The BOM stated the admission staff would interview the resident or the resident's family member to agree on a payment plan. The BOM stated she spoke to the SW on 8/5/25 regarding the referral. The BOM stated she explained the three midnight stay qualifying requirement for Medicare coverage to the SW. The BOM stated since [Hospital A] did not bill