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	02/07/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 48424 Based on observation, interview, and record review, the facility failed to ensure dignity was provided for two of 11 sampled residents (Resident 3, and 305) when: 1. Resident 3's foley catheter (a soft, flexible tube inserted into the bladder to help drain urine into a bag) drainage bag was without a dignity bag (a bag used to the cover and hold the catheter drainage and collection bag so it is not visible), leaving the urine visible to anyone who walked into Resident 3's room This failure resulted in Resident 3 not being provided his right to have a dignified existence while in the facility. 2. Resident 305's foley catheter drainage bag was without a dignity bag. This failure violated Resident 305's privacy and had the potential to affect the self-esteem, self-worth, and quality of life of Resident 305. Findings: 1. During an observation on 2/3/25 at 9:57 a.m. in Resident 3's room, Residents 3 foley catheter bag was uncovered leaving the urine visible to anyone who entered the room. During a concurrent observation and interview on 2/3/25 at 10:00 a.m. with Certified Nursing Assistant (CNA) 9, Resident 3's catheter bag was uncovered leaving the urine visible. CNA 9 stated the catheter bag needed to be covered it was the policy of the facility. CNA 9 stated providing a privacy bag for Resident 3's catheter ensured he was given dignity, and it was his right to have dignity. CNA 9 stated residents with catheters could feel vulnerable or embarrassed because it was not a common thing for people to have. During an interview on 2/6/25 at 9:59 a.m. with CNA 10, CNA 10 stated Resident 3 should have had a privacy bag to cover his catheter. CNA 10 it was not dignified to leave Resident 3's catheter bag uncovered. (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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/6/25 at 11:57 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 3 should have had a privacy bag placed on his catheter bag. LVN 1 stated a privacy bag provided dignity and privacy for Resident 3's medical condition. LVN 1 stated it was unacceptable for Resident 3 to have his catheter bag uncovered During an interview on 2/7/25 at 3:43 a.m. with the Director of Nursing (DON), the DON stated Resident 3's right for dignity was violated as a result of not having a privacy bag over his catheter. The DON stated having the catheter bag uncovered did not provide dignity or follow the facility's policy. During a review of the facility's policy and procedure (P&P) titled, Resident Rights, dated 10/22, indicated, . The resident has the right to a dignified existence . the resident has the right to be treated with respect and dignity . 48739 2. During a concurrent observation and interview on 2/03/25 at 8:32 a.m. with Resident 305 in Resident 305's room, Resident 305 was observed lying in bed with head elevated, wearing a gown with left amputated (surgically removed) lower limb uncovered, and eating breakfast. Resident 305's catheter bag was observed hanging on the side of Resident 305's bed without a dignity cover. Resident 305 stated he did not know if his urinary bag was covered when he went out of his room. During a review of Resident 305's Admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 2/6/25, the AR indicated Resident 305 was admitted to the facility from the acute care hospital on 10/26/22, with a readmission on 1/28/25. Resident 305's diagnoses consisted of aftercare following surgical amputation (surgical removal of a body part), acquired absence of left leg below the knee, Type 2 Diabetes Mellitus (when the blood sugar levels in the body are too high), atrial fibrillation (an irregular heartbeat), peripheral vascular disease (the reduced circulation of blood to the arms or legs), and neuromuscular dysfunction of the bladder (when a person does not have bladder control because of brain, spinal cord or nerve problem). During a review of Resident 305's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 2/6/25, the MDS section C indicated Resident 305 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive (involving the process of thinking, learning and understanding) understanding on a scale of 1-15) score of 14 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which indicated Resident 305 was cognitively intact. During a concurrent observation and interview on 2/03/25 at 8:51 a.m. with CNA 13 in Resident 305's room, Resident 305's urinary catheter bag was observed without a dignity bag. CNA 13 stated Resident 305 should have had a privacy bag cover over his urinary catheter bag. CNA 13 stated the privacy bag cover was used to protect Resident 305's privacy and dignity. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/06/25 at 10:13 a.m. with LVN 3, LVN 3 stated residents with urinary catheters should have had a dignity covering over their urinary bag. LVN 3 stated the dignity covering was for residents' privacy. During a review of the facility's P&P titled, Dignity - Promoting/Maintaining Dignity, dated 10/2022, the P&P indicated, . staff members involved in providing care or interacting with residents must promote and maintain resident dignity . maintain resident privacy . During a review of the facility's P&P titled, Resident Rights, dated 10/2022, the P&P indicated, . the resident has the right to a dignified existence . the resident has a right to be treated with respect and dignity . 47888

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49949 Based on interview and record review, the facility failed to inform and provide written information on how to formulate an advance directive (a legal document that outlines a person's wishes regarding their medical care in the event they become unable to make decisions for themselves due to illness or injury) for four of 163 residents (Resident 12, Resident 30, Resident 57 and Resident 306) when the facility did not document information on how to obtain an advance directive in residents charts. This failure violated the rights of Resident 12, Resident 30, Resident 57 and Resident 306, which could have potentially prevented these residents' wishes from being followed if they were unable to make decisions. Findings: During an interview on [DATE] at 8:55 a.m. with Resident 30 in Resident 30's room, Resident 30 stated she did not have an advanced directive and the facility did not speak to her about formulating one. During a review of Resident30's Admission Record (AR-a document with personal identifiable and medical information), dated [DATE], the AR indicated, Resident 12 was admitted to the facility on [DATE] with diagnoses which included hypertension (high blood pressure), protein caloric malnutrition (PCM- is the state of inadequate intake of food, depression (a mental health condition characterized by persistent low mood, loss of interest or pleasure in activities, and other symptoms that interfere with daily functioning), constipation, trigeminal neuralgia (a chronic nerve disorder that causes severe, sudden, and excruciating pain in the face), anemia (a condition in which the body does not have enough red blood cells). During a review of Resident 30's Minimum Data Set (MDS-a functional and cognitive abilities assessment) assessment, dated [DATE], the MDS assessment indicated the Brief Interview for Mental Status (BIMS) score was 15 out of 15 (a BIMS score of ,d+[DATE] indicates cognitively intact (having clear thinking, learning, and memory, which allows someone to perform daily tasks.), ,d+[DATE] indicates moderately impaired and ,d+[DATE] indicates severe impairment), which indicated Resident 30 was cognitively intact. During a review of Resident 30's Advanced Directives (AD), dated undated the AD indicated, no advance directives. There was no documented information on how to obtain an advance directive in resident 30's charts. During an interview on [DATE] at 1:01 p.m. with Resident 12, Resident 12 stated she did not have an advance directive and was not aware the facility offered to formulate an advance directive. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a record review of Resident 12 's AR, dated [DATE], the AR indicated, Resident 12 was admitted to the facility on [DATE] with diagnoses which included hypotension (low blood pressure), atrial fibrillation (a common heart rhythm disorder where the upper chambers of the heart beat irregularly and rapidly), schizophrenia (a chronic mental illness characterized by disruptions in thought processes, perceptions, emotions, and social interactions), depression (a common mental health condition characterized by persistent low mood, loss of interest or pleasure in activities, and other symptoms that interfere with daily functioning), and anxiety. During a review of Resident 12's MDS assessment, dated [DATE], the MDS indicated the Brief Interview for Mental Status (BIMS) score was 14 out of 15. During a review of Resident 12's AD, undated, the AD indicated, no advance directives. There was no document information on how to obtain an advance directive in Resident 12's charts. During an interview on [DATE] at 9:50 a.m. with Resident 57 in Resident 57's room, Resident 57 stated he provided a copy of his advance directives to the facility. Resident 57 stated the facility should have a copy in his medical record. During a review of Resident 57 's AR , dated [DATE], the AR indicated, Resident 57 was admitted to the facility on [DATE] with diagnoses which included diabetes mellitus type II (DM- a chronic condition where the body does not use insulin ([a hormone produced by the pancreas that plays a crucial role in regulating blood sugar level] effectively or does not produce enough insulin to regulate blood sugar levels), hypertension (HTN-high blood pressure), anemia (condition in which the body does not have enough red blood cells (RBCs) or hemoglobin (an iron-containing protein found in red blood cells that is responsible for transporting oxygen throughout the body), constipation, spinal stenosis (a condition where the spaces in the spine narrow, putting pressure on the spinal cord and nerve roots) and gastric ulcer (a sore that develops on the lining of the stomach). During a review of Resident 57's MDS assessment, dated [DATE], the MDS assessment indicated the BIMS score was 13 out of 15. During a review of Resident 57's AD, undated, the AD indicated, No advance directives. There was no document in Resident57's medical record and no information regarding an advance directive. During an interview on [DATE] at 10:11 a.m. with License Vocation Nurse (LVN) 3, LVN 3 stated, he did not remember asking residents if they would like assistance with formulation an advance directive. LVN 3 stated an advance directive was a legal documentation that required a paralegal (a legal professional who performs legal tasks under the supervision of a lawyer) and he would have to refer them to the social services director (SSD). LVN 3 stated, an advance directive was important to honor the wishes of the residents. LVN 3 stated, residents without an advance directive would have been considered full code. LVN 3 stated there were no documentation for Resident 12, 30 and 57 about the facility discussing about formulating an advance directive or if it was offered to residents. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 10:19 a.m. with the Social Services Director (SSD), the SSD stated the Admission Coordinators (AC) were responsible to speak to residents or family members about formulating an advance directive. The SSD stated residents without an advance directive were referred to the Ombudsmen (define) to help assist with formulating an advance directive. The SSD stated Residents 12, 30, and 57 were not offered advance directive assistance. The SSD stated there was no documentation on record to state the facility offered to help with obtaining an advance directive. The SSD stated it was important to have an advance directive in case of an emergency, the facility would have to make medical decisions based on the residents wishes. The SSD stated without an advance directive, the resident's wishes would not be honored. The SSD stated, We do not have anything in our documentation to state we offered the resident help to formulate one for the resident. During an interview on [DATE] at 10:32 a.m. with AC 2, AC2 stated she discussed advance directives during admission. AC 2 stated residents and their family member were asked if they had an advance directive. AC 2 stated she never did not document in the resident's chart about the discussion of the advance directives. The AC 2 stated it was important to have an advance directive in case of emergency Residents wishes were honored. During an interview on [DATE] at 6:43 p.m. with the Director of Nursing (DON), the DON stated, the facility should have discussed advance directives with residents and family members during admission. The DON stated the social services department should have helped residents with formulating an advance directive. The DON stated it was important to keep the wishes of the residents. The DON stated residents without an advance directive could have been do not resuscitate (DNR- also known as Do Not Attempt Resuscitation (DNAR), Do Not Attempt Cardiopulmonary Resuscitation (DNACPR), no code and sent to the hospital. The DON stated an advance directive in place ensured residents wishes were followed. During a review of the facility's policy and procedure (P&P) titled, Advance Directives, dated ,d+[DATE], the P&P indicated, The Patient Self-Determine Act of 1990 requires all skilled nursing facilities to inform new residents of their right to establish an advance directive .The facility has the resident or responsible party sign a form that acknowledges they have received this information and whether or not an advance directive already exist or if the resident would like to established one .Not an advance directive .POLST . 48739 During a review of Resident 306's AR, dated [DATE], the AR indicated Resident 306 was admitted to the facility from the acute care hospital on [DATE] with diagnoses of MRSA (Methicillin Resistant Staphylococcus Aureus - a bacteria that does not get better with the type of antibiotics [a medication that inhibits or destroys infections caused by bacteria] that usually cure staph infections), Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), and depression (a mental health disorder characterized by persistently depressed mood or loss of interest in activities). (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 306's MDS, dated [DATE], the MDS section C indicated Resident 306 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of ,d+[DATE]) score of 15 (a score of ,d+[DATE] suggests severe cognitive impairment, ,d+[DATE] suggests moderately impaired, ,d+[DATE] suggests cognitively intact), which indicated Resident 306 was cognitively intact. During a concurrent interview and record review on [DATE] at 2:10 p.m. with AC 2, Resident 306's Electronic Medical Record (EMR), undated was reviewed. AC 2 stated Resident 306 did not have an advanced directive on file. AC 2 stated when residents were admitted , staff asked the resident or called the resident's responsible party (RP) to discuss an advanced directive. AC 2 stated she would verify the resident's information before they were brought to the facility and asked if the resident had an advanced directive. AC 2 stated the SSD would follow up with the resident or RP regarding advanced directives. During an interview on [DATE] at 2:23 p.m. with the Social Service Director Assistant (SSDA), the SSDA stated she was a discharge planner and did not do advanced directives for residents. The SSDA stated the SSD would discuss advanced directives with the residents. During an interview on [DATE] at 2:51 p.m. with the Assistant Director of Nursing (ADON), the ADON stated the admissions nurse, nursing supervisor, and SSD were responsible for residents advance directives. The ADON stated staff tried to prioritize getting the advance directives on admission. The ADON stated if there were any changes in the resident's medical condition, staff needed to respect and honor the wishes of the resident's advance directives. The ADON stated her expectations was all residents should have a discussion on advance directives. During an interview on [DATE] at 3:11 p.m. with the SSD, the SSD stated residents do not get referred to her unless they want an advanced directive. The SSD stated advanced directives for the residents were discussed with the family, nurse or admissions department. The SSD stated there was no documentation by the facility regarding discussion with residents about advanced directives in the computer. The SSD stated if the residents did not have advanced directives, there was no documentation if it was offered or discussed with resident or RP. During a review of the facility's job description document titled, Director, Social Services, dated [DATE], the document indicated, . manages department to assure assessments, discharges and psychological [relating to the mental and emotional state of a person] needs of residents are met . orient resident to long term care environment and facilitate adjust upon placement . organize family groups to promote communication, education between family, resident and facility staff . assist in the education of community regarding aging, rights of residents and facility services . During a review of the facility P&P titled, Resident Rights, dated ,d+[DATE], the P&P indicated, . the facility will inform Resident both orally and in writing . of his or her rights . the right to request, refuse, and/or discontinue treatment . to formulate an advance directive . (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility P&P titled, Promoting the Right of Self-Determination for Healthcare Decisions and Advanced Healthcare Directives, dated Nov/2016, the P&PN indicated . each resident will receive the necessary care and services to attain or maintain the highest practice physical, mental, and psychosocial wellbeing, in accordance with comprehensive assessments and plan of care. Each resident and/or legal healthcare decision maker will be provided a mechanism for reaching decisions concerning preferred intensity of care, including the right to forego or withdraw life sustaining treatment. Residents will be informed upon admission, and periodically, of their rights concerning self-determination of preferred intensity of care and the process for creating and implementing advanced healthcare directives .

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	056207	A. Building B. Wing	02/07/2025

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49949 Based on observation, interview, and record review, the facility failed to maintain a safe, clean, comfortable, and homelike environment for: 1. Two of 156 residents (Resident 34 and Resident 57) when Resident 34 and Resident 57 were cold at night and staff did not ensure the temperature range was between 71-81-degree Fahrenheit (a measurement of temperature on a standard in which 32 is the temperature at which water freezes and 212 that at which it boils) This failure resulted in an uncomfortable homelike environment for Resident 34 and Resident 57, which had the potential risk for causing hypothermia (a medical emergency that occurs when your body loses heat faster than it can produce heat) in an already vulnerable population due to their decreased ability to regulate heat. 2. When Resident 42's wall was observed with one large hole and one small hole with exposed insulation and wiring on the wall behind the bed. This failure had the potential to result in exposure to environmental hazards including the potential for contamination or infiltration by pollutants, affecting the safety and environmental standards required for compliance. 3. Resident 305's television (TV) did not receive clear channels and Resident 305's bed was broken and would not go up or down. These failures resulted in Resident 305 to not have a comfortable homelike environment and put resident 305 at risk of harm from a malfunctioning bed. Findings: 1. During an observation and interview on 2/3/25 at 11:17 a.m. in Resident 34's room, Resident 34 had a sheet and 2 blankets on his bed. Resident 34 stated, The room is cold at night, and we are freezing. Resident 34 stated, I spoke to everyone, it's been ongoing for three months and it's still cold. Resident 34 stated he woke up at night from it being too cold. During a review of Resident 34 's Admission Record (AR-a document with personal identifiable and medical information), dated 2/6/25, the AR indicated, Resident 34 was admitted to the facility on [DATE] with diagnoses which included pneumonia (inflammation (a localized physical condition in which part of the body becomes reddened, swollen, hot, and often painful, especially as a reaction to injury or infection) and fluid in the lungs caused by a bacterial, viral or fungal infection), myasthenia gravis (chronic neuromuscular disease that causes weakness in the voluntary muscles), chronic obstruction pulmonary disease (COPD- group of lung diseases that cause airflow obstruction and breathing problems), pleural effusion (condition where excess fluid accumulates in the pleural space, the area between the lungs and the chest wall), pain. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 34's Minimum Data Set (MDS-a functional and cognitive abilities assessment) assessment, dated 1/6/2 4 indicated the Brief Interview for Mental Status (BIMS) score was 15 out of 15 (a BIMS score of 13-15 indicates cognitively intact (having clear thinking, learning, and memory, which allows someone to perform daily tasks.), 8-12 indicates moderately impaired and 0-7 indicates severe impairment), which indicated Resident 34 was cognitively intact . During a review of Resident 57 's AR , dated 2/6/25, the AR indicated, Resident 57 was admitted to the facility on [DATE] with diagnoses which included diabetes mellitus type II (DM- a chronic condition where the body does not use insulin(s a hormone produced by the pancreas that plays a crucial role in regulating blood sugar level) effectively or does not produce enough insulin to regulate blood sugar levels), hypertension (HTN-high blood pressure), anemia (condition in which the body does not have enough red blood cells (RBCs) or hemoglobin (an iron-containing protein found in red blood cells that is responsible for transporting oxygen throughout the body), constipation, spinal stenosis (a condition where the spaces in the spine narrow, putting pressure on the spinal cord and nerve roots) and gastric ulcer (a sore that develops on the lining of the stomach). During a review of Resident 57's MDS assessment, dated 10/31/24, the MDS assessment indicated the BIMS score was 13 out of 15 . During an observation and interview on 2/3/25 at 11:35 a.m. in Resident 57's room, Resident 57 had 2 blankets on his bed. Resident 57 stated the room was cold at night and needed extra blankets. Resident 57 stated he complained to the staffs about the cold room at night. Resident 57 stated the facility gave extra blankets and he was still cold. During an interview on 2/5/25 at 4:21 p.m. with Certified Nursing Assistant (CNA) 6, CNA 6 stated Resident 57 complained the room was cold one week ago. CNA 6 stated he entered an order into Direct Supply TELS(TELS- a building management platform and service provided by Direct Supply, primarily designed for senior living facilities, that helps manage maintenance tasks, track compliance, optimize equipment performance, and streamline operational efficiency across a building through technology and a network of service providers) and had not heard anything from the maintenance department. CNA 6 stated it was important to ensure the temperature was acceptable for resident comfort. CNA 6 stated he was aware of the Maintenance Supervisor (MS) checked the residents room temperatures during the day. CNA 6 stated he was not sure if nighttime room temperatures were comfortable for residents. CNA 6 stated it was important to maintain comfortable temperature levels for residents to rest. CNA 6 stated, To maintain the resident comfort the room should be a temperature within a certain range, if the room was too cold it can affect the quality of life for residents, and they can get sick. During an interview on 2/5/25 at 4:40 p.m. with the MS, the MS stated he was responsible to check room temperatures. The MS stated he checked room temperatures during the daytime but not at nighttime. The MS stated room temperatures should have been between 71-81-degree Fahrenheit for comfort. The MS stated he did not check room temperatures and could not state room temperatures were within 71-81 degrees Fahrenheit. The MS stated it was important to keep residents comfortable. The MS stated he should have checked room temperatures at night. The MS stated, If my grandmother lived here and she complained I would have checked the temperature to ensure it was comfortable for her. The MS stated room temperatures should have been what residents preferred. The MS stated cold rooms did not provide a homelike environment. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/6/25 at 11:23 a.m. with the Administrator (ADM), the ADM stated the MS should have checked the temperatures of the room each. The ADM stated, there should have been a temperature log every Friday entered TELS. The ADM stated room temperatures should have been between 71-81-degree Fahrenheit. The ADM stated it was important to maintain room temperature between 71-81-degree Fahrenheit for regulation and residents comfort. The ADM stated he was aware Resident 34 and Resident 57 complained about their room being cold at night. The ADM stated, staff should have checked room temperatures at night when residents complained of rooms being cold. The ADM stated room temperatures should have been checked at night to ensure it was within range. The ADM stated staff members did not check room temperatures at night. The ADM stated cold rooms were not considered a comfortable homelike environment. During a review of the facility's policy and procedure (P&P) titled, Safe, Clean, Comfortable, and Homelike Environment, dated 6/2023, the P&P indicated, .7. The facility will strive to maintain comfortable and safe temperature level. a. Facility should strive to keep temperature in common area between 71-81 degrees Fahrenheit . 51134 2. During an observation on 2/3/25 at 8:33 a.m., behind Resident 42's bed observed one large hole in the wall measuring about 12 inches by 8 inches, exposed insulation, two outlets with no cover that were in use with the bed plug connected to one of the outlets and a smaller second hole with exposed wiring. Photo was taken. During an observation on 2/4/25 at 8:52 a.m., one large hole and one small hole in the wall was observed behind Resident 42's bed. The large hole remained open with exposed insulation, two outlets without a cover with the bed plugged into one of the two outlets. Small hole was observed with exposed wiring. During an interview on 2/4/25 at 8:55 a.m. with Certified Nursing Assistant (CNA) 14, CNA 14 stated she has seen the hole in the wall behind Resident 42's bed but unknown when she first saw it. CNA 14 stated she had seen someone working on the wall a couple of weeks ago but not since then. CNA 14 stated if the holes in the wall were not fixed, it could be a hazard. During an observation on 2/4/25 at 10:12 a.m., the larger hole in the wall behind Resident 42's bed was patched up and the smaller hole remained opened with exposed wiring. The large hole containing the two outlets, remained without an outlet cover and bed was plugged into one of the two outlets. Photo was taken. During an interview on 2/4/25 at 10:17 a.m. with the Maintenance Assistant (MA), the MA stated when a maintenance order needed to be placed, staff would place it into online system called TELS. The MA stated there was not physical documentation for maintenance orders to be done, it is all through TELS and the Administrator (ADM) had access. The MA stated a report for the hole in Resident 42's wall was not placed into the system. The MA stated the expectation was for staff to place incidents like a hole in the wall into TELS. The MA stated if the holes were left open and someone touched the outlet, they could be electrocuted. The MA stated the exposed wires were telephone wires and those were capped off. (continued on next page)

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	056207	A. Building B. Wing	02/07/2025

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/7/25 at 4:49 p.m. with the Maintenance Supervisor (MS), the MS stated no order was placed into TELS for the large and small holes in the wall behind Resident 42's bed. The MS stated the expectation was for staff to report any maintenance requests into TELS. The MS stated if no order was placed and the holes were to remain open, this could cause an electrocution (the injury or killing of someone by electric shock). During an interview on 2/7/25 at 5:00 p.m. with the Director of Nursing (DON), the DON stated the expectation was staff should place a maintenance order into TELS and maintenance should be notified. The DON stated if a hole was left in the wall, it could be a hazard, and an accident could occur especially if there was wire in the wall. The DON stated even if the exposed wires were capped, you could not assume it would not cause harm. During a review of the Job Description/ Performance Evaluation - Maintenance Supervisor, undated, the Job Description/ Performance Evaluation - Maintenance Supervisor indicated, .Ensure that all patient and resident rooms are properly maintained (furniture, wall covering, flooring, plumbing, lights, [etcetera]) . During a review of the facility's policy and procedure (P&P) titled, Maintenance Manual Policies and Procedures, dated 8/14, the P&P indicated, .1. The Maintenance Department will maintain the facility's physical plant in accordance with the TELS schedule that will serve to provide a safe, functional and aesthetically (in a way that gives pleasure through beauty) pleasing environment .4. The facility staff shall prepare and submit a Maintenance Work Order Form for any corrective maintenance repair work identified or required . 48739 3. During a concurrent observation and interview on 2/03/25 at 8:32 a.m. with Resident 305, in Resident 305's room, Resident 305 was observed wearing a gown, in bed with head of bed elevated, eating breakfast. Resident 305 stated he had been at the facility for four days for a left below the knee amputation (BKA - surgical removal of the leg below the knee). Resident 305 stated he was not happy with his room. Resident 305 stated the white board in his room was blank, missing the date, nurse's name and nursing assistant's name. Resident 305 stated he did not know what day it was. Resident 305 stated his TV did not work due to bad reception. Observed Resident 305 changing channels with no pictures coming through the TV. Resident 305 stated his bed was broken, and the bed would not move when he pressed his buttons. Resident 305 stated this was not his first time at the facility and things were always broken. During a review of Resident 305's Admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 2/6/25, the AR indicated Resident 305 was admitted to the facility from the acute care hospital on 10/26/22, with a readmission on 1/28/25. Resident 305's diagnoses consisted of aftercare following surgical amputation, acquired absence of left leg below the knee, Type 2 Diabetes Mellitus (when the blood sugar levels in the body are too high), atrial fibrillation (an irregular heartbeat), peripheral vascular disease (the reduced circulation of blood to the arms or legs), and neuromuscular dysfunction of the bladder (when a person does not have bladder control because of brain, spinal cord or nerve problem). (continued on next page)

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	056207	A. Building B. Wing	02/07/2025

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 305's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 2/6/25, the MDS section C indicated Resident 305 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15) score of 14 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which indicated Resident 305 was cognitively intact. During an interview on 2/03/25 at 8:51 a.m. with Certified Nursing Assistant (CNA) 13, CNA 13 stated Resident 305 had a broken bed. CNA 13 stated Resident 305's bed did not go up or down or lift the head or legs. CNA 13 stated Resident 305's bed was working two days ago when he took care of Resident 305. CNA 13 stated Resident 305's TV channels were also not working. CNA 13 stated maintenance needed to move the antenna into the correct position. CNA 13 stated maintenance was aware of Resident 305's broken bed and the TV not showing clear channels. During an interview on 2/05/25 at 10:34 a.m. with the Maintenance Supervisor (MS), the MS stated the facility used the TELS System to notify his department of any issues that needed repair. The MS stated any staff could access the system for repairs. The MS stated the resident's TVs have been working on and off. The MS stated the TVs used an antenna and the facility was looking into getting the antennas replaced with wiring for cable. The MS stated residents had bed control issues when the wired plugs were caught and pulled off when the bed side table was moved. The MS reviewed the maintenance log on his phone through the TELS system and stated 1/22/25 was the most recent repair logged in for Resident 305. The MS stated Resident 305's bed was stuck in the seated position. The MS stated he was notified on 1/23/25 of the incident but had no other requests for repairs for Resident 305's bed. The MS stated residents who are bed bound with broken beds were at risk of injury. The MS stated residents should have properly working beds and TVs. During a review of the facility's job description document titled, Supervisor, Maintenance, undated, the document indicated, . ensure timely and effective repairs to all systems, and equipment as required . ensure that all patient and resident rooms are properly maintained (furniture, wall covering, flooring, plumbing, lights, etc.) . During a review of the facility's policy and procedure (P&P) titled, Safe, Clean, Comfortable, and Homelike Environment, dated 6/2023, the P&P indicated, . in accordance with residents' rights, the facility will strive to provide a safe, clean, comfortable and homelike environment . that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk . refers to any environment in the facility that is frequented by residents, including (but not limited to) the residents' rooms . a determination of homelike should include the resident's opinion of the living environment . housekeeping and maintenance services will be provided as necessary . promptly reporting issues to maintenance department, such as . furniture or other bedside equipment in disrepair . broken or malfunctioning electrical equipment broken or unsafe facility equipment . ED, DON, and/or Maintenance/Housekeeping Supervisor should conduct regular facility rounds and provide general monitoring/oversight of efforts to maintain a safe, clean, comfortable environment . (continued on next page)

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	056207	A. Building B. Wing	02/07/2025

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's Maintenance Manual P&P titled, Scope of Services, dated 8/2014, the P&P indicated, . the Maintenance Department is responsible for the condition and function of the facility's physical plant, including all utilities, grounds, and equipment . all areas of the facility and equipment therein, are inspected and maintained in accordance with the TELS Preventive Maintenance Program .

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 48424 Based on interview and record review the facility failed to provide residents and residents' responsible party (RP- a person designated to make decisions for a resident) written information regarding the bed hold policy for two of six sampled (Resident 3 and Resident 455) when: 1. No written notices about the facility's bed hold policy was provided to Resident 3 or their RP when he was transferred to the hospital on 2/2/25. This failure violated Resident 3 and his RP's right to be notified in writing of the facility's bed hold policy. 2. Resident 455 was not provided a bed hold policy prior to being transferred out of the facility due to being a non-Medi-Cal member. This failure had the potential to result in loss of bed availability, confusion, disputes, and quality of care concerns for Resident 455. Findings: 1. During a concurrent interview and record review on 2/6/25 at 10:53a.m. with Licensed Vocational Nurse (LVN) 3, Resident 3's Notice of Transfer (NT),dated 2/6/25 was reviewed. The NT indicated Resident 3 was transferred to the hospital on 2/2/25. LVN 3 stated nursing staff called Resident 3's RP to notify them of the bed hold information and gave Resident 3 the NT form but not the bed hold policy. LVN 3 stated he was not aware residents, or their representatives needed to be provided with the bed hold policy upon transfer to the hospital. During an interview on 2/7/25 at 2:28 p.m. with LVN 6, LVN 6 stated nurses called Resident 3's RP about information regarding the bed hold, but did not give the resident or their RP the facility's bed hold policy. LVN 6 stated giving Resident 3's RP the bed hold policy would allow them to better understand the policy and read it on their own time. During an interview on 2/7/25 at 3:01 p.m. with Admissions Coordinator (AC) 1, AC1 stated Resident 3 was notified of the facility's bed hold policy upon admission and when he was sent out to the hospital his nurse called his RP to let them know of the bed hold policy as well. AC 1 stated the admissions office called the resident or their RP in the hospital to remind them of the bed hold policy, but the phone call was not documented anywhere. The admissions office staff or nursing staff did not give Resident 3 notice of the bed hold policy prior to his transfer to the hospital. During an interview on 2/7/25 at 3:43 a.m. with the Director of Nursing (DON), the DON stated, Resident 3 was not notified of the facility's bed hold policy upon his transfer to the hospital. The DON stated it was important to provide residents the bed hold policy during transfers to the hospital because it helped ensure residents or their RPs could understand the bed hold policy and were able to ask questions if needed. (continued on next page)

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	056207	A. Building B. Wing	02/07/2025

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's Policy and Procedure (P&P) titled, Admission, Transfer, Discharge, and Bed Holds, dated 12/16, the P&P indicated, . The facility will notify the resident or resident representative at the time admission and again prior to hospital transfer or therapeutic leave, of bed hold and readmission policies . 51134 2. During an observation and interview on 2/4/25 at 4:00 p.m. with Resident 455, Resident 455 stated when he was transferred out of the facility to the hospital, he was never provided with a bed hold policy. Resident 455 was observed looking through documents provided to him by the facility and only had documents regarding Medicare coverage. Resident 455 was unable to locate documents for a bed hold policy. During a review of Resident 455's Minimum Data Set (MDS - a resident assessment tool), dated 1/25/25, the MDS indicated in Section C, Cognitive (thinking, reasoning or remembering) Patterns, 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 was a 15 out of 15 (0-7 indicated severe cognitive impairment [memory loss, poor decision making skills], 8-12 moderate cognitive impairment, 13-15 cognitively intact) indicating Resident 455 was cognitively intact. During a review of the facility'sNT, dated 1/18/25, the NT indicated the responsible party was himself, and Resident 455 was notified of the transfer to the hospital and was aware of the clinical situation. The NT indicated Resident 455 was, .alert, oriented and follows instructions . The Form indicated a bed hold policy was not given to Resident 455 prior to hospital transfer. During an interview on 2/4/25 at 4:25 p.m. with the Social Services Director (SSD), the SSD stated Resident 455's health insurance would not pay for the resident's bed hold and only Medi-Cal residents would have a bed hold because it was paid for. The SSD was unable to locate documentation to confirm if the bed hold policy was given to Resident 455 prior to being sent to the hospital. During an interview on 2/5/25 at 2:57 p.m. with LVN 3, LVN 3 stated residents were not provided with a bed hold policy when they were transferred out of the facility. LVN 3 stated residents were provided with the transfer form that was filled out with the resident's information. LVN 3 stated, haven't heard of giving a resident a bed hold policy. During an interview on 2/7/25 at 3:00 p.m. with AC 1, AC 1 stated residents would be given a bed hold policy upon admission into the facility in the admission packet. AC 1 stated a resident would not receive another bed hold policy when they were transferred out from the facility by the admission office. AC 1 stated residents with Resident 455's health insurance were not offered a bed hold upon transfer. AC 1 stated many residents do not know how the bed hold process works, and it would make sense to provide them with an additional bed hold policy upon transfer out of the facility to inform the resident of what that meant. During an interview on 2/7/25 at 5:00 p.m. with the DON, the DON stated Resident 455's health insurance would not pay for a bed hold but residents with Resident 455's health insurance would be asked if they would like to pay out of pocket for a bed hold. The DON stated that a bed hold policy was not given to a resident prior to being transferred out of the facility. (continued on next page)

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	056207	A. Building B. Wing	02/07/2025

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, Discharge/Transfer of the Resident, dated 2006, the P&P indicated, .Complete Bed hold notification form per facility procedure . The P&P did not indicate a physical copy of the bed hold policy should be provided to a resident prior to being transferred out of the facility. During a review of the facility's P&P titled Admission, Transfer, Discharge and Bed-Holds, dated 2016, the P&P indicated, .Upon transfer or discharge, a notice of transfer and discharge, as well as the bed hold notification will be completed and given to the resident at the time of the transfer or discharge or as soon as practicable .The facility will notify the resident or resident representative at the time [of] admission and again prior to hospital transfer or therapeutic leave, of bed hold and readmission policies. The notification will include the duration of the state bed hold allowance in which the resident is permitted to return and resume residence within the facility and the reserve bed-payment requirements of the State plan . The P&P did not indicate a physical copy of the bed hold policy should be provided to a resident prior to being transferred out of the facility.

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	056207	A. Building B. Wing	02/07/2025

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F 0656 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47888 Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan (CP - a detailed approach to care customized to an individual resident's needs) for 7 of 36 sampled residents (Residents 20, 26, 34, 37, 54, 86, and 409) when: 1. Resident 37 did not have a CP developed for an indwelling foley catheter (a thin, flexible tube that is inserted into your bladder to drain urine). This failure of developing a CP for Resident 37's foley catheter had the potential to place Resident 37's safety at risk and her specific needs not being met. 2. Resident 26's CP interventions were not implemented to meet his visual needs. This failure resulted in Resident 26 not wearing his glasses for five days which had the potential to lead to injury or decreased participation in activities of daily living (ADLs). 3. Resident 409's CP was not developed to address the use of an anticoagulant (blood thinner). This failure had the potential for Resident 409 to experience severe bruising and bleeding which could lead to serious medical condition and hospitalization . 4. Resident 86 did not have a CP for anticoagulation (a medication that prevents blood from clotting) medication monitoring. This failure placed Resident 86 at risk for increased bleeding and bruising. 5. Resident 34 did not have a CP for his oxygen and albuterol sulfate (medication used to treat breathing problems caused shortness of breath) nebulizer (a small machine that turns liquid medicine into a mist that can be easily inhaled) treatment. This failure did not allow the team to collaborate and communicate Resident 34's respiratory needs and had the potential for needs to go unmet. 6. Resident 20's CP was not accurate when Resident 20 had a diagnosis of right sided weakness but the CP indicated Resident 20 had left sided weakness. This failure resulted in Resident 20's physical needs not being met for performing range of motion (ROM-the extent or degree of movement that a joint or series of joints can achieve in a specific direction) for the right upper extremity that led to the development of a contracture (a stiffening/shortening at any joint, that reduces the joint's range of motion). (continued on next page)

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	056207	A. Building B. Wing	02/07/2025

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7. Resident 54 with known decline in functional status (loss of ability to perform daily activities independently), impaired safety awareness (reduced ability to recognize and respond to dangers) and the need to be supervised and assisted while transferring and ambulating (walking) was not adequately supervised when Resident 54 was in her room. This failure resulted in Resident 54 experiencing multiple unwitnessed falls due to a lack of supervision on the following dates 01/17/25, 01/06/25, 12/23/24, 11/22/24, 09/01/24, 07/22/24, and 03/19/24. Findings: 1. During a review of Resident 37's Face Sheet (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 2/5/25, the Face Sheet indicated, Resident 37 was admitted to the facility on [DATE] with a diagnosis of cellulitis (a serious deep infection of the skin caused by bacteria) of the left lower limb, muscle weakness (loss of muscle strength), mild dementia (a brain condition that causes memory loss, thinking problems, and behavioral changes), neuromuscular dysfunction of the bladder (occurs when the nerves that control the bladder don't work properly) and peripheral vascular disease (a condition that occurs when blood vessels narrow or block, reducing blood flow to the arms and legs). During a review of Resident 37's Minimum Data Set (MDS - a resident assessment tool used to identify resident cognitive and physical function) assessment, dated 1/16/25, the MDS assessment indicated Resident 37's Brief Interview for Mental Status (BIMS -assessment of cognitive(define) status for memory and judgment) assessment score was 15 out of 15 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07 indicates severe impairment). The BIMS assessment indicated Resident 37 was cognitively intact. During a review of Resident 37's Physician Order (PO), dated 1/31/25, the PO indicated, . Order date: 1/31/25 . Communication Method: Phone . Order Summary: Foley Catheter . Confirmed by: RN . During a concurrent observation and interview on 2/4/25 at 9:05 a.m. with Resident 37, in Resident 37's room, Resident 37 was observed to have an indwelling foley catheter, Resident 37 stated she had the catheter for a few weeks. During a review of Resident 37's Electronic Medical Record (EMR), on 2/4/25, the EMR indicated no CP was developed for Resident 37's foley catheter. During an interview on 2/6/25 at 10:27 a.m. with Registered Nurse (RN) 3, RN 3 stated Resident 37 did not have a CP in place at the time of record review RN 3 stated Resident 37 should have had a CP put in place on 1/31/25 when the foley catheter order was placed and it was not. RN 3 stated CP's were important to protect Resident 37 from further complications and they direct the care for the resident on a daily basis. RN 3 stated CP's tell all staff members what they should be monitoring for the foley catheter and all staff have to follow them. (continued on next page)

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	056207	A. Building B. Wing	02/07/2025

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/6/25 at 11:07 a.m. with the Director of Staff Development (DSD), the DSD stated the reason for Resident 37 not having a CP was a break down in communication between staff. The DSD stated staff would not know the approach on what to do for the residents catheter with no CP in place. During an interview on 2/7/25 at 2:15 p.m. with the Infection Preventionist (IP), the IP stated Resident 37 had a change of condition and needed a foley catheter placed for a neurogenic bladder (occurs when the nerves that control the bladder do not work properly). The IP stated when a change of condition occurred, a CP should have been created and it was not. The IP stated he created a CP for Resident 37's foley catheter on 2/5/25, but Resident 37 did not have one in the EMR prior. The IP stated CP's were important for staff communication and helped notify them on how to care for the foley catheter. The IP stated due to the CP not being in the EMR, staff could have improperly handled the catheter and this could have increased the Resident 37's risk for infection and ultimately their safety. The IP stated staff did not follow the facility's policy and procedure (P&P) Care Plan, Comprehensive. During an interview on 2/7/25 at 4:35 p.m. with the DON, the DON stated the foley catheter was placed at an outside Urology appointment in January 2025. The DON stated the foley catheter CP should have been created when Resident 37's change of condition occurred and it did not. The DON stated CP's are vital so staff knew the plan of care for the resident. The DON stated the facility did not follow the P&P, Care Plans, Comprehensive. During a review of Resident 37's Urology Office Visit (UOV), dated 1/15/25, the UOV indicated, .Assessment: Feeling of incomplete bladder emptying . neuromuscular dysfunction of bladder . retention of urine . Plan: . catheter placed . During a review of the facility's P&P titled, CPs, Comprehensive, dated 12/2017, the P&P indicated, .It is the policy of this facility to develop . the comprehensive resident CP. The CP is directed toward achieving and maintaining optimal status of health, functional ability and quality of life . plans are reviewed and revised by the Interdisciplinary Team . following an assessment for a significant change of condition . 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)

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	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 of such assist in ensuring a positive outcome. Nursing CPs are essential in this phase of goal setting. CPs 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 CP. CPs 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 . 2. During a review of Resident 26's Admission Record (AR- document containing resident personal information), dated 2/4/25, the AR indicated, Resident 26 was admitted to the facility on [DATE], with diagnoses which included peripheral vascular disease, unspecified (reduced circulation of blood to a body part, other than the brain or heart, due to a narrowed or blocked blood vessel) muscle weakness generalized, other reduced mobility, unspecified dementia, severe (an advanced stage of cognitive decline where significant impairment in memory, thinking, reasoning, and daily functioning occurs), with psychotic disturbance (a mental illness that causes a loss of contact with reality), and primary open-angle glaucoma, bilateral, stage unspecified (a progressive condition that can cause permanent vision loss, and even blindness). During a review of Resident 26's MDS, dated [DATE], the MDS assessment indicated Resident 26's BIMS assessment score was 12 out of 15 which indicated Resident 26 had moderate cognitive deficit (a decline in thinking abilities, like memory, reasoning, and problem-solving, where someone struggles with complex tasks and may need assistance with daily activities, but can still perform basic self-care and understands most situations). The MDS assessment indicated Resident 26's Hearing, Speech, and Vision was moderately impaired (limited vision; not able to see newspaper headlines but can identify objects). The MDS assessment indicated Resident 26 had corrective lenses. During a review of Resident 26's Reconciliation Records Patient's Clothes and Possessions, dated 12/12/24, the Reconciliation Records Patient's Clothes and Possessions indicated Resident 26 was admitted with glasses. During a review of Resident 26's CP, dated 12/13/24, the CP indicated, .The resident has impaired visual function [related to] Primary open angle glaucoma bilateral stage unspecified .Remind resident to wear glasses when up. Ensure resident is wearing glasses which are clean free from scratches and in good repair. Report any damage to nurse/family .Tell the resident where you are placing their items . During a concurrent observation and interview on 2/3/25 at 10:40 a.m. with Resident 26 in Resident 26's room, Resident 26 was observed sitting in his wheelchair, between his bed and the wall, with no glasses on. Resident 26 stated, I do not see well. Resident 26 stated he had glaucoma in both eyes, and it was difficult to see the clock on the wall, read newspapers, or dial numbers on his phone. Resident 26 stated he relied on staff to set things up in front of him to perform tasks. Resident 26 stated all of his personal belongings were kept in the top drawer of his nightstand. Resident 26 stated he had not worn or seen his glasses for several days. Resident 26 stated his glasses helped him see better. (continued on next page)

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	02/07/2025

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 2/3/25 at 12:17 p.m. with Resident 26 in Resident 26's room, Resident 26 was observed sitting in his wheelchair, between his bed and the wall, with no glasses on. Resident 26 stated the clock on the wall to his right was difficult to read even though it was close. Resident 26 stated he called his daughter most days at 9:00 a.m. but it had gotten harder to see the phone pad numbers. Resident 26 stated he needed assistance from staff to make calls to his daughter. Resident 26 stated when staff were busy, he had to wait for staff to be available to assist him with calling his daughter or to ask for the time. During an interview on 2/4/25 at 4:09 p.m. with RN 2, RN 2 stated Certified Nursing Assistants (CNA), Licensed Vocational Nurses (LVN), and RN's were responsible to review and follow CPs for each resident. RN 2 stated CPs notified staff of each resident's needs and how to provide individualized care. RN 2 stated Resident 26 was admitted to the facility in December and never saw him wearing glasses. RN 2 stated Resident 26's CP should have been followed to ensure Resident 26 was wearing his glasses when up. RN 2 stated glasses helped improve vision. RN 2 stated Resident 26 was at risk for injury without his glasses. RN 2 stated Resident 26 was at risk for not participating in activities if he could not see. During a concurrent observation and interview on 2/4/25 at 4:16 p.m. with CNA 3 in Resident 26's room, CNA 3 stated she could not locate Resident 26's glasses in his nightstand, bedside table, closet or bed. CNA 3 stated she had never seen Resident 26 with glasses on. CNA 3 stated Resident 26 was at risk for injury if he could not see an obstacle near him. CNA 3 stated Resident 26 was at risk for decreased participation in activities and eating if he could not see items in front of him. CNA 3 stated missing glasses were reported to the Social Services Director (SSD). During an interview on 2/4/25 at 4:19 p.m. with the SSD, the SSD stated she expected staff to assist residents with their vision needs and follow care planned interventions. The SSD stated Resident 26 was admitted to the facility with glasses and no reports had been made for his missing glasses. The SSD stated she expected staff to follow assessments and interventions to assist each resident to see. The SSD stated she expected staff to notify her when Resident 26's glasses could not be located. During an interview on 2/5/25 at 10:16 a.m. with the Customer Services/Social Services (SS), the SS stated she spoke to Resident 26's Responsible Party (RP) on 2/4/25 and the RP stated she had taken the glasses home on 1/30/25. The SS stated Resident 26 went 5 days without his glasses. The SS stated CNAs, LVNs and RNs had not implemented Resident 26's careplanned vision interventions. The SS stated if Resident 26's vision care planned interventions were implemented, it would have identified his glasses were missing 5 days ago. The SS stated Resident 26 was at risk for injury without his glasses. During an interview on 2/6/25 at 5:02 p.m. with the DON, the DON stated she expected all staff to implement care planned interventions. The DON stated staff had not implemented Resident 26's vision care planned interventions to remind and ensure him to wear his glasses when up. The DON stated staff should have identified and reported Resident 26 did not have his glasses on 1/30/25 to the SSD. The DON stated the CP should have been updated to reflect Resident 26 no longer had glasses. The DON stated it was important each resident had a personalized and individualized CP. (continued on next page)

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	056207	A. Building B. Wing	02/07/2025

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 2/7/25 at 10:12 a.m. with LVN 3, Resident 26's CP, dated 12/13/25 was reviewed. The CP indicated Resident 26 required assistance and reminders to wear his glasses when up. LVN 3 stated Resident 26 should have been wearing his glasses every day when awake. LVN 3 stated all staff providing care to Resident 26 should have reviewed his CP and ensured he had his glasses on when up. LVN 3 stated staff were not implementing Resident 26's vision care planned interventions or it would have been identified he no longer had his glasses on 1/30/25. During a review of the facility's policy and procedure (P&P) titled, Vision Services, dated 11/2017, the P&P indicated, .If residents use adaptive device, these items will be included in the resident's plan of care . During a review of the facility's training lesson titled, ADL Care and Call Lights, undated, the ADL Care and Call Lights training lesson indicated the program was attended by all-staff. The training lesson indicated, . identify ADL needs for all residents .eyeglasses .eyewear should be clean and placed on residents daily, removing when in bed/shower and storing in proper containers . 3.During a review of Resident 409's AR, dated 2/4/25, the AR indicated, Resident 409 was admitted to the facility on [DATE], with diagnoses which included other sequelae of cerebral infarction (a medical condition where blood flow to the brain is interrupted, leading to the death of brain cells.), type 2 diabetes mellitus (a medical condition in which the sugar level is high in the blood stream), chronic kidney disease stage 3 (a moderate level of kidney damage that reduces the kidneys' ability to filter waste from the blood), intracardiac thrombosis (a condition where a blood clot forms within the chambers of the heart), personal history of transient ischemic attack (TIA-a temporary interruption of blood flow to the brain, causing stroke-like symptoms (symptoms that mimic a stroke, but are caused by another condition. Symptoms of stroke-like conditions include sudden weakness, numbness, difficulty speaking, vision changes, or loss of balance) and cerebral infarction (a stroke that occurs when blood flow to the brain is blocked) without residual deficits (a loss of function that can occur after an injury to the brain). During a review of Resident 409's MDS assessment, dated 2/3/25, the MDS assessment indicated Resident 409's BIMS assessment score was 15 out of 15 which indicated Resident 409 had no cognitive deficit. During a review of Resident 409's Medication Administration Record (MAR- a standardized record that organizes essential information about a patient and their prescribed medications), dated 1/25/25, the MAR indicated, .Apixaban Oral Tablet 5 [milligrams- a unit of measurement used to measure the dosage of medication] (Apixaban [a type of medicine known as an anticoagulant. It decreases the clotting ability of the blood and helps prevent harmful blood clots from forming]) give 1 tablet by mouth two times a day . order date 1/25/25 .[discontinued] date 2/1/25 . The MAR indicated, .Apixaban Oral Tablet 5 MG (Apixaban) Give 1 tablet by mouth two times a day .order date 2/1/25 . During a review of Resident 409's Order Review Report, dated 2/5/25, the Order Review Report indicated, Apixaban Oral Tablet 5 MG give 1 tablet by mouth two times a day for [left ventricular- the lower left chamber of the heart] mural thrombus [a blood clot that sticks to the wall of a blood vessel or heart chamber] The Order Review Report indicated, .order status .active . (continued on next page)

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	02/07/2025

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 2/4/25 at 12:21 p.m. with Resident 409 in Resident 409's room, Resident 409 was observed sitting in her wheelchair eating lunch. Resident 409 stated she was admitted to the facility following a prolonged hospitalization for a TIA. Resident 409 stated she started the anticoagulant at the hospital and had taken the anticoagulants for .at least a month . Resident 409 stated she had not received any education since admission to the facility on anticoagulant side effects or potential complications. Resident 409 stated she was not aware of any side effects or complications to monitor for. During a concurrent interview and record review on 2/4/25 at 12:25 p.m. with RN 2, Resident 409's MAR and CP, dated 1/25/25 were reviewed. RN 2 stated Resident 409 had received Apixaban since admission. RN 2 stated Apixaban was an anticoagulant. RN 2 stated anticoagulants were a blood thinner, and Resident 409 could bruise easily and have uncontrolled bleeding if injured. RN 2 could not locate an anticoagulant CP for Resident 409. RN 2 stated Resident 409 did not have a CP to address the use of an anticoagulant and one would be created immediately for her safety. RN 2 stated a CP must be in place for all residents to address the use of an anticoagulant. RN 2 stated it was important the CP reflected the use of an anticoagulant to ensure education and monitoring were in place. RN 2 stated the purpose of the CP was to reflect each residents current conditions and alert all staff to individualized treatment, side effects, and monitoring precautions. During an interview on 2/5/25 at 10:53 a.m. with LVN 1, LVN 1 stated all CPs were expected to be personalized and reflect Residents current conditions. LVN 1 stated all residents on anticoagulant therapy must have a CP in place. LVN 1 stated the anticoagulant CP ensured all members of the healthcare team were aware, took precaution to prevent injury, and monitored for anticoagulant side effects. LVN 1 stated common side effects were bruises, tarry stools, and uncontrolled bleeding. LVN 1 stated the CP ensured ongoing education was provided to Resident 409 to report any injuries, avoid sharp objects such as razors and any bleeding. LVN 1 stated Resident 409 was at risk for uncontrolled bleeding if side effects were not identified from the CP. During an interview on 2/6/25 at 5:02 p.m. with the DON, the DON stated all members of the interdisciplinary team (IDT), including the resident, were responsible to participate in developing the CP. The DON stated all CPs were expected to reflect the residents needs and active orders to ensure appropriate monitoring precautions and goals were in place. The DON stated Apixaban was an anticoagulant and all anticoagulants were expected to be care planned. The DON stated it was expected Resident 409 had an anticoagulant CP to ensure she was being monitored by all members of the healthcare team. The DON stated the CP ensured continuing education was provided to the resident regarding anticoagulation therapy. The DON stated without an anticoagulant CP Resident 409 was not being monitored and was at risk for bruising and uncontrolled internal bleeding. The DON stated it was important all members of the IDT were aware Resident 409 was on an anticoagulant to accurately reflect her needs, goals, and interventions. The DON stated it was important each resident had a personalized and individualized CP. The DON stated she expected all staff to follow care planned interventions. (continued on next page)

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	02/07/2025

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, Care Plan, Comprehensive, dated 12/2017, the P&P indicated, . the CP is directed toward achieving and maintaining optimal status of health, functional ability, and quality of life . CPs should be developed by the interdisciplinary team (IDT), which includes .nursing management . Licensed Nurses and Nursing Assistants .CPs are individualized through the identification of resident concerns, unique characteristics, strengths and individual needs .CPs become a comprehensive tool for the IDT to utilize as a reference for identified concerns and approaches to establish guidance for meeting resident individual needs .Individualized CPs should be accessible to all caregivers .Problem resolution and changes in goals and approaches may be identified and initiated by any IDT member . During a review of the facility's P&P titled, Resident Rights, dated 10/2022, the P&P indicated, .the resident has .the right to participate in the development and implementation of his or her person-centered plan of care .the right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care .the right to be informed .of the risks and benefits of proposed care .and treatment . During a review of the facility's job description document titled, Certified Nursing Assistant, dated 11/13/17, the document indicated, .The primary purpose of this position is to provide each of your assigned residents with routine daily nursing care and services in accordance with the residents assessment and CP, assuring resident safety .Provide Restorative assistance and support to maintain residents ADL function as per the plan of care .Provide the clinical and support services needed to meet all physical and psycho-social needs of the residents and patients . During a review of the facility's job description document titled, LVN/LPN, dated 11/13/17, the document indicated, .Develops, implements, evaluates, and updates plans of care accordingly .Encourages Patients to participate in prescribed therapies .Reports, documents, and CPs non-compliance .participates in IDT .and reviews plan of care for assigned Patients .Identifies Patient risk(s) areas and appropriately implements preventative measures as needed .facilitates compliance with individualized CPs .Collaborates/Educates Patients .to achieve highest level of wellness in accordance with plans of care .Develops, reviews, and amends CPs accordingly . During a review of the facility's job description document titled, Registered Nurse, dated 11/13/17, the document indicated, .Develops, implements, evaluates, and updates plans of care accordingly .Encourages Patients to participate in prescribed therapies .Reports, documents, and CPs non-compliance . participates in IDT .and reviews plan of care for assigned Patients . Identifies Patient risk(s) areas and appropriately implements preventative measures as needed . Collaborates/Educates Patients .to achieve highest level of wellness in accordance with plans of care . Develops, reviews, and amends CPs accordingly . 4. During a concurrent observation and interview on 2/03/25 at 9:51 a.m. with Resident 86 in Resident 86's room, Resident 86 was observed dressed, lying in bed, wearing a neck collar (an instrument used to support the neck and spine and limit head movement). Resident 86 stated she was admitted to the facility on [DATE], after having neck surgery. Resident 86 stated she was taking a pain medication for her neck pain and headaches. Resident denied bleeding, and no bruising was observed. (continued on next page)

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	056207	A. Building B. Wing	02/07/2025

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 86's AR dated 2/6/25, the AR indicated Resident 86 was admitted to the facility from the acute care hospital on 1/10/25 with diagnoses of chronic obstructive pyelonephritis (scarring of the kidney due to recurrent urinary infections [a condition in which bacteria invade and grow in the urinary tract]), acute embolism and thrombosis (obstruction of an artery by a clot of blood) of the deep vein of the left lower extremity (lower leg), type 2 diabetes (when the blood sugar levels in the body are too high), fusion of the spine (a surgical procedure used to correct problems with the small bones in the spine), cervical region (neck area of the spine), atrial fibrillation (an irregular heartbeat), and anxiety disorder (a mental health disorder characterized by feelings of worry or fear that are strong enough to interfere with one's daily activities). During a review of Resident 86's MDS, dated [DATE], the MDS section C indicated Resident 86 had a BIMS score of 14 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which indicated Resident 86 was cognitively intact. During a review of Resident 86's Clinical Physician Orders, dated 2/6/25, the Clinical Physician Orders indicated, . Apixaban [a prescription anticoagulant medication that helps prevent and treat blood clots)] Oral Tablet 5 [milligrams (MG) - a unit of measurement] . Anticoagulant [medication used to stop the blood from clotting too easily] Side Effect Monitoring [every] shift: Monitor for excessive signs/symptoms of bleeding and/or bruising . Directions . every shift . Start Date . 1/11/2025 07:00 . During a concurrent interview and record review on 2/06/25 at 9:54 a.m. with LVN 3 Resident 86's CP (CP), undated was reviewed. The CP indicated, . the resident is on anticoagulant therapy . [related to] atrial fibrillation [an irregular heartbeat] . Date Initiated: 01/11/2025 . Goal . the resident will be free from discomfort or adverse reactions related to anticoagulant use . LVN 3 stated there were no monitoring interventions for bleeding or bruising. LVN 3 stated there should have been interventions to monitor for bleeding or bruising for Resident 86's anticoagulation medication. LVN 3 stated monitoring was important due to the risk of increased bleeding for Resident 86. LVN 3 stated Resident 86 should have had an anti-coagulant CP with monitoring for bleeding and bruising. During an interview on 2/06/25 at 2:51 p.m. with the Assistant Director of Nursing (ADON), the ADON stated the medication CP was completed by the admitting supervisor on the resident's admission to the facility. The ADON stated residents ordered anticoagulant medications should have had a CP completed by the admitting supervisor. The ADON stated her expectation was for residents on anti-coagulation medication to have a CP to monitor for bleeding and bruising. During a review of the facility's policy and procedure (P&P) titled, Care Plan, Comprehensive, dated 12/2017, the P&P indicated, . the CP is directed toward achieving and maintaining optimal status of health . CPs are individualized . baseline CPs are initiated within 48-hours of admission and completed no later than seven (7) days after the completion of the RAI .individualized CPs should be accessible to all caregivers . CPs should be reviewed within 21 days after admission . (continued on next page)

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	02/07/2025

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Pacific Gardens Nursing and Rehabilitation Center	577 S. Peach Ave. Fresno, CA 93727

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. During a review of Resident 34 's AR dated 2/6/25, the AR indicated, Resident 34 was admitted to the facility on [DATE] with diagnoses which included pneumonia (inflammation (a protective response of the body to harmful stimuli, such as infections, injuries, or toxins) and fluid in your lungs caused by a bacterial, viral or fungal infection), myasthenia gravis (chronic neuromuscular disease that causes weakness in the voluntary muscles), chronic obstruction pulmonary disease (COPD- group of lung diseases that cause airflow obstruction and breathing problems), pleural effusion (condition where excess fluid accumulates in the area between the lungs and the chest wall), and pain. During a review of Resident 34's MDS, dated [DATE], the MDS indicated the BIMS score was 15 out of 15 (a BIMS score of 13-15 indicates cognitively intact (having the ability to think, learn, and remember clearly)8-12 indicates moderately impaired and 0-7 indicates severe impairment), which indicated Resident 34 was cognitively intact. During an interview on 2/3/25 at 11:17 a.m. in Resident 34's room, Resident 34 stated he used oxygen (supplemental oxygen can help with shortness of breath caused by lung disease) and nebulizer (nebulizer is a medical device that turns liquid medications into a fine mist that can be inhaled through a mouthpiece or mask) treatment for his shortness of breath. Resident 34 stated he has used oxygen and nebulizer treatment for more than one year. Dur [TRUNCATED]

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	056207	A. Building B. Wing	02/07/2025

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51271 Based on observation, interview, and record review, the facility failed to revise a comprehensive person-centered care plan for one of three sampled residents (Resident 120), when Resident 120's care plan had active treatment interventions (actions to address resident identified needs) for a stage two pressure ulcer (partial-thickness loss of skin, presenting as a shallow open sore or wound) that had already healed. This failure had the potential for Resident 120's care to not be centered and could cause unclear communication amongst the healthcare team. Findings: During the review of Resident 120's Admission Record (AR- a document that provides resident contact details, a brief medical history, level of functioning, preferences, and wishes) dated 12/8/23, the AR indicated Resident 120 was admitted on [DATE] with the diagnoses of: hypertension (HTN-high blood pressure), obesity (excessive fat accumulation that presents a health risk), and gait abnormalities (unusual or irregular walking pattern). During a review of Resident 120's Minimum Data Set (MDS- resident assessment tool which indicated physical and cognitive abilities), dated 1/20/25, the MDS indicated a Brief Interview for Metal Status (BIMS- an assessment of cognitive function) score of fifteen (0-7 severe cognitive impairment, 8-12 moderate cognitive impairment, 13-15 no cognitive impairment), which indicated Resident 120 had no cognitive impairment. During an interview on 2/4/25 at 9:38 a.m. in Resident 120's room, Resident 120 stated she got blisters on her bottom from time to time. Resident 120 stated staff treated the area by applying powder and bandages. During an interview on 2/5/25 at 9:57 a.m. with Certified Nurse Assistant (CNA 7), CNA 7 stated Resident 120 did not have a wound. CNA 7 stated that care plans guided how to care for the resident. CNA 7 stated if the care plans were not accurate, they would not know what needed to be done. During an interview on 2/5/25 at 10:15 a.m. with CNA 8, CNA 8 stated care plans informed them on how to care for the resident. CNA 8 stated an updated care plan provided them with the necessary information for Resident 120's care. During a concurrent interview and record review on 2/5/25 at 1:44 p.m. with License Vocational Nurse (LVN 1), Resident 120's MDS was reviewed. The MDS dated [DATE] indicated Resident 120's stage two left gluteal (group of muscles that make up the buttock area) pressure ulcer had healed on 1/15/25. Resident 120's care plan dated 12/2/24 was also reviewed. The care plan indicated Resident 120 had an active care plan for a stage two pressure ulcer. LVN 1 stated the care plan should have been resolved once the wound healed. LVN 1 stated it was important for care plans to be resolved so that, if the issue happened again, staff would be aware of it. LVN 1 stated if care plans were not updated, specific care for the resident could be missed. (continued on next page)

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	056207	A. Building B. Wing	02/07/2025

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/7/25 at 8:20 a.m. with the Director of Nursing (DON). The DON stated it was important for resident care plans to be accurate, because it communicated the needs of the resident. The DON stated there was potential for a negative outcome if care plans were not accurate. The DON stated the care plans should be updated and revised if any issues or problems were resolved. The DON stated that the revision of the care plan should show that the needs of the resident were being met. The DON stated the needs of the resident were not clearly communicated if the care plans were not updated. The DON stated that the care plan for Resident 120 should have been resolved when the wound was considered healed. The DON stated the nurse should have resolved Resident 120's wound care plan by the end of their shift on 1/15/25. During a review of the facilities policy and procedure (P & P) titled Care Plan, Comprehensive, dated 12/2017, the document indicated, .resident progress is regularly evaluated, and approaches revised or updated as appropriate .problem resolution and changes in goals and approaches may be identified and initiated by any interdisciplinary team member .

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	056207	A. Building B. Wing	02/07/2025

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48739 Based on observation, interview, and record review, the facility failed to meet professional standards of practice for two of nine sampled residents (Resident 112 and Resident 306) when: 1. Resident 112 was receiving 2.5 liters per minute (LPM- a unit that expresses flow rate define) of oxygen when the continuous oxygen ordered was for 2 LPM. 2. Resident 306's oxygen flow rate was set at 3 L/min and not 2 L/min as indicated on the physician order (a set of instructions written by a doctor for clinicians to follow when caring for a resident). These failures had the potential to result in serious health conditions for the resident including oxygen toxicity that could cause damage to lung tissue and respiratory issues. 3. Resident 306's oxygen tubing was not labeled with the date the tubing should be changed. This failure put Resident 306 at risk of infection. Findings: 1. During a review of Resident 112's Admission Record (AR), dated 2/5/25, the AR indicated Resident 112 had a diagnosis of Chronic Obstructive Pulmonary Disease (COPD - a chronic lung disease causing difficulty in breathing), emphysema (a chronic lung disease characterized by the destruction of the air sacs in the lungs), obstructive sleep apnea (a sleep disorder characterized by repeated episodes of complete or partial blockage of the upper airway during sleep, leading to disruptions in breathing) and dependence on supplemental oxygen. During a review of Resident 112's Order Summary, dated 12/7/24, the Order Summary, indicated, Oxygen at 2 LPM via nasal cannula continuous every shift. During a review of Resident 112's Care Plan (CP), dated 12/7/24, the CP indicated, Focus: The resident has Emphysema/COPD Date initiated: 12/7/24 . Goal: The resident will be free of [signs and symptoms] of respiratory infections through review date .Interventions: Administer Oxygen as ordered . During an observation on 2/3/25 at 8:45 a.m., observed Resident 112 in bed awake, wearing a nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen). Observed the oxygen rate set at 2.5 LPM. During an observation on 2/4/25 at 8:45 a.m. observed Resident 112 asleep in bed with nasal cannula on. Observed oxygen rate set at 2.5 LPM. During an observation on 2/5/25 at 8:12 a.m., observed Resident 112 awake in bed with nasal cannula on. Observed oxygen rate set at 2.5 LPM. (continued on next page)

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	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pacific Gardens Nursing and Rehabilitation Center	577 S. Peach Ave. Fresno, CA 93727

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 112's Medication Administration Record (MAR), dated 2/2025, the MAR indicated during day shift, Resident 112 received continuous oxygen at 2 LPM on 2/3/25, 2/4/25 and 2/5/25. During a concurrent observation and interview on 2/5/25 at 8:21 a.m. with Registered Nurse (RN) 5, RN 5 observed the oxygen flow rate for Resident 112. RN 5 stated the oxygen flow rate is set at 3 LPM. RN 5 stated she recently checked the oxygen order and it was for 2 LPM and was unsure why Resident 112 had the oxygen rate set at 3 LPM. During a concurrent interview and record review on 2/5/25 at 4:04 p.m. with RN 5, Resident 112's Oxygen order, dated 12/7/24 was reviewed. The Oxygen order indicated, Oxygen at 2 LPM via nasal cannula continuous every shift. RN 5 stated the order was not followed when the oxygen rate was set at 2.5 LPM and the order was for 2 LPM. RN 5 stated it was important to follow the order to know how the resident was doing with their breathing and if they were maintaining their oxygen level. RN 5 stated if the resident was receiving more oxygen than was ordered, the nurse would have to notify the doctor. During an interview on 2/7/25 at 5:00 p.m. with the Director of Nursing (DON), the DON stated the oxygen order was not followed for Resident 112 when the resident was receiving 2.5 LPM and the order was for 2 LPM of oxygen. The DON stated the resident received more oxygen than was ordered and this could be detrimental to the resident. During a review of the facility's policy and procedure (P&P) titled Oxygen Administration, dated 8/2014, the P&P indicated, .Procedure. 1. Check physician's order for liter flow and method of administration . 2 During a concurrent observation and interview on 2/3/25 at 10:18 a.m. with Resident 306 in Resident 306's room, Resident 306 was dressed, lying in bed with oxygen infusing via nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) at 3L/min. Resident 306's oxygen tubing was observed to be unlabeled with the date it was taken out for use. Resident 306 stated she had been at the facility for five or six days due to an inability to walk. During a review of Resident 306's AR, dated 2/6/25, the AR indicated Resident 306 was admitted to the facility from the acute care hospital on 1/19/25 with diagnoses of Methicillin Resistant Staphylococcus Aureus (MRSA - a bacteria that does not get better with the type of antibiotics [a medication that inhibits or destroys infections caused by bacteria] that usually cure staph infections [infections that are caused by bacteria usually found on the skin or in the nose]), Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), and depression (a mental health disorder characterized by sadness or loss of interest in activities). (continued on next page)

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	056207	A. Building B. Wing	02/07/2025

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 306's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 1/28/25, the MDS section C indicated Resident 306 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive [involving the process of thinking, learning and understanding] understanding on a scale of 1-15) score of 15 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which indicated Resident 306 was cognitively intact. During a concurrent interview and record review on 2/06/25 at 10:14 a.m. with Licensed Vocational Nurse (LVN) 3, Resident 306's Clinical Physician Orders, dated 2/6/35 was reviewed. The Clinical Physician Orders indicated, . oxygen at 2 LPM via Nasal Cannula [as needed] [shortness of breath] or Oxygen Saturation [measurement of oxygen in the blood] less than 92% on [room air] . LVN 3 did not go into Resident 306's room for an observation of Resident 306's oxygen setting. LVN 3 stated he checked Resident 306 earlier that morning and Resident 306's oxygen saturation was at 96% and did not require oxygen. LVN 3 stated it was important for staff to follow physician's orders for oxygen administration. LVN 3 stated oxygen was considered a medication. LVN 3 stated nursing staff should put the oxygen tubing on residents and should set the oxygen infusion rate. LVN 3 stated there was a risk of harm to residents if nurses did not follow physician's orders. 3. During a concurrent observation and interview on 2/03/25 at 10:25 a.m. with Certified Nursing Assistant (CNA) 15 in Resident 306's room, Resident 306's oxygen tubing was observed without a date label. CNA 15 stated there was no date on the oxygen tubing indicating when it was placed or changed. CNA 15 stated the nurses dated the tubing. During a concurrent observation and interview on 2/3/25 at 10:29 a.m. with LVN 4 in Resident 306's room, Resident 306's oxygen tubing was observed without a date label. LVN 4 stated there should have been a date on the oxygen tubing indicating when it was placed or changed. LVN 4 stated the oxygen tubing should be changed every week. LVN 4 stated a date label was needed so staff would know the last time the oxygen tubing was changed. LVN 4 stated the tubing and nasal cannula could become dirty and block the oxygen flow. LVN 4 stated a dirty cannula, and dirty tubing placed a resident at risk for infection. During an interview on 2/06/25 at 2:51 p.m. with the Assistant Director of Nursing (ADON), the ADON stated her expectation was for oxygen tubing to be labeled with a date so staff would know when the tubing was changed and to prevent infection from soiled tubing. The ADON stated the oxygen tubing should have been changed weekly to maintain patency (being open, expanded, or unobstructed) of the tubing and to prevent kinked or soiled tubing which could be a risk for infection to the resident. The ADON stated her expectation was for the residents' oxygen flow rate to be followed as written or verbally ordered by the physician. The ADON stated if the order was not followed, there was a risk for resident's medical condition to worsen. During a review of the facility's P&P titled, Oxygen Administration, dated 8/2014, the P&P indicated, . to administer oxygen to the resident when insufficient oxygen is being carried by the blood to the tissues . check physician's order for liter flow and method of administration . set the flow meter to the rate ordered by the physician . change humidifier and tubing per facility procedure . PRECAUTION: CONSTANT FLOW OF OXYGEN CAN CAUSE DRYING AND THICKENING OF NORMAL SECRETIONS RESULTING IN LARYNGEAL ULCERATION [an open sore on or near the vocal cords] . at regular intervals, check and clean oxygen equipment, masks, tubing and cannula . (continued on next page)

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	056207	A. Building B. Wing	02/07/2025

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, Oxygen Administration per Nasal Cannula, dated 1/1/14, the P&P indicated, . a physician's order shall be required for administering oxygen . humidifier and nasal cannula shall be changed every 7 days or frequently when needed . connect the nasal cannula to the bubble humidifier and turn flow meter to flow rate ordered by the physician . documentation . date and time . method of oxygen administration and rate of flow . During a review of the facility P&P titled, Processing Physician Orders, dated 8/2017, the P&P indicated, . to verify and maintain accuracy of physician orders to provide appropriate care . prior to saving orders to the patient record, LN's [licensed nurses] are to clarify orders with the attending physician . 51134

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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51059 Based on observation, interview, and record review, the facility failed to ensure one of five sampled Residents (Resident 28), received toenail care consistent with professional standards of practice when Resident 28's toenails were long and jagged. This failure resulted in Resident 28's toenails to become long, jagged, and caused discomfort which had the potential to lead to ingrown toenails, infection, and injury. Findings: During a review of Resident 28's Admission Record (AR- document containing resident personal information), dated 11/25/24, the AR indicated, Resident 28 was admitted to the facility on [DATE], with diagnoses which included, displaced intertrochanteric fracture of right femur (a break in the bone just below the hip joint) subsequent encounter for closed fracture (a type of bone break where the broken bone does not penetrate the skin) with routine healing, muscle weakness generalized, need for assistance with personal care, and other reduced mobility. During a review of Resident 28's Minimum Data Set (MDS- a resident assessment tool) assessment, dated 12/4/24, the MDS assessment indicated Resident 28's Brief Interview for Mental Status (BIMS- an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) assessment score was 15 out of 15 which indicated Resident 28 had no cognitive deficit (a decline in mental processes that affect a person's ability to learn, think, and understand). The MDS assessment indicated Resident 28's functional abilities (the capacity to perform daily tasks and activities) required substantial/maximal assistance (Helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) for lower body dressing and putting on/taking off footwear. The MDS assessment indicated Resident 28's functional abilities required partial/moderate assistance (Helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) for personal hygiene. During an interview on 2/3/25 at 8:24 a.m. with Resident 28, Resident 28 stated her toenails were long, jagged, and uncomfortable. Resident 28 stated she had limited range of motion (joint that has a reduced ability to move) and could not provide her own toenail care. Resident 28 stated she relied on staff to perform toenail care. Resident 28 stated she would never leave her toenails jagged, sharp, uneven and long. Resident 28 stated Certified Nursing Assistants (CNAs) and Licensed Vocational Nurses (LVNs) trimmed her toenails and left them jagged, sharp, uneven, and long. Resident 28 stated her toenails were trimmed once since admitted to the facility. Resident 28 stated her toenails had not been filed smoothly. (continued on next page)

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	056207	A. Building B. Wing	02/07/2025

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/4/25 at 10:25 a.m. with Certified Nursing Assistant (CNA) 5, CNA 5 stated CNAs were responsible to provide routine toenail care twice a week with every shower, as needed, and when requested by the resident. CNA 5 stated toenail care included a trim, file, and cleaning underneath the toenail. CNA 5 stated toenail care was documented on the Shower Day Inspection form. CNA 5 stated if a resident was non-compliant or refused toenail care it was expected to be documented on the Shower Day Inspection form. CNA 5 stated it was expected all residents' toenails were smooth and clean. CNA 5 stated long, jagged, and sharp toenails could become dirty, ingrown, or lead to an infection. During a concurrent observation and interview on 2/4/25 at 10:31 a.m. with Resident 28 in Resident 28's room, Resident 28's toenails were observed to be long, jagged, and uneven (all ten toes). Resident 28's right big toenail was observed longer than the other nine toenails, growing toward the right at an angle into the toe. Resident 28 stated her right big toenail was the longest and scratched her, even when wearing socks. Resident 28 stated all her toenails were sharp and it made her uncomfortable. Resident 28 stated she had to wear socks to prevent her toenails from scratching her legs and feet. Resident 28 stated she did not want to wear socks all the time. Resident 28 stated she had requested assistance to file her toenails smoothly, but it was not provided. During an interview on 2/4/25 at 1:30 p.m. with Licensed Vocational Nurse (LVN) 6, LVN 6 stated nursing staff were responsible to provide routine toenail care. LVN 6 stated she expected CNAs to trim, file, and clean all residents toenails twice a week with each shower. LVN 6 stated she expected all residents toenail preferences and requests to be followed. LVN 6 stated toenails should not be left long, jagged or sharp. LVN 6 stated residents with long, jagged, and sharp toenails were at risk of becoming dirty and had the potential to cut the resident and cause an infection. During a concurrent interview and record review on 2/4/25 at 3:03 p.m. with Registered Nurse(RN) 2, a photograph taken of Resident 28's toenails, dated 2/4/25, was reviewed. RN 2 stated Resident 28's toenails were long, jagged, and sharp. RN 2 stated Resident 28's right big toenail was longer than the other nine toenails, growing toward the right at an angle into the toe. RN 2 stated sharp toenails could cut Resident 28 and lead to injury or infection. RN 2 stated she expected Resident 28's toenails to be smooth and equal in length. During an interview on 2/6/25 at 2:07 p.m. with the Director of Staff Development (DSD), the DSD stated she was responsible to provide training and education to all staff within the facility and ensured staff competency by return demonstration. The DSD stated she performed an all-staff training titled, ADL [Activities of daily living- activities related to personal care. They include bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet, and eating.] Care and Call Lights, on 4/7/24 which covered toenail care. The DSD stated she expected all nursing staff to follow toenail training guidelines and facility policy. The DSD expected all resident toenails to be trimmed, filed, and cleaned twice a week with each shower, as needed, or when requested by the resident. The DSD stated CNAs were responsible to document routine toenail care on the Shower Day Inspection form and documented if the resident refused or was non-compliant with toenail care. The DSD stated resident toenails should not be long, jagged or sharp to prevent ingrown toenails, discomfort, and injury. (continued on next page)

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	056207	A. Building B. Wing	02/07/2025

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 2/6/25 at 5:02 p.m. with the Director of Nursing (DON), a photograph taken of Resident 28's toenails, dated 2/4/25, was reviewed. The DON stated Resident 28's toenails were long, uneven in length, jagged, and sharp. The DON stated she expected routine toenail care to be provided to all residents twice a week with each shower, as needed, or when requested by the resident. The DON stated she expected all resident toenails to be trimmed and filled smoothly. The DON stated she expected CNAs to document toenail care on the Shower Day Inspection form and document refusal or non-compliance with toenail care. The DON stated long, jagged, and sharp toenails could lead to discomfort and injury if Resident 28 scratched herself with her toenails. During a review of Resident 28's Care Plan, dated 11/26/24, the Care Plan indicated, .Self-care deficit as evidence by: needs assistance with ADL's related to muscle weakness .personal hygiene .physical assistance required . During a review of Resident 28's Shower Day Inspection form, dated 2/1/25, the Shower Day Inspection form indicated Resident 28's routine toenail care was not completed. During a review of the facility's training lesson titled, ADL Care and Call Lights, undated, the ADL Care and Call Lights training lesson indicated the program was attended by all staff and taught by the DSD. The training lesson indicated, .identify ADL needs for all residents .nail care-hands and feet .daily nail cleaning should be provided to each resident, trimming and filing as needed and shower days. Toenails should be filed straight across and cleaned . During a review of the facility's policy and procedure (P&P) titled, Activities of Daily Living (ADL's), dated 2/2023, the P&P indicated, .care and services will be provided for the following activities of daily living . grooming .a resident who is unable to carry out activities of daily living will receive the necessary services to maintain .grooming, and personal .hygiene . During a review of the facility's P&P titled, Foot Care, dated 2006, the P&P indicated, .toenails are to be clipped and filed smoothly .to prevention infection of the feet .to prevent irritation of the feet .to prevent skin break in skin integrity of the feet .to promote cleanliness . During a review of the facility job description document titled, Certified Nursing Assistant, dated 11/13/17, the document indicated, .The primary purpose of this position is to provide each of your assigned residents with routine daily nursing care and service .Provide .assistance and support to maintain residents ADL function . Provide the clinical and support services needed to meet all physical and psycho-social needs of the residents and patients .provide support and assistance with grooming, including shower as scheduled .and nail care . During a review of the Nursing Times article titled, Foot Assessment and Care for Older People, dated 12/9/14, the article indicated, .Foot care is a crucial part of nursing care, particularly for older patients, who may be unable to care for their own feet .Nails that become too long .can damage the skin on adjacent toes . Ingrown toenails occur when a nail grows into the skin, and can cause pain, swelling, redness and infection .

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	056207	A. Building B. Wing	02/07/2025

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F 0688 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45580 Based on observation, interview, and record review, the facility failed to provide required treatment and services to one of five residents (Resident 20), when Resident 20 did not receive restorative nursing assistant (RNA - helps patient regain physical skills through therapeutic care including mobility exercises, dressing, eating and bathing) services ordered by the physical therapist (PT-a person qualified to treat disease, injury or deformity by physical methods such as massage, heat treatment and exercise) once PT was discontinued on 3/6/24. Resident 20 did not receive range of motion (ROM- full movement potential of a joint) treatment from 3/6/24, when Resident 20 was discharged from PT, until 2/4/25, when Resident 20 was reevaluated by an occupational therapist (OT - healthcare professional who helps individuals improve their ability to perform activities of daily living [ADL]), a time lapse of 10 months and 29 days. These failures by PT to coordinate with RNA services to continue Resident 20's exercise treatments, potentially contributed to Resident 20 developing decreased ROM of the right hand leading to a contracture (a stiffening/shortening at any joint, that reduces the joint's ROM). Findings: During a concurrent observation and interview on 2/3/25 at 2:34 p.m. with Resident 20 and Resident 20's responsible party (RP - health care decision maker) in Resident 20's room, Resident 20's right hand was observed to have slight movement of the middle finger, while the other three fingers and thumb remained in a bent position and did not move. The RP stated, I visit my wife every single day and am here from 7 a.m. to 3 p.m. The RP stated Resident 20's right hand has worsened since admission. The RP stated no ROM had been done since the Resident was discharged from physical therapy in March of 2024. The RP stated he did not know why PT was no longer provided but the RP had informed staff a few months ago in a meeting about wanting treatment for Resident 20's right hand. The RP stated Resident 20's right hand was more bent than when she came into the facility, and she could no longer extend four fingers. During a review of Resident 20's Admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 2/5/25, the AR indicated Resident 20 was admitted to the facility on [DATE] with a diagnosis of hemiplegia (total loss of the ability to move the arm, leg, and trunk on the same side of the body) and hemiparesis (one-sided muscle weakness) following cerebral infarction (when blood flow to the brain is interrupted, causing brain cells to die) affecting left non-dominant side and encephalopathy (a change in how the brain functions and leads to declining ability to reason and concentrate). During a review of Doctor of Medicine/Nurse Practitioner/Physician's Assistant Progress Note (MD/NP/PA), dated 1/22/25, the MD/NP/PA Progress Note indicated, . [Resident 20] has a history of multiple strokes with right side weakness . [History] of stroke [blood flow to the brain is interrupted leading to brain cell damage and death] with right hemiparesis . (continued on next page)

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	056207	A. Building B. Wing	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0688 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During a review of Resident 20's Care Plan (CP), dated 1/30/24, the CP indicated, Self-Care Deficit as Evidence by: Needs maximal to dependent assistance with [activities of daily living (ADL)] [related to] multiple medical conditions, *With [diagnosis] of CVA [cerebrovascular accident- known as a stroke, where blood flow to the brain is interrupted] [with/left] SIDED WEAKNESS With impaired [right lower extremity (limbs of the body, such as the arms and legs)/bilateral upper extremity (RLE/BUE)] ROM. Date initiated: 1/30/24 . Revision on 2/6/25 . During a concurrent interview and record review on 2/7/25 at 10:02 a.m. with the Administrator (ADM), Resident 20's CP, dated 1/30/24 was reviewed. The CP indicated, .Interventions .Transfer: Two- person physical assistance required .Locomotion [movement or the ability to move from one place to another]- One-person physical assist required as needed .Bathing - One- person physical assist required . The ADM stated this CP is current. The ADM stated the CP did not state to perform ROM, but locomotion would be considered movement with raising of arms. During a review of Resident 20's Minimum Data Set (MDS - a resident assessment tool), dated 7/19/24, the MDS indicated Resident 20's 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 was 3 out of 15 (0-7 indicated severe cognitive impairment [memory loss, poor decision making skills] 8-12 moderate cognitive impairment, 13-15 cognitively intact) which indicated resident had a severe cognitive impairment. During a review of Resident 20's N Adv- Skilled Evaluation - V 16 (Evaluation), dated 1/31/24, the Evaluation indicated, the right hand was normal with no weakness, tremors (involuntary, rhythmic shaking movements that can affect various parts of the body including the hands), numbness or tingling. During a review of Resident 20's PT Evaluation, dated 1/31/24, the PT Evaluation indicated, .Assessment summary .without skilled therapeutic intervention [a goal-oriented treatment that is tailored to a resident's needs and performed by a licensed therapist], the patient is at risk for further decline in function, decreased ability to return to prior living environment and increased dependency upon caregivers . The PT Evaluation indicated, Reason for Referral: Patient referred to PT due to new onset of increased need for assistance from others, decrease in functional mobility, compromised physical exertion level during activity, functional limitation with ambulation [ability to walk from one place to another, either independently or with the help of a device] and decrease in strength . The PT Evaluation indicated the ROM for both lower extremities were within functional limits (WFL) and strength for bilateral lower extremities (BLE) was impaired but did not indicate the ROM and strength for bilateral upper extremities (BUE). During a review of Resident 20's Physical Therapy PT Discharge Summary, dated 3/6/24, the Physical Therapy PT Discharge Summary indicated, . Prognosis to Maintain [current level of function] = Good with strong family support, good with consistent staff follow-through . (continued on next page)

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	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0688 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During a review of Resident 20's Occupational Therapy OT Evaluation, dated 1/31/24, the Occupational Therapy OT Evaluation indicated, Resident 20's baseline (starting point) for upper body dressing was, Max A (51-75% assist- [PT and resident each put in about half of the effort]), Section GG: Substantial/Maximal Assist [level of assistance where a patient needs a significant amount of help to complete a task] . The Occupational Therapy OT Evaluation indicated for section musculoskeletal [having to do with muscles, bones, tendons, ligaments, joints and cartilage] ROM, [upper extremity (UE)] ROM: [right upper extremity (RUE)] ROM= Impaired . The Occupational Therapy OT Evaluation indicated, .without skilled therapeutic intervention, this patient is at risk for rehospitalization , decreased ability to return to prior level of function . decrease in level of mobility, falls, further decline in function, increased dependency upon caregivers and decreased participation in functional tasks . The Occupational Therapy OT Evaluation did not indicate ROM specifically for right hand and right fingers. During a review of Resident 20's Occupational Therapy OT Discharge Summary, dated 3/6/24, the Occupational Therapy OT Discharge Summary indicated, . Progress & Response to Treatment: Patient responded positively to passive techniques to stimulate functional performance and enhance safety to prevent further decline . Restorative Programs. Restorative Program Established/Trained = Restorative Range of Motion Program. Range of Motion Program Established/Trained: UE ROM [performed ROM] exercises for shoulder flexion [a bending movement around a joint in a limb that decreases the angle between the bones of the limb at the joint]/extension [movement of a joint that increases the angle between the bones involved], abduction [movement of a body part away from the midline of the body], elbow flexion/extension, wrist flexion/extension, [finger] flexion . During a review of Resident 20's Occupational Therapy OT Discharge Recertification, dated 3/6/24, the Occupational Therapy OT Discharge Recertification indicated, .Communication. Collaboration/Transition plan: Reviewed patient's plan of treatment and treatment services with interdisciplinary team members . During a review of Resident 20's Progress Note (PN), dated 3/1/24, the PN indicated, .Functional: Able to move all extremities. Upper extremity ROM: No Impairment Physical Therapy Resident continues to participate in therapy as ordered. Occupational therapy: Resident continues to participate in therapy as ordered . During a review of Resident 20's Restorative Therapy Referral - V 1, dated 3/6/24, the Restorative Therapy Referral - V 1 indicated, .D. RNA Program. 1. Current Problems: Patient is at elevated risk of loss of UE/ ([lower extremity (LE)] ROM and inability to tolerate upright activity. 2. Goals: Maintain current UE/LE ROM and tolerance to upright activity. 3. Approaches: Right/Left upper and lower extremity PROM to tolerance all planes [a flat surface, a cut through the body] 3 sets[group of repetitions of an exercise performed consecutively without stopping] [times] 10 [repetitions] [up in chair (UIC)] via [patient lift - a mechanical device used to lift and/or transfer a person) daily [times] 1 or to tolerance Position [right] UE with pillow between body and UE . The Restorative Therapy Referral - V 1 indicated check marks for both boxes stating, Program reviewed with RNA and training completed and RAI [Resident Assessment Instrument- tool that helps nursing home staff assess a resident's needs and strengths]/MDS made aware of transfer of care. (continued on next page)

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	02/07/2025

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F 0688 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During a review of Resident 20's Interdisciplinary team (IDT) Assessment & Progress Note - V 3 (IDT Assessment), dated 4/24/24, the IDT Assessment indicated, Restorative Care/ PT/OT (occupational therapy)/ST (speech therapy) . 2. Functional ROM limitations . check marked for both sides-upper extremity. The IDT Assessment indicated no checkmark for current PT, OT and ST, and no checkmarks for current RNA programs including .1. Ambulation/locomotion 3. Splint [an external device used to immobilize an injury or joint /Contracture management 5. ROM 2. ADL 4. Dining . The IDT Assessment indicated, . [Resident 20] Requires maximal to dependent assist with ADL'S needs . During a review of Resident 20's IDT Assessment & Progress Note - V 3 (IDT Assessment), dated 7/12/24, the IDT Assessment indicated, Restorative Care/ PT/OT/ST . 2. Functional ROM limitations . check marked placed for, .1. None-upper extremity 2. None-lower extremity . The IDT Assessment indicated no checkmark for current PT, OT and ST, and no checkmarks for current RNA programs including .1. Ambulation/locomotion 3. Splint/Contracture management 5. ROM 2. ADL 4. Dining . During a review of Resident 20's IDT Assessment & Progress Note - V 4 (IDT Assessment), dated 10/11/24, the IDT Assessment indicated, Restorative Care/ PT/OT/ST . 2. Functional ROM limitations . check marked for both sides-upper extremity. The IDT Assessment indicated no checkmark for current PT, OT and ST, and no checkmarks for current RNA programs including .1. Ambulation/locomotion 3. Splint/Contracture management 5. ROM 2. ADL 4. Dining . The IDT Assessment indicated, . [Resident 20] Requires maximal to dependent assist with ADL'S needs . During a review of IDT Assessment & Progress Note - V 4 (IDT Assessment), dated 1/9/25, the IDT Assessment indicated, Restorative Care/ PT/OT/ST . 2. Functional ROM limitations . check marked for, 2. None-Lower Extremity . 5. Both sides Upper Extremity . The IDT Assessment indicated no checkmark for current PT, OT and ST, and no checkmarks for current RNA programs including .1. Ambulation/locomotion 3. Splint/Contracture management 5. ROM 2. ADL 4. Dining . The IDT Assessment indicated, .5. New Referrals for PT/OT [evaluation] and [treatment] . During an interview on 2/6/25 at 9:11 a.m. with Restorative Nursing Assistant (RNA) 1, RNA 1 stated, there was no RNA program for Resident 20 and a restorative therapy referral form was never received from a PT. RNA 1 stated the process of transitioning a resident from PT to the RNA program was the PT would create the restorative therapy referral form that included the RNA treatment. RNA 1 stated this form would then be printed out by the PT, provided to and reviewed with the RNA. RNA 1 stated the PT would provide instructions if needed and both the PT and RNA would sign the form and keep a copy. The RNA would then present the copy to the MDS Coordinator (a nurse who manages the assessment process for long-term care patients) to upload into Point Click Care (PCC- online charting system). RNA 1 stated once uploaded, the form was given back to the RNA and the form was stored in a binder in the RNA office. RNA 1 was unable to locate a copy of the restorative therapy referral form that would have been completed and signed by an RNA and PT on 3/6/24 for Resident 20. (continued on next page)

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	056207	A. Building B. Wing	02/07/2025

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F 0688 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During a concurrent interview and record review on 2/6/25 at 9:50 a.m. with Physical Therapist (PT) 1, Resident 20's Restorative Therapy Referral - V 1, dated 3/6/24 was reviewed. The Restorative Therapy Referral - V 1 indicated an established RNA program that specified therapy treatments to be conducted by an RNA with Resident 20.The Restorative Therapy Referral - V 1 indicated the RNA program, was reviewed with RNA and training completed . and .RAI/MDS was made aware of the transfer of care . The Restorative Therapy Referral - V 1 indicated the form was electronically signed by the physical therapist on 3/6/24 and is seen in the resident's medical record. PT 1 stated this form was signed on 3/6/24 by a temporary PT that is no longer at the facility. PT stated there is no signature by the RNA on this form. PT 1 stated there was a physical therapy evaluation done on 2/5/25 for Resident 20. During an interview on 2/6/25 at 10:00 a.m. with Occupational Therapist (OT) 1, OT 1 stated an occupational therapy evaluation was conducted for Resident 20 on 2/4/25. OT 1 stated, I saw a new developing contracture on the resident's right hand. OT 1 stated splinting (medical procedure that involves immobilizing an injured area with a supportive device) would be done for this contracture. OT 1 stated Resident 20 will be fitted for a splint (a rigid or flexible device that maintains in position a displaced or movable part) and one would be placed. During a review of Resident 20's MD/NP/PA Progress Note dated 1/22/25, the MD/NP/PA Progress Note indicated, . No new concern. Husband at bedside wondering if there is treatment for [Resident 20's] right hand contracture . The MD/NP/PA Progress Note indicated in the musculoskeletal category, box for negative and box for contractures were check marked and indicated .mild right-hand contracture . The MD/NP/PA Progress Note indicated in the comments section, . Right hand contracture: continue to place a rolled towel in her hand . During an interview on 2/6/25 at 10:09 a.m. with the Assistant Director of Rehab (ADOR), the ADOR stated she was unable to locate the restorative therapy referral form in the records kept in her office for Resident 20 from 3/6/24. The ADOR stated currently there was a real change of condition conducted on 1/27/24 for Resident 20. The ADOR stated the current plan for Resident 20 was to have PT and OT services done and once these services are completed, Resident 20 would be placed in the RNA program. The ADOR stated a splint for Resident 20's RUE wrist for finger flexion will be ordered once the resident is fitted for one. The ADOR stated, I do see there is a significant change of condition for resident in development of a contracture. During a review of Resident 20's Rehabilitation Referral, dated 1/27/25, the Rehabilitation Referral indicated for section splinting/contracture management, contracture upper (contracture found on RUE) was check marked. The Rehabilitation Referral indicated for section physical care/mobility skills box for weakness upper/lower extremities was check marked and box for limited ROM was check marked. The Rehabilitation Referral indicated, Comments: PT/OT eval for BUE/BLE strengthening. (continued on next page)

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	056207	A. Building B. Wing	02/07/2025

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F 0688 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During a concurrent interview and record review on 2/6/25 at 10:30 a.m. with the MDS Coordinator, the MDS Coordinator stated there was no RNA program done for Resident 20 when the resident was discharge from PT in March of 2024 and was unable to locate the Restorative Therapy Referral - V 1 form completed on 3/6/24. The MDS Coordinator stated the expectation was for the RNA to be informed by the PT of the restorative program, the form signed by both the RNA and PT and the form presented to MDS Coordinator to upload into PCC. The MDS Coordinator stated this process was not done and it should have been. The MDS Coordinator stated Resident 20's RP informed her, sometime in January of 2025, of Resident 20's right hand and observed it to appear different and placed an order for a PT and OT evaluation on 1/10/25. The MDS Coordinator stated, there should have been an order for ROM done by the RNA. During a review of Resident 20's Order Details, dated 1/10/25, indicated an order for, Occupational Therapy Evaluation and Treatment was placed on 1/10/25 by the MDS Coordinator and signed by the MD on 1/14/25. During a review of Resident 20's Order Details, dated 1/10/25, indicated an order for Physical Therapy Evaluation and Treat was placed on 1/10/25 by the MDS Coordinator and signed by the MD on 1/14/25. During a review of Resident 20's Occupational Therapy PT Evaluation, dated 2/4/25, the Occupational Therapy PT Evaluation indicated, . RUE ROM. Hand = Impaired (Contractures developing in R [right] hand) . The Occupational Therapy PT Evaluation indicated, .RUE strength = Impaired . The Occupational Therapy PT Evaluation indicated, . Reason for Skilled Services: Patient requires skilled occupational therapy services at the prescribed frequency and duration to address the following: splinting in R hand in order to enhance this patient's quality of life by improving hand ROM. Due to the documented deficits (lacking something necessary or not meeting a standard) and the patient's complicated medical history, without skilled therapeutic intervention, this patient is at risk for contracture(s) . The Occupational Therapy PT Evaluation did not specifically mention evaluation of the fingers on the right hand. During a review of Resident 20's Physical Therapy PT Evaluation, dated 2/5/25, the Physical Therapy PT Evaluation indicated, Reason for Referral: Patient referred to PT due to new onset of decrease in functional mobility, decreased postural alignment, decrease in strength and ROM . The Physical Therapy PT Evaluation indicated ROM for the right lower extremity (RLE) is impaired and the left lower extremity (LLE) is WFL but did not indicate ROM for both upper extremities. The Physical Therapy PT Evaluation indicated strength for both RLE and LLE was impaired but did not indicate strength for both upper extremities. During an interview on 2/6/25 at 1:40 p.m. with the ADOR, the ADOR stated the Director of Rehab (DOR) oversaw a resident's transition from PT to the RNA program and oversight was not done for Resident 20. The ADOR stated the purpose of performing the RNA program was for the resident to maintain their current level of function once discharged from PT or OT services. The ADOR stated Resident 20 may have developed a contracture because the RNA program had not been done. During an interview on 2/6/25 at 2:03 p.m. with the Director of Nursing (DON), the DON stated there was no policy in place for the process of transitioning a resident from PT to the RNA program. (continued on next page)

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	056207	A. Building B. Wing	02/07/2025

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F 0688 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 2/7/25 at 1:39 p.m. with Resident 20's RP, the RP stated he noticed Resident 20's 4 fingers and right hand started to bend in June of 2024. The RP stated Resident 20 would tell him she was unable to straighten out her fingers when he would ask her to. The RP stated he notified staff about Resident 20's right hand in a meeting held about 3 months ago and in the following meeting he brought it up again because nothing had been done. The RP stated one of the social workers suggested placing a towel in Resident 20's right hand but stated, I felt like it wouldn't help because I don't want her hand like in a fist, I want it straightened out. During an interview on 2/7/25 at 5:00 p.m. with the DON, the DON stated there was a failure by PT for not following the process of transitioning a resident from PT services to the RNA program. The DON stated the process was broken. The DON stated the importance of following the process was to make sure that the recommendation made by the PT was followed especially if the resident was not in rehab and for maintenance by the RNA, CNAs, and nurses. The DON stated she wanted the residents to maintain ADLs. The DON stated, we failed to follow the recommendation [by the PT]. During a review of the facility's policy and procedure (P&P) titled, Nursing Rehab/Restorative Care Program, (undated), the P&P indicated, The primary goal . is to ensure that all residents receive care and services that promote their ability to live and function as independently as possible; to maintain and/or improve function and prevent decline . Members of various clinical disciplines and support services use their observational and assessment skills to identify each resident's functional strengths, weaknesses and needs .For residents in a RNA program, monthly progress notes by the Restorative Nurse Aide provide specifics on delivery of Nursing Rehab and/or Restorative activities and the resident's response to them (how they are progressing toward their goals). The progress notes are signed off by restorative nurse or by state requirements . During a review of the facility's Job Description (JD) titled, Job Description/Performance Evaluation RNA, dated 11/13/17, the JD indicated, .The primary purpose of this position is to assist in performing restorative nursing procedures that maximize the resident's existing abilities, emphasize independence, minimize the negative effects of disability with an attitude of realistic optimism .Meets with administration, nursing staff, therapy department, as well as other related departments in planning restorative care. Maintains restorative care standards . Maintains treatment grids, care plans and progress notes as required . During a review of the facility's JD titled, .Rehabilitation Job Description for Physical Therapist, dated 12/8/15, the JD indicated, . The Physical Therapist identifies the need for and makes referral(s) to other disciplines to address the comprehensive needs of the patients. They implement individualized therapy programs designed to restore, reinforce, and enhance performance. In addition, the Physical Therapist instructs, educates and trains patients and caregivers in those skills and functions essential for promoting independence and productively, in order to diminish or correct pathology [the study of disease, including its causes, effects and progression]. They direct activities to promote and maintain health . Responsibilities/Accountabilities . 4. Makes referrals to other disciplines and agencies in order to address the comprehensive needs of the patient. 5. Consults with other members of the rehabilitation team to select the most appropriate therapeutic regimen consistent with the needs and capabilities of each patient .11 . completes all related documentation and record keeping regarding these services .15. Performs routine reexamination as needed/required to modify/progress plan of treatment . (continued on next page)

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	056207	A. Building B. Wing	02/07/2025

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F 0688 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During a review of the facility's JD titled, .Rehabilitation Job Description for Assistant Director of Rehab PT (DRAP), dated 2/20/23, the JD indicated, .This position also assists in integration of rehabilitation services in all settings .Responsibilities/Accountabilities .1. Fills in for the Director of Rehab in their absence . 6. Assists in management of therapy staff . During a review of the facility's JD titled, .Rehabilitation Job Description for Director of Rehab PT (DRGP), dated 2/20/23, the JD indicated, .This position also assists in integration of rehabilitation services in all settings. The Director of Rehab PT ensures that the highest standard of rehabilitation services is delivered and maintained . 2. Provides direct patient care. 3. Monitors the standard of clinical services being delivered and maintained in all sites and ensures an ethical and compliant product is being delivered . During a review of the facility's JD titled, Job Description/Performance Evaluation MDS Coordinator, dated 11/13/17, the JD indicated, The primary purpose of this position is to manage the MDS function and processes to: (1) maximize clinical outcomes for patients and residents, assuring resident safety and (2) ensure timely, accurate and complete clinical and support documentation . The JD was current during the time of Resident 20's care.

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	056207	A. Building B. Wing	02/07/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47888 48430 Based on observation, interview, and record review the facility failed to ensure one of six sampled residents (Resident 37), was free from accidents when: 1. Resident 37's foley catheter (helps drain urine from your bladder) tubing was wrapped around her prosthetic (artificial leg that replaces the part of the leg below the knee joint) right lower leg while sitting in her wheelchair. This failure had the likelihood to cause a fall or injury to Resident 37 via the catheter tripping her during a transfer (movement from wheelchair to bed and vice versa) or being pulled from her bladder as a result of being caught on her prosthesis (artificial leg). Findings: 1. During a review of Resident 37's Face Sheet (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 2/5/25, the Face Sheet indicated, Resident 37 was admitted to the facility on [DATE] with a diagnosis of cellulitis (a serious deep infection of the skin caused by bacteria) of the left lower limb, muscle weakness (loss of muscle strength), mild dementia (a brain condition that causes memory loss, thinking problems, and behavioral changes), neuromuscular dysfunction of the bladder (occurs when the nerves that control the bladder do not work properly) and peripheral vascular disease (a condition that occurs when blood vessels narrow or block, reducing blood flow to the arms and legs). During a review of Resident 37's Minimum Data Set (MDS - a resident assessment tool used to identify resident cognitive and physical function) assessment, dated 1/16/25, the MDS assessment indicated Resident 37's BIMS assessment score was 15 out of 15. The BIMS assessment indicated Resident 37 was cognitively intact. During a concurrent observation and interview on 2/4/25 at 9:05 a.m. with Resident 37, in Resident 37's room, Resident 37's foley catheter tubing was wrapped around her prosthetic right lower leg. Resident 37 stated she was unaware the tubing was wrapped around her leg. Resident 37 stated the tubing could make me fall or pulled out. Resident 37 stated I could have got hurt. During a concurrent observation and interview on 2/4/25 at 9:15 a.m. with CNA 11, in Resident 37's room, Resident 37's foley catheter tubing was wrapped around her prosthetic right lower leg. CNA 11 stated the catheter was a trip hazard for the resident and should not have been wrapped around her lower leg. CNA 11 stated Resident 37 was moved to her wheelchair from her bed this morning by the physical therapy department. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/4/25 at 12:01 p.m. with PTA 2, PTA 2 stated he transferred Resident 37 from her bed to her wheelchair that morning and moved her foley catheter to the wheelchair. PTA 2 stated her foley catheter should not have been wrapped around her prosthetic leg and was not sure when that happened. PTA 2 stated the expectation was for the foley catheter to not be a trip hazard but it was. PTA 2 stated Resident 37 was not safe. PTA 2 stated he was never trained on where to place the foley catheter on Resident 37's wheelchair. During an interview on 2/6/25 at 10:27 a.m. with RN 3, RN 3 stated Resident 37 was at high risk for a fall with the foley catheter like that. RN 3 stated the foley catheter should have been attached to her left leg. RN 3 stated Resident 37's catheter was dangerous and she could have fell . RN 3 stated Resident 37 also could have had her catheter pulled out and suffered a bladder injury. During an interview on 2/6/25 at 11:07 a.m. with the Director of Staff Development (DSD), the DSD stated all staff needed to know how to safely manage a resident's foley catheter. The DSD stated the foley catheter should not have been wrapped around Resident 37's leg. During an interview on 2/6/25 at 1:59 p.m. with the Assistant Director of Rehabilitation (ADR), the ADR stated she was in charge of PTA's. The ADR stated the PTA's get informal verbal training and did not have record of it. The ADR stated Resident 37 could have fell and get a fracture (broken bone). The ADR stated all staff at the facility had to abide by all facility policy and procedures. During an interview on 2/7/25 at 2:15 p.m. with the Infection Preventionist (IP), the IP stated the foley tubing wrapped around Resident 37's prosthetic leg could lead to unwanted tugs and increased risk for resident injury. The IP stated Resident 37 could have got injured due to a fall and had a potential hospitalization . The IP stated the foley catheter was a hazard due to its placement and staff did not follow the facilities policy and procedures Falls Management and Incident Management Policy. During an interview on 2/7/25 at 4:35 p.m. with the DON, the DON stated the foley catheter around Resident 37's leg was dangerous and could have gotten tangled, which would have resulted in a fall. The DON stated facility staff did not follow the policy and procedures, Falls Management and Incident Management Policy. During a review of the facility's P&P titled, Incident Management Policy, dated 10/2017, the P&P indicated, . To promptly acknowledge . individuals are identified and addressed to analyze contributing factors and environmental conditions . in order to provide a safe environment and reduce incidence of reoccurrence . During a review of the facility's P&P titled, Incident Management Policy, dated 10/2010, the P&P indicated, . Purpose: to evaluate risk factors and provide interventions to minimize risk, injury and occurrences .

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 49949 Based on observations, interview, and record review the facility failed to post the total number of licensed and unlicensed staff and actual hours worked when the posting did not represent the actual hours worked by direct care staff daily. This failure resulted in all residents and their family members to not have access to view the actual direct care staff hours and total number of direct care staff providing care daily and possibly not meeting the needs of the residents. Findings: During an observation on 2/6/25 at 2:35 p.m. in the hallway, the Census and Direct Care Services Hours Per Patient Day (DHPPD) form (a document used in healthcare facilities, to track the total number of direct care hours provided to patients each day) did not contain the total number and the actual hours worked by Registered Nurses (RN), Licensed Vocational Nurses (LVN) and Certified Nursing Assistants (CNA). During an interview on 2/6/25 3:46 p.m. with the Assistant Staff Development Coordinator (ASDC), the ASDC stated she was responsible for filling out the DHPPD form. The ASDC stated, I cannot tell you how many hours were provided by the RNs or LVNs by looking at the form we posted. The ASDC stated, I would have to look at the PPD [Per Patient Day] hours work sheet and this sheet is only available for me to see and not posted. The ASDC stated it was important to post hours to indicate how many hours were worked by the facility direct care staff. The ASDC stated, it was important to know the census in order to provide enough staffing hours for the residents. The ASDC stated, the staffing department was responsible to post the hours worked by the facility direct care staff. The ASDC stated, Residents and families have a right to know the information. During an interview on 2/6/25 at 4:05 p.m. with the Administrator (ADM), the ADM stated, the DHPPD form did not contain the hours of RNs and LVNs. The ADM stated the public had the right to know how many RN and LVN hours were worked per day. The ADM stated it was not posted and should have been posted. The ADM stated the facility used a form provided by California Department of Public Health (CDPH- the state department responsible for public health in California). The ADM stated he was not aware of the requirement by Centers for Medicare & Medicaid Services (CMS-the federal agency that provides health coverage to more than 160 million through Medicare, Medicaid, the Children's Health Insurance Program). During a review of the professional reference titled, State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities retrieved from, chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.cms.gov/medicare/provider-enrollment-and-certification/guidancefo, the article indicated, . The facility must post the following information on a daily basis: (i)Facility name. (ii)The current date. (iii)The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A)Registered nurses. (B)Licensed practical nurses or licensed vocational nurses (as defined under State law). (C)Certified nurse aides. (iv)Resident census .

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	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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. 48424 Based on observation, interview, and record review the facility failed to provide a drug regimen which was free from unnecessary drugs for one of six sampled residents (Resident 3) when Resident 3 was administered mirtazapine (a medication used to treat depression [a condition characterized by extreme sadness]) from 11/2/24 to 2/6/24 without any documented attempts at a gradual dose reduction (GDR- a system used to slowly stop the use of medication over time). This failure had the potential of causing Resident 3 to receive unwanted side effects such as dry mouth, dizziness, constipation, drowsiness, and headaches as a result of being given the mirtazapine unnecessarily. Findings: During a review of Resident 3's Admission Record (AR- a document that provides resident contact details, a brief medical history, level of functioning, preferences, and wishes), dated 2/6/25, the AR indicated, Resident 3 was admitted to the facility with diagnoses of depression and anxiety (a mental health disorder characterized by feelings of worry or fear that are strong enough to interfere with one's daily activities). During a concurrent interview and record review on 2/6/25 at 10:25 a.m. with Licensed Vocational Nurse (LVN) 3, Resident 3's Clinical Record (CR), dated 2/6/25, was reviewed. The CR indicated Resident 3 was administered mirtazapine every day during 11/24 following his admission on 11/2/24, everyday 12/24, everyday 1/25, and all but one day 2/1/25 to 2/5/25. LVN 3 stated Resident 3 regularly received mirtazapine, and he would have benefitted from a GDR since he had no recorded depressive episodes. LVN 3 stated no GDR attempt was documented on Resident 3's CR. LVN 3 stated it was important to document GDR's because it ensured residents did not receive unnecessary medication. During a concurrent interview on 2/6/25 at 11:57 a.m. with the Social Services Director (SSD) and the Director of Nursing (DON), the SSD stated Resident 3 had not had a GDR attempted since his admission on 11/2/24 . The DON stated the last medication review was done on 11/24, but no GDR was recommended. The SSD stated she did not properly document the doctor's recommendation regarding a GDR for Resident 3. The SSD stated she should have documented the phone discussion with the doctor regarding the GDR because it would have explained why a GDR was not done. The DON stated it was important to document whether or not a GDR was done because it ensured residents were not administered unnecessary medication(s), which could possibly cause side effects. During a review of the facility's policy and procedure (P&P) titled, Psychotropic Medication Management, dated 12/17, the P&P indicated, .Psychotropic Medications should only be used when necessary to minimize or eliminate medical symptoms and promote/maintain a Resident's highest practicable mental, physical, and psychosocial well being . IDT (interdisciplinary team) should evaluate psychotropic effectiveness (towards therapeutic goals), any medication related adverse consequences, functional changes, and continued necessity at least quarterly . Documentation guidelines (Documentation may include): . GDR assessment forms .

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	056207	A. Building B. Wing	02/07/2025

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48430 Based on observation, interview, and record review, the facility failed to ensure one of six sampled residents (Resident 556), were free of any significant medication errors when Resident 556's potassium chloride (a type of salt that gives the body potassium that gives the body minerals needed for the muscle and heart) 20MEQ (milliequivalent- a unit of measure) was not given according to manufacturer's instructions. This failure had the potential to cause poor absorption of the medication (meaning the body could not use it properly) and stomach upset for Resident 556. Findings: During an observation on 02/04/25 at 9:25 a.m. in Resident 556's room, Resident 556 was awake and lying down in bed watching tv. During a concurrent observation and interview on 02/04/25 at 9:56 a.m. with RN 1, Resident 556's potassium medication blister pack (a card that packages doses of medication within small, clear, or light-resistant amber-colored plastic bubbles [or blisters]) indicated, .Potassium CHL (chloride) 20MEQ TABLET .GIVE 1 TABLET BY MOUTH ONE TIME A DAY FOR SUPPLEMENT .Avoid lying down for at least 10 minutes after taking this medication .take this medication with a meal . RN 1 stated Resident 556 had breakfast around 7:30 a.m. During a concurrent observation and interview on 02/04/25 at 10:13 a.m. with RN 1 and Resident 556 inside Resident 556's room, RN 1 administered Resident 556's scheduled potassium chloride 20MEQ. RN 1 stated, the potassium chloride was scheduled as a morning medication. RN 1 administered the potassium chloride while Resident 556 was in bed with a glass of water. Resident 556 laid back down in bed to watch tv. Resident 556 stated, he ate breakfast around 7:30 a.m. During an interview on 02/04/25 at 11:21 a.m. with RN 1, RN 1 stated, she gave the potassium chloride at around 10:10 a.m. RN 1stated, she should have given the potassium chloride with a meal and kept Resident 556 up for at least 10 minutes after medication administration. RN 1 stated, she did not follow the manufacturer's guidelines printed on the medication blister pack. RN 1 stated, not following the manufacturer's guidelines could have potentially resulted in the medications were not absorbed by the body and would not have been effective. During an interview on 02/06/25 at 1:10 p.m. with the Assistant Director of Nursing (ADON), the ADON stated, RN 1 did not follow the manufacturer's instructions on the medication blister pack. The ADON stated, nurses should have read all instructions before giving any medications to any resident. The ADON stated, it was important to read manufacturer's instructions to avoid any medication error. The ADON stated, not following the manufacturer's instructions could have potentially led to the potassium chloride to not be absorbed by the body and could have caused stomach upset. The ADON stated, it was important for Resident 556 avoid lying down at least 10 minutes after taking the potassium chloride to prevent any dysrhythmias (irregular heartbeat). (continued on next page)

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	056207	A. Building B. Wing	02/07/2025

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 556's Admission Record (AR), dated 02/06/25, the AR indicated, Resident 556 was admitted on [DATE] with a diagnosis of paroxysmal atrial fibrillation (a fast, irregular heartbeat that only lasts a few hours or days) and gastro-esophageal reflux disease without esophagitis (stomach acid repeatedly flows back up into the tube connecting the mouth and stomach). During a review of Resident 556's Minimum Data Set Section C (MDSC - a resident assessment tool used to identify resident cognitive and physical function) assessment, dated 10/01/24, theMDS assessment indicated Resident 556's Brief Interview for Mental Status (BIMS -assessment of cognitive status for memory and judgment) assessment score was 15 out of 15 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07 indicates severe impairment). A BIMS summary score of 15 indicated Resident 556 had an intact cognitive status (processes of thinking and reasoning) for memory and judgment. During a review of Resident 556's Clinical Physician Orders (CPO), dated 02/04/25, the CPO indicated, . Potassium Chloride ER (extended release) Tablet Extended Release 20 MEQ . During a review Resident 556's Medication Admission Record (MAR), dated 02/01/25-02/28/25, the MAR indicated, .Tue [Tuesday] .4 .[signed] by RN 1 .Potassium Chloride ER Tablet Extended Release 20 MEQ . Give 1 tablet by mouth one time a day for supplement . During a review of the facility's policy and procedure (P&P) titled, General Dose Preparation and Medication Administration, dated 12/01/07, the P&P indicated, .Facility staff should verify that the medication and name and dose are correct . During a review of the professional reference (PR) titled, Medication Safety and Your Health, dated 11/18/24 found on https://www.cdc.gov/medication-safety/about/index.html , the PR indicated, .Medicines are safe when used as prescribed or as directed on the label .Take medicines as directed on the label .Some medicines should be taken with meals .Always .Read the label .Follow directions .

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	056207	A. Building B. Wing	02/07/2025

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48430 Based on observation, interview, and record review, the facility failed to properly store, and label drugs and supplies in accordance with acceptable standards of practice when: 1. Two inhalers did not have an open date and expiration date for two of 16 sampled residents (Resident 507 and Resident 36). 2. Two of four sampled refrigerators' temperatures were not within parameters that stored three residents (Resident 558, Resident 138, and Resident 506) medications. These failures had the potential to place Residents at risk of receiving spoiled, expired, and ineffective medications and placed Residents at risk for experiencing adverse reactions (define) from spoiled, expired and ineffective medications. Findings: 1. During a concurrent observation and interview on 02/04/25 at 3:01 p.m. with Licensed Vocational Nurse (LVN) 3 in Station 1 medication cart, an inhaler (a small, handheld device that delivers medications directly into the lungs) of fluticasone (define), umeclidinium (define), and vilanterol (medications to help with Chronic Obstructive Pulmonary Disease [COPD-a lung disease that makes it hard to breathe]) was not dated with the open date or expiration date. LVN3 stated, the inhaler should have been labeled with the open date and expiration date. LVN 3 stated, it was important for the inhaler to be dated to ensure potency (effectiveness) of Resident 507's inhaler medication During a concurrent observation and interview on 02/05/25 at 8:43 a.m. with LVN 1 in Station 4 medication cart, an inhaler of calcitonin-salmon (a medication used to treat osteoporosis [brittle bones]) that belonged to Resident 36 was not labeled with the open date or expiration date. LVN 1 stated, any new medications when opened must be labeled with the open date and expiration date on both the box and inhaler. LVN 1 stated, it was important to label medications with the open and expiration date to ensure residents were not administered expired medications. LVN 1 stated, expired medications would not have been effective and could potentially have caused adverse reactions. During an interview on 02/06/25 at 12:00 p.m. with the Director of Infection Prevention (DIP), the DIP stated, when opened, inhalers should have been labeled with an open date and expiration date. The DIP stated, expired medications could have degraded (reduced in quality and effectiveness) and would no longer be effective. The DIP stated, it was important to label inhalers with opened and expired dates to ensure the medication's potency and avoid potential adverse effects. During a record review of Resident 507's Admission Record (AR), dated 02/05/25, the AR indicated, Resident 507 was admitted on [DATE] with a diagnosis of asthma (a chronic disease in which the bronchial airways in the lungs become narrowed and swollen, making it difficult to breathe). (continued on next page)

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	056207	A. Building B. Wing	02/07/2025

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 507's Order Summary Report (OSR), dated, 02/06/25, the OSR indicated, . [brand name] Inhalation Aerosol (a substance consisting of very fine particles of a liquid or solid suspended in a gas) Powder Breath Activated 100-62.5-25 .(Fluticasone-Umeclidinium-Vilanterol) 1 puff inhale orally (by mouth) one time a day for UNSPECIFIED ASTHMA . During a review of Resident 36's AR dated 02/06/25, the AR indicated, Resident 36 was admitted on [DATE] with a diagnosis of age-related osteoporosis. During a review of Resident 36's Clinical Physician Orders (CPO) dated 02/06/25, the CPO indicated, . [brand name] solution 200 UNIT .(calcitonin (Salmon)) . During a review of Resident 36's Medication Administration Record (MAR) dated 02/01/25-02/28/25, the MAR indicated, . [brand name] solution 200 UNIT .(Calcitonin (Salmon)) .1 spray alternating nostrils one time a day .for OSTEOPEROSIS . During a review of the facility's policy and procedure (P&P) titled, General Dose Preparation and Medication Administration, dated 2013, the P&P indicated, .facility staff should not administer a medication if the medication or prescription label is missing or illegible .Facility staff may record the expiration date based on date opened on the label of medications with shortened expiration dates .Check the expiration date on the medication . 2. During a concurrent observation and interview on 02/05/25 at 8:59 a.m. with LVN 1, in Station 4 medication room's refrigerator, LVN 1 stated, the temperature inside the refrigerator according to the thermometer inside the refrigerator indicated it was 30 F (degrees Fahrenheit-a unit of measure). LVN 1 stated, the temperature range of the refrigerator should have been between 36 F to 46 F. LVN 1 stated, the refrigerator temperature of 30 F was below the appropriate range of 36 F to 46 F. During a concurrent observation and interview on 02/05/25 at 9:18 a.m. with the Assistant Director of Nursing (ADON) in Station 1 medication room refrigerator, the refrigerator thermometer inside indicated the temperature was 48 F. The ADON stated, .it should not be above 46 F . The ADON stated, the refrigerator temperature was out of range. The ADON stated, it was important to keep the temperature range between 36 F to 46 F to ensure the medications stored were stable and potency could be preserved. The ADON stated, the medications inside were: cyanocobalamin (a type of vitamin), a probiotic (live microorganisms that are beneficial) epoetin alfa (medication that treats anemia [not enough red blood cells], tuberculin purified derivative (a skin test is a test that determines if you have tuberculosis [disease that affects the lungs]), evolocumab injection (a medication used to treat hyperlipidemia-[high levels of fat in the blood]), Influenza vaccine (an injection to help prevent flu-[an infection of the nose, throat, and lungs]), and an E-Kit (Emergency Kit- small supply of medications kept in the home to quickly treat symptoms that may occur) that contained lorazepam (a medication to treat anxiety), Humulin R (a medication that treats diabetes-high levels of sugar in the blood) insulin lispro (a medication that treats diabetes), Novolin NPH (a medication that treats diabetes). The ADON stated, the Cyanocobalamin belonged to Resident 558, the epoetin alfa belonged to Resident 138, and the evolocumab injection belonged to Resident 506. During a concurrent observation and interview on 02/05/25 at 1:31 p.m. with the ADON in Station 4's medication room, the thermometer indicated 32 F. The ADON stated, the temperature was still below the range of 36 F to 46 F. The ADON stated, she will re-adjust the temperature control and recheck. (continued on next page)

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	056207	A. Building B. Wing	02/07/2025

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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 02/05/25 at 1:39 p.m. with the ADON in Station 1's medication room, the thermometer indicated 60 F. A temp gun (a point-and-click handheld gun that you can point at a non-organic surface to receive a temperature reading) was used to verify the thermometer reading and the temp gun indicated 51 F-61 F. The ADON stated, this refrigerator should have been replaced. During a concurrent observation and interview on 02/05/25 at 3:06 p.m. with the ADON in Station 1's medication room , the thermometer in the refrigerator indicated a temperature of 60 FThe ADON stated, the refrigerator was replaced 15 minutes ago. The ADON stated, the new refrigerator's temperature was 60 F. A temp gun was used to verify the temperature inside and it indicated 51 F. The ADON stated, the temperature was not in parameter. During an interview on 02/05/25 at 4:36 p.m. with the Director of Nursing (DON), the DON stated, the refrigerator in Station 1 medication room was out of range for six hours and 30 minutes. The DON stated, the refrigerator temperatures should not have been out of range to preserve the medications stored in it. The DON stated, the medications stored in the Station 1 refrigerator were discarded and replaced. The DON stated, medications not stored properly could potentially lose their potency and may cause adverse reactions. During an interview on 02/25/25 at 12:05 p.m. with the DIP, the DIP stated, medications not stored at the correct temperature could potentially degrade. The DIP stated, degraded medications would not have been effective and could have potentially caused adverse reactions to the residents. During a review of Resident 558's AR, dated 02/06/25, the AR indicated, Resident 558 was admitted on [DATE] with a diagnosis of autoimmune anemia (a condition where the immune system destroys red blood cells), vitamin b12 deficiency anemia (a condition when the body cannot make enough red blood cells because it does not have enough vitamin b12, and anemia). During a review of Resident 558's CPO, dated 02/06/25, the CPO indicated, . cyanobalamin solution 1000 [Micrograms (MCG)-a unit of measure] .inject 1 [milliliter-(ml) a unit of measure] . During a review of Resident 138's AR, dated 02/06/25, the AR indicated, Resident 138 was admitted on [DATE] with a diagnosis of end stage renal disease (kidneys no longer work as they should) and anemia in chronic kidney disease (low red blood cell counts due to diseased kidneys). During a review of Resident 138's CPO, dated 02/06/25, the CPO indicated, . [brand name] 10,000 units inject 1ml SQ (subcutaneous-under the skin) every Monday, Wednesday, and Friday to be given at dialysis (a type of treatment that helps your body remove extra fluid and waste products from your blood when the kidneys are not able to) . During a review of Resident 506's AR, dated 02/06/25, the AR indicated, Resident 506 was admitted on [DATE] with a diagnosis of hyperlipidemia. During a review of Resident 506's CPO, dated 02/06/25, the CPO indicated, . [brand name] Subcutaneous [under the skin] Solution .140[milligram/milliliter(MG/ML)-a unit of measure] [Evolocumab] . (continued on next page)

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	056207	A. Building B. Wing	02/07/2025

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled, Storage and Expiration of Medications, Biologicals (medications derived from living organisms), Syringes, and Needles, dated 2013, the P&P indicated, .facility should ensure .products and supplies are stored .under appropriate temperature and sterility conditions, according to the manufacturer's or supplier's recommendations .facility should ensure that medications and biologicals are stored at their appropriate temperatures .Refrigeration .36 F to 46 F .Facility personnel should inspect nursing station storage areas for proper storage compliance on a regularly scheduled basis .

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	056207	A. Building B. Wing	02/07/2025

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 51223 Based on observation, interview, and record review the facility cook staff failed to accurately measure milk and margarine when preparing the pureed rice recipe for 12 of 12 sampled Residents (Resident 64, 505, 78, 95, 9, 96, 111, 123, 65, 93, 74, 85) with a pureed diet order. This failure had the potential to result in 12 Residents (Resident 64, 505, 78, 95, 9, 96, 111, 123, 65, 93, 74, 85) to receive reduced or excess amount of nutrients in their food potentially leading to unexpected weight loss or weight gain. Findings: During a concurrent observation and interview on 2/4/25 at 10:28 a.m. with the [NAME] (COOK) 1 in the kitchen, COOK 1 measured 1.5 cup of milk using the 1/2 cup metal measuring cup three times, and the milk did not level to the top edge of the measuring cup for each measurement. COOK 1 placed a round plastic measuring cup that was larger than the width of the square block of margarine, pushed the measuring cup completely through the block of margarine leaving open areas between the block and measuring cup wall, and the margarine was not pushed down to ensure the 3/4 cup measurement was accurate. COOK 1 flipped the measuring cup over and placed the margarine into the blender. COOK 1 blended all ingredients for 15 to 30 seconds then stopped the blender to open and check the pureed texture. COOK 1 would add 1/2 cup of milk each time the blended ingredients did not achieve the targeted pudding texture. COOK 1 added a total of 2 additional cups of 2% milk before the pureed rice achieved a pudding texture. COOK 1 stated, it was important to follow the recipe as written to ensure the pureed food had the targeted pudding consistency. COOK 1 stated if the pureed consistency was too thick, the resident could choke and if the receipt was not followed, it could have led to reduced or excess nutrients in the food which could result in resident weight loss or weight gain. During an interview on 2/5/25 at 9:43 a.m. with the Registered Dietician (RD) in the RD office, the RD stated it was important for the cook to follow the pureed recipes to ensure the right consistency was achieved. The RD stated if the recipe was not measured or followed exactly, the food would not have the correct consistency. The RD stated for pureed rice, she would expect the cook to add more liquid than noted on the recipe to ensure the proper pureed consistency was achieved. The RD stated additional 2% milk would not increase the protein content significantly and would not harm the residents. The RD stated she expected the margarine to be measured in a cup and expected the cook to fill the measuring cup completely to ensure there was an accurate measurement (leaving no gaps between the cup and the margarine). The RD stated she had not thought to verify whether staff were properly measuring ingredients. The RD stated she should observe all staff for proper measuring as she was responsible to oversee the whole kitchen department. During an interview on 2/5/25 at 11:23 a.m. with the Director of Nursing (DON) in the DON office, the DON stated the facility did not have a policy & procedure for pureed food preparation. The DON stated the facility expected the cook to follow the recipes. (continued on next page)

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	056207	A. Building B. Wing	02/07/2025

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/6/25 at 9:57 a.m. with COOK 2 in the kitchen, COOK2 stated he just prepared pureed white rice for lunch. COOK 2 stated he prepared 13 servings as there were 12 residents on a pureed diet. COOK 2 stated he measured 13.5 cups of rice, 1 1/4 cup 2% milk and 1/2 cup + 3 tablespoons of margarine. COOK 2 stated he used the cylinder plastic measuring cup for the milk because it was numbered. COOK 2 stated he measured melted margarine as it was easier to blend. COOK 2 stated if he measured solid margarine, he would use a measuring cup and push down the margarine to ensure all sides of the measuring cup was filled to ensure accurate measurement. COOK 2 stated the risk of not ensuring ingredients were measured correctly could lead to the resident's meal losing fat content or decrease nutritive value (the amount of carbohydrates, fats, proteins, vitamins, minerals that the body uses for energy and growth). COOK 2 stated if additional liquid was needed to achieve the targeted consistency, COOK 2 would add liquid as stated on the recipe (example: 2% milk for the pureed rice recipe). During a review of Resident Listing Report-Diet Order, dated 2/6/25, the Resident Listing Report-Diet Order indicated the facility had 12 residents with a pureed diet order. During a review of [Name of facility] Winter 2025 Diet Spreadsheet X-format, dated 2/4/25, the lunch menu indicated the pureed diet residents would be served white rice puree. During a review of [Name of Brand] Production Recipe, dated 2/4/25, the RICE SCR PU recipe indicated yield 16 servings: portions 16 #10 scoop; ingredients & instructions: rice 16 1/2 cup, 2% milk 1 1/2 cup, margarine 3/4 cup +1 Tablespoon (Tbsp). 2. Process cooked rice until smooth . During a review of Job Description/Performance Evaluation, dated 11/13/17, the Job Title: [NAME] indicated a key/essential duty prepare food as assigned and by .standardized recipes and facility procedures; .prepare and serve food in accordance with .recipes . During a review of Job Description/Performance Evaluation, dated 11/13/17, the Job Title: Manager, Dietary indicated a key/essential duty all meals are properly prepared for each resident . During a review of Job Description/Performance Evaluation, dated 11/13/17, the Job Title: Registered Dietician indicated a key essential duty evaluates and monitors the operations of the Dietary Department to assure the provision of adequate, high-quality food .

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	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pacific Gardens Nursing and Rehabilitation Center	577 S. Peach Ave. Fresno, CA 93727

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51223 Based on observation, interview, and record review, the facility failed to maintain safe and sanitary food preparation and storage practices when: 1. A box of potatoes was not labeled with a received date or use-by date. 2. A dietary aide failed to wash their hands after scratching their ear and continued to place clean cups in a clean crate. 3. Thawing frozen beef kabobs were not labeled with the prepared by or use-by date, was found in the walk-in refrigerator. 4. Dust was identified on the ceiling above the fan in the food storage room. These failures had the potential to cause food borne illness to a highly susceptible population of 163 residents who received food from the kitchen. Findings: 1. During a concurrent observation and interview on [DATE] at 8:02 a.m. with the Dietary Manager (DM) in the kitchen, raw potatoes were stored in an uncovered box without a label identifying the received date or use-by date. The DM stated the box of potatoes were not dated. The DM stated all food should be dated so kitchen staff knew how long food had been on the shelf. The DM stated old food could grow germs (such as salmonella-a bacterial infection that causes diarrhea, vomiting, fever and stomach cramps) which had the potential to cause medically fragile residents to get sick. During an interview on [DATE] at 9:43 a.m. with the Registered Dietician (RD) in the RD office, the RD stated she expected all food to be labeled and dated. The RD stated if staff did not label or date food, they would not be compliant with facility policy. The RD stated unlabeled or undated foods created a potential risk of kitchen staff not knowing when food may have expired or spoiled. The RD stated if residents were served expired or spoiled food, the residents could develop food borne illnesses. During a review of the facility's Job Description/Performance Evaluation, dated [DATE], the Job Title: Manager, Dietary indicated the primary purpose of the DM, .is to lead and manage the Dietary Department . Key/essential duties .All food storage meets regulation and standards. All kitchen and storage area meets regulations and standards .Comply with all [name of facility] policies and procedures. Demonstrate key competencies as required by the position and in accordance with State/Federal regulations. (continued on next page)

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	056207	A. Building B. Wing	02/07/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Job Description/Performance Evaluation, dated [DATE], the Job Title: Registered Dietician (RD) indicated, .key/essential duties: Evaluates and monitors the operations of Dietary Department to assure the provision of adequate, high-quality food .Monitors and recommends food service standards of sanitation, safety and infection control . Comply with all Covenant Care policies, procedures, and standards . During a review of the facility's policy and procedure (P&P) titled, Food Safety in Receiving and Storage, dated ,d+[DATE], the P&P indicated, .receiving guidelines .2. Expiration dates and use-by dates will be checked to assure the dates are within acceptable parameters . 2. During a concurrent observation and interview on [DATE] at 8:05 a.m. with the DM in the kitchen, a dietary aide scratched his ear and continued to place clean cups in a clean crate without washing his hands. The DM stated staff should wash their hands after they touched their head/face before resuming tasks to prevent cross contamination (accidentally transferring harmful bacteria or allergens from one food or surface to another). The DM stated if the facility used contaminated cups, there would be potential for residents to get sick due to cross contamination. During an interview on [DATE] at 9:49 a.m. with Dietary Aide (DA) 2, DA 2 stated if she touched her face while working, she would wash her hands before resuming her tasks. DA 2 stated the risk of not washing her hands could lead to cross contamination of the clean dishes which could lead to resident illness if residents were served food on contaminated dishes. During an interview on [DATE] at 9:43 a.m. with the RD, the RD stated she oversees all staff in the kitchen department. The RD stated staff were expected to wash their hands before performing tasks. The RD stated if staff were to scratch their face or ear, she would expect them to wash their hands to promote infection control and food safety practices. The RD stated if staff did not wash their hands after scratching their head or ear, the potential harm to residents could result in acquiring a food borne illness. During a review of the facility's Job Description/Performance Evaluation, dated [DATE], the Job Title: Dietary Aide indicated, .the primary purpose of the position is to provide assistance in all dietary functions as directed/instructed and in accordance with established dietary policies and procedures. key/essential duties . use proper hand washing procedures and wash hands often; adhere to universal precautions and sanitary and infection control policies and procedures; adheres to sanitary infection control policies with clean and dirty dishes . During a review of the facility's Job Description/Performance Evaluation, dated [DATE], the Job Title: Manager, Dietary indicated, .the primary purpose of the DM .is to lead and manage the Dietary Department . Key/essential duties .All food storage meets regulation and standards. All kitchen and storage area meets regulations and standards .Comply with all Covenant Care policies and procedures. Demonstrate key competencies as required by the position and in accordance with State/Federal regulations. During a review of the facility's Job Description/Performance Evaluation, dated [DATE], the Job Title: Registered Dietician (RD) indicated, .key/essential duties: Evaluates and monitors the operations of Dietary Department to assure the provision of adequate, high-quality food .Monitors and recommends food service standards of sanitation, safety and infection control . Comply with all Covenant Care policies, procedures, and standards . (continued on next page)

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	056207	A. Building B. Wing	02/07/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled, Personnel Sanitation Standards, dated ,d+[DATE], the P&P indicated, .food and dining services personnel follow sanitary standards and practices. 3.0 Procedure: 1. food .personnel .will be required to adhere to the following sanitary standards: c. Hands must be washed . after touching the hair, mouth or nose, and at any other time it is necessary. D. Food .personnel must avoid personal habits such as touching face .when working in the food service area . 3. During a concurrent observation and interview on [DATE] at 8:10 a.m. with the DM in the kitchen, unlabeled and undated sealed, packaged, frozen meat was thawing in plastic bins on the bottom shelf of the walk-in refrigerator. The DM stated she had placed the frozen beef kabobs in the refrigerator the previous night and should have labeled and dated the kebobs. The DM stated all food should be labeled and dated to indicate the prepare by and use-by date. The DM stated the potential risk of not labeling food was, the kitchen staff could use old food as they would not know how long the food had been on the shelf. The DM stated old food could grow germs and if residents were served contaminated food, there could be potential for medically fragile residents to become ill. During an interview on [DATE] at 9:34 a.m. with COOK 1 in the kitchen, COOK 1 stated frozen meat should be labeled when thawed in the refrigerator overnight to be used the next day. COOK 1 stated if residents were served old food, the food could be contaminated which may cause resident sickness. During an interview on [DATE] at 9:43 a.m. with the RD in the RD's office in the kitchen, the RD stated she expected all food to be labeled and dated. The RD stated if staff did not label or date food, they would not be following facility policy. The RD stated unlabeled or undated foods created a potential risk of kitchen staff not knowing when food had expired or spoiled. The RD stated if residents were served expired or spoiled food, the residents could develop food borne illness. During a review of the facility's Job Description/Performance Evaluation, dated [DATE], the Job Title: [NAME] indicated, .key/essential duties: provide all dietary services in a safe manner and use proper sanitation and infection control measures .proper food handling, labeling with dates, and storage of all food items . During a review of the facility's Job Description/Performance Evaluation, dated [DATE], the Job Title: Manager, Dietary indicated, .the primary purpose of the DM .is to lead and manage the Dietary Department . Key/essential duties .All food storage meets regulation and standards. All kitchen and storage area meets regulations and standards .Comply with all Covenant Care policies and procedures. Demonstrate key competencies as required by the position and in accordance with State/Federal regulations. During a review of the facility's Job Description/Performance Evaluation, dated [DATE], the Job Title: Registered Dietician (RD) indicated, .key/essential duties: Evaluates and monitors the operations of Dietary Department to assure the provision of adequate, high-quality food .Monitors and recommends food service standards of sanitation, safety and infection control . Comply with all Covenant Care policies, procedures, and standards . During a review of the facility's P&P titled, Food Safety in Receiving and Storage, dated ,d+[DATE], the P&P indicated, .3. Food that is repackaged will be placed in a leak-proof .container .the container will be labeled with name of the contents and dated with the date it was transferred to the new container . (continued on next page)

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	056207	A. Building B. Wing	02/07/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. During a concurrent observation and interview on [DATE] at 8:20 a.m. with the DM in the food storage room, fine dark brown particles were identified on the ceiling above the storage room fan. The DM stated the fine dark particles were dust and the maintenance department was responsible to clean the fan and ceiling. The DM stated the risk of having dust in the storage room could result in poor circulation, which could affect temperature control thereby leading to spoiled food. The DM stated if spoiled food was served to the residents, the residents could develop food borne illnesses. During an interview on [DATE] at 3:02 p.m. with the Supervisor of Maintenance (MS), the MS stated maintenance department staff were responsible to clean the kitchen condenser fans in the storage room. The MS stated he was made aware of dust identified on the ceiling above the fan in the storage room. The MS stated the fan should be cleaned once a month or more often as needed. The MS stated a newly hired maintenance worker was assigned to clean the storage room fan and wiped the fan as instructed. The MS stated the maintenance worker was not instructed to wipe the dust on the ceiling. The MS stated he expected the maintenance worker to clean all dust from the food storage area which included the fans, the ceiling, and the walls. The MS stated dust in the storage room could create a fire hazard for the facility. During an interview on [DATE] at 9:43 a.m. with the RD in the RD's office in the kitchen, the RD stated the food storage area should be cleaned daily. The RD stated dust should not be on the ceiling as it may contaminate food which could lead to food borne illnesses for residents. During a review of the facility's Job Description/Performance Evaluation, dated [DATE], the Job Title: Manager, Dietary indicated, .the primary purpose of the DM .is to lead and manage the Dietary Department . Key/essential duties .All food storage meets regulation and standards. All kitchen and storage area meets regulations and standards .Comply with all Covenant Care policies and procedures. Demonstrate key competencies as required by the position and in accordance with State/Federal regulations. During a review of the facility's Job Description/Performance Evaluation, dated [DATE], the Job Title: Registered Dietician (RD) indicated, .key/essential duties: Evaluates and monitors the operations of Dietary Department to assure the provision of adequate, high-quality food .Monitors and recommends food service standards of sanitation, safety and infection control . Comply with all Covenant Care policies, procedures, and standards . During a review of the facility's Job Description/Performance Evaluation, dated (date), the Job Title: Supervisor, Maintenance (MS) indicated, .the primary purpose of this position is to lead and supervise the Maintenance function by utilizing available resources to ensure that the grounds, facility, equipment and mechanical systems function in accordance with federal, state and local standards, guidelines, and regulations and to assure the facility is maintained in a safe and effective manner. key/essential duties . ensure all required preventative maintenance is timely and effectively completed; survey-substantial compliance; comply with and supervise others to comply with .all laws and regulations; comply with all [name of facility] policies and procedures. During a review of the facility's P&P titled, Kitchen Sanitation & Cleaning Schedules, dated ,d+[DATE], the P&P indicated the facility was to, .ensure a clean and sanitary food environment. The P&P indicated, .1. The Food and Dining Services Manager develops, implements and monitors a cleaning schedule that assigns specific cleaning responsibilities to specific individuals .3.0 Procedure .6. All floors in the food .storage areas are washable .Walls and ceilings are also washable . (continued on next page)

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	056207	A. Building B. Wing	02/07/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the professional reference titled, 2022 Food Code U.S. Food and Drug Administration, dated [DATE], (found at https://www.fda.gov/media/164194/download?attachment) the reference indicated, XXX,d+[DATE].11 Food Storage .food shall be protected from contamination by storing the food: (2) where it is not exposed to .dust, or other contamination . Preventing contamination from the premises .pathogens can contaminate and/or grow in food that is not stored properly .drafts of unfiltered air can be sources of microbial contamination for stored food .

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	056207	A. Building B. Wing	02/07/2025

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48739 Based on interview and record review, the facility failed to ensure accurate and complete medical records in accordance with professional standards of practice were maintained for one of five sampled residents Resident 306, when the Physician Orders for Life-Sustaining Treatment (POLST- a form that contains written medical orders for healthcare professionals regarding specific medical treatments that can or cannot be done at the end-of life) was not complete. This failure had the potential for Resident 306's decisions regarding treatment options and end of life wishes to not be honored. Findings: During a concurrent observation and interview on [DATE] at 10:18 a.m. with Resident 306 in Resident 306's room, Resident 306 was observed dressed, lying in bed with oxygen infusing via nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) at 3L/min (Liters per minute - a unit of measurement). Resident 306 stated she had been at the facility for five or six days due to inability to walk. During a review of Resident 306's AR, dated [DATE], the AR indicated Resident 306 was admitted to the facility from the acute care hospital on [DATE] with diagnoses of Methicillin Resistant Staphylococcus Aureus (MRSA - a bacteria that does not get better with the type of antibiotics [a medication that inhibits or destroys infections caused by bacteria] that usually cure staph infections [infections that are caused by bacteria usually found on the skin or in the nose]), Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), and depression (a mental health disorder characterized by persistently depressed mood or loss of interest in activities). During a review of Resident 306's MDS, dated [DATE], the MDS section C indicated Resident 86 had a BIMS score of 15, which indicated Resident 86 was cognitively intact. During a review of Resident 306's Clinical Physician Orders, dated [DATE], the Clinical Physician Orders indicated, . do not resuscitate (DNR) . revision date . [DATE] . (continued on next page)

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	056207	A. Building B. Wing	02/07/2025

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on [DATE] at 1:35 p.m. with the MRA, Resident 306's chart was reviewed. The MRA stated there was no completed POLST on file for Resident 306. The MRA reviewed her resident list and Resident 306 had a zero marked by her name. The MRA stated a zero mark indicated a POLST was not completed for Resident 306. The MRA stated Resident 306 was admitted on [DATE]. The MRA stated a POLST was important in case Resident 306 had an emergency, such as not breathing. The MRA stated a POLST indicated to staff what the resident's code status (DNR - Do Not Resuscitate - a medical order written by a doctor to instruct health care providers NOT to do cardiopulmonary resuscitation [CPR - an emergency lifesaving procedure performed when breathing stops or the heart stops beating] if breathing stops or the heart stops beating) was. The MRA checked for a paper copy of Resident 306's POLST. The MRA stated Resident 306 did not have a POLST. The MRA stated Resident 306's POLST should have been discussed during admission. The MRA stated without a POLST, staff would perform a full code, including CPR, even if the resident was a DNR, which would go against the resident or family's wishes. During an interview on [DATE] at 2:51 p.m. with the Assistant Director of Nursing (ADON), the ADON stated the POLST was important because it stated medical interventions for any changes in the resident's medical condition. The ADON stated staff needed to respect the wishes of the resident. The ADON stated the POLST gave resident's decisions for code status, nutrition, etc. The ADON stated staff was to honor the rights of the resident for any kind of life sustaining treatment in any kind of emergency. The ADON stated having an incomplete POLST for one month was not acceptable. The ADON stated her expectation was for all residents to have a completed POLST. During a review of the facility's job description document titled, Health Information Manager, dated [DATE], the document indicated . monitors compliance of documentation via each of the clinical applications . follows [name of facility] auditing guidelines . provides required documentation needed triple-check . During a review of the facility's policy and procedure (P&P) titled, Admission Audit Best Practice Guidelines, undated, the P&P indicated, . objective . to ensure all admission health records are initiated and completed timely . it is the practice of this facility to audit all health records at 48 hours, 7 days, 14 days, 21 days, and at 30 days (if needed) . the Medical Records Department will initiate an admission audit within 72 hours of admission for each Resident entering the facility .

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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** 48739 Based on observation, interview, and record review, the facility failed to establish and maintain an effective infection prevention and control program for six of 17 sampled residents (Resident 34, 37, 152, 305, 306, and 505) when: 1. When Resident 34's handheld nebulizer mouthpiece (a piece of plastic that fits into a small, handheld machine that turns liquid medicine into a mist and resident inhale the mist through the mouthpiece for delivery of medication) was observed on top of the machine next to a urinal. 2. Resident 37's foley catheter (helps drain urine from your bladder) bag and tubing were on the ground. 3. Resident 152's urinal (a vessel used for receiving urine) containing urine was on top of Resident 152's bedside table with food, a glass of water, water pitcher and cell phone. 4. Enhanced Barrier Precautions (EBP- an infection control intervention designed to reduce transmission of resistant organisms [bacteria that have become resistant to certain antibiotics] that requires gown and glove use during high contact resident care activities) were not in place when licensed nurses provided wound care to Resident 152 and Resident 305's surgical wounds. 5. EBP were not followed by therapy staff when entering and performing Activities of Daily Living (ADL - the tasks of everyday life that include eating, dressing, getting into or out of a bed or chair, taking a bath or shower, and using the toilet) tasks with Resident 306. 6. Resident 505's nasal cannula (flexible tube with two prongs that fit inside the nostrils), and oxygen tubing (flexible tube connected to an oxygen source) were found on the floor. 7. An opened debridement tray (a sterile [free from germs]) medical kit containing necessary instruments used to remove dead, damaged, or infected bodily tissue to promote wound healing) containing a tweezer, scissor, and scalpel (a small straight thin-bladed knife used especially in surgery) was found on the bottom drawer of Station 1's treatment cart (a mobile cart with drawers stocked with supplies for wound care and dressing changes) where other unopened and clean wound dressing supplies were stored. 8. Staff's personal belongings including seven liquid container bottles, a backpack, piece of clothing (a jacket), and a cup were found inside Station 1's utility supplies room. One re-usable liquid container bottle was found next to a samples collection refrigerator where residents urine, stool, and culture samples were stored. One re-usable liquid container bottle and a cup was in the sink, and the backpack, article of clothing, and one disposable water bottle, and four re-usable liquid containers were on top of the counter. 9. An opened syringe outside its package was found in Station 1's medication room in a cabinet where clean, unopened syringes were stored. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	These failures placed residents at risk for cross-contamination (the process when germs are unintentionally transferred from one substance or object to another, which causes a harmful effect) and infection (an invasion of the body by germs that cause disease). Findings: 1. During a review of Resident 34 's Admission Record (AR-a document with personal identifiable and medical information), dated 2/6/25, the AR indicated, Resident 34 was admitted to the facility on [DATE] with diagnoses which included pneumonia (inflammation (a protective response of the body to harmful stimuli, such as infections, injuries, or toxins) and fluid in your lungs caused by a bacterial, viral or fungal infection), myasthenia gravis (chronic neuromuscular disease that causes weakness in the voluntary muscles), chronic obstruction pulmonary disease (COPD- group of lung diseases that cause airflow obstruction and breathing problems), pleural effusion (condition where excess fluid accumulates in the area between the lungs and the chest wall), and pain. During a review of Resident 34's Minimum Data Set (MDS-a functional and cognitive abilities assessment) assessment, dated 1/6/24, the MDS indicated the Brief Interview for Mental Status (BIMS) score was 15 out of 15 (a BIMS score of 13-15 indicates cognitively intact (having the ability to think, learn, and remember clearly)8-12 indicates moderately impaired and 0-7 indicates severe impairment), which indicated Resident 34 was cognitively intact. During a concurrent observation and interview on 2/3/25 at 11:17 a.m. in Resident 34's room, a nebulizer (a small machine that turns liquid medicine into a mist that can be easily inhaled) and handheld mouthpiece w observed on top of the machine next to a urinal. Resident 34 stated he used the nebulizer for shortness of breath. During a concurrent observation and interview on 2/3/25 at 2:18 p.m. with License Vocation nurse (LVN) 1, LVN 1 stated the handheld nebulizer mouthpiece should have been stored in a bag after each use. LVN 1 stated storing the handheld nebulizer mouthpiece in a bag was important to prevent cross contamination. LVN 1 stated Resident 34 was at risk for a respiratory infection when the handheld nebulizer mouthpiece was out on the table next to the urinal. LVN 1 stated nurses were responsible to store the nebulizer handheld mouthpiece away. During an interview on 2/7/25 at 4:10 p.m. with the Director of Infection Prevention (DIP), the DIP stated the nebulizer handheld mouthpiece should have been stored in a bag when not in use. The DIP stated storing the nebulizer handheld mouthpiece in a bag could prevent cross contamination. The DIP stated Resident 34 was at risk for respiratory infections. The DIP stated all nursing department were responsible for storing the nebulizer handheld mouthpiece in the bag. During an interview on 2/7/24 at 6:01 p.m. with the Director of Nursing (DON) the DON stated all nurses were expected to wash, dry, and put the nebulizer handheld mouthpiece in a clear plastic bag after each use. The DON stated the nebulizer handheld mouthpiece should have been in a clear plastic bag. The DON stated Resident 34 was at risk for respiratory infections from cross contamination. The DON stated all nurses and Infection Preventionists (IP) were responsible for ensuring the handheld nebulizer was stored correctly. The DON stated the nurses and IP did not follow the facility policy when the nebulizer handheld mouthpiece was not stored appropriately. (continued on next page)

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	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pacific Gardens Nursing and Rehabilitation Center	577 S. Peach Ave. Fresno, CA 93727

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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 (P&P) titled, Nebulized Medication/Handheld Nebulizer, dated 9/2016, the P&P indicated, .9. Discard any residue of the medication, rinse the nebulizer and mouthpiece. Shake to air dry and store in a plastic bag that is labeled with the resident name and room number . 2. During a review of Resident 37's Face Sheet (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 2/5/25, the Face Sheet indicated, Resident 37 was admitted to the facility on [DATE] with a diagnosis of cellulitis (a serious deep infection of the skin caused by bacteria) of the left lower limb, muscle weakness (loss of muscle strength), mild dementia (a brain condition that causes memory loss, thinking problems, and behavioral changes), neuromuscular dysfunction of the bladder (occurs when the nerves that control the bladder do not work properly) and peripheral vascular disease (a condition that occurs when blood vessels narrow or block, reducing blood flow to the arms and legs). During a review of Resident 37's Minimum Data Set (MDS - a resident assessment tool used to identify resident cognitive and physical function) assessment, dated 1/16/25, the MDS assessment indicated Resident 37's Brief Interview for Mental Status (BIMS -assessment of cognitive status for memory and judgment) assessment score was 15 out of 15 (a score of 13-15 indicates cognitively intact (a person is able to think clearly, remember things well, and make sound decisions, essentially having normal brain function with no significant problems with thinking, learning, or reasoning abilities), 08-12 indicates moderately impaired, and 00-07 indicates severe impairment). The BIMS assessment indicated Resident 37 was cognitively intact. During a concurrent observation and interview on 2/4/25 at 9:15 a.m. with Resident 37, in Resident 37's room, Resident 37's foley catheter bag and tubing was set on the floor by Certified Nursing Assistant (CNA) 11 while adjusting her wheelchair. Resident 37 stated she was unaware the bag and tubing were on the floor. During an interview on 2/6/25 at 10:27 a.m. with Registered Nurse (RN) 3, RN 3 stated she was the nurse for Resident 37. RN 3 stated Resident 37's catheter bag and tubing should never be on the floor. RN 3 stated this put the resident at risk for cross-contamination and the floor was a source of infection. RN 3 stated due to the resident's co-morbidities (when a person has more than one disease or condition at the same time) an infection for her could result in a hospitalization . During an interview on 2/6/25 at 11:07 a.m. with the Director of Staff Development (DSD), the DSD stated the CNA should have cleaned the tubing and the catheter bag after it hit the floor. The DSD stated this issue was an infection problem. During an interview on 2/7/25 at 2:15 p.m. with the Infection Preventionist (IP), the IP stated the tubing and catheter bag on the floor was an infection risk for Resident 37. The IP stated cross-contamination of bacteria could have occurred. The IP stated the CNA should have cleaned the bag and tubing with alcohol wipes. The IP stated the facility did not have a specific policy for staff to follow in terms of foley catheter maintenance and infection control. During an interview on 2/7/25 at 4:35 p.m. with the Director of Nursing, the DON stated the catheter and tubing on the ground was a safety issue for Resident 37. The DON stated she could have developed an infection from the cross-contamination. (continued on next page)

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	056207	A. Building B. Wing	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pacific Gardens Nursing and Rehabilitation Center	577 S. Peach Ave. Fresno, CA 93727

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a professional reference review from the Centers for Disease Control and Prevention (CDC) titled, Guideline for Prevention of Catheter-Associated Urinary Tract Infections 2009, dated 6/6/2019, (retrieved from https://www.cdc.gov/infection-control/media/pdfs/Guideline-CAUTI-H.pdf) the reference indicated, . Proper Techniques for Urinary Catheter Maintenance . 2. Keep the collecting bag below the level of the bladder at all times. Do not rest the bag on the floor . 3. During a concurrent observation and interview on 2/03/25 at 4:20 p.m. with Resident 152 in Resident 152's room, Resident 152 was observed dressed, sleeping in bed with a left below the knee amputation (BKA - surgical removal of the portion of the leg below the knee). Resident 152 stated he had been at the facility for a couple weeks due to a left BKA. Observed a bandage wrapped on Resident 152's left leg. No bruising observed. Observed urinal on bed side table containing urine, with residents reading glasses, phone, cup of water, water pitcher and sandwich on bedside table. During a review of Resident 152's Admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 2/6/25, the AR indicated Resident 152 was admitted to the facility from the acute care hospital on 1/17/25 with diagnoses of aftercare following surgical amputation (surgical removal of a body part), acquired absence of left leg below the knee, Type 2 Diabetes Mellitus (when the blood sugar levels in the body are too high), atrial fibrillation (an irregular heartbeat), peripheral vascular disease (the reduced circulation of blood to the arms or legs), Hepatitis B (an infection of the liver), and chronic obstructive pulmonary disease (COPD - a chronic lung disease causing difficulty in breathing). During a review of Resident 152's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 1/20/25, the MDS section C indicated Resident 152 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive (involving the process of thinking, learning and understanding) understanding on a scale of 1-15) score of 15 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which indicated Resident 152 was cognitively intact. During an interview on 2/05/25 at 10:13 with Certified Nursing Assistant (CNA) 16, CNA 16 stated it was not appropriate for a urinal to be on top of Resident 152's bed side table. CNA 16 stated a urinal on the bed side table was not adhering to Resident 152's dignity care plan and was not sanitary. CNA 16 stated the bedside table was where Resident 152 ate his meals. CNA 16 stated urine could have spilled on Resident 152's food and put Resident 152 at risk for infection. CNA 16 stated Resident 152 could have gotten sick. During a review of the facility's job description document titled, Certified Nursing Assistant (CNA), dated 11/13/17, the document indicated, . provide restorative assistance and support to maintain resident ADL function as per the plan of care . provide the clinical and support services needed to meet all physical and psycho-social needs of the residents and patients . maintains privacy and dignity while providing care and services . ensures resident personal care products/items are stored at bedside appropriate and are labeled/bagged as necessary . (continued on next page)

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	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/05/25 at 10:13 a.m. with CNA 16, CNA 16 stated staff received Infection Prevention training with the Infection Preventionist (IP). CNA 16 stated staff received in-services regarding what PPE to wear for residents on EBP. During an interview on 2/05/25 at 10:48 a.m. with the IP, the IP stated if a resident was on EBP, he would have put up a sign on the resident's door. The IP stated a resident would have met EBP criteria if they had an indwelling medical device, such as a catheter or chronic wound. The IP stated his understanding of a chronic wound was a wound present longer than 12 months. The IP stated stage III ulcers, or surgical sites did not require EBP precautions. The IP stated he gave training to staff two times a year, so staff would know what to do to keep residents safe. The IP stated staff training included Occupational Therapists and Physical Therapists. The IP stated if staff did not follow EBP with appropriate Personal Protective Equipment (Gowns, gloves, and masks), the risk of infections to residents increased. During a concurrent interview and record review on 2/05/25 at 3:16 p.m. with the IP, the facility's Infection Prevention Manual titled, Enhanced Barrier Precautions, dated 5/2024 was reviewed. The Manual indicated . an order for enhanced barrier precautions should be obtained for any of the following . wounds [e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers] and/or indwelling medical devices [e.g., central lines, urinary catheters, feeding tubes] . make gowns and gloves available immediately near or outside of the Resident's room. Note: face protection may also be needed if performing activity with risk of splash or spray [i.e., wound irrigation] . the Infection Preventionist should incorporate periodic adherence monitoring to determine additional training and education needs . The IP stated the facility used the Infection Prevention Manual's EBP policy and procedure (P&P) as the facility's P&P. The IP stated the facility was not following the P&P criteria for placing residents on EBP. The IP stated not following the P&P for EBP put residents at risk for infection. During an interview on 2/06/25 at 9:54 a.m. with LVN 3, LVN 3 stated the IP informed nurses on changes or updates to EBP practices. LVN 3 stated only residents with infections would have been on EBP. During an interview on 2/06/25 at 10:44 a.m. with the Director of Staff Development (DSD), the DSD stated the IP should notify staff if a resident was on EBP. The DSD stated she should notify the charge nurses to inform the CNAs of residents on EBP. The DSD stated carts and signs should have been placed next to the resident's room if on EBP. The IP stated her expectation was for staff to not expose residents to infections out of carelessness. During an interview on 2/06/25 at 2:51 p.m. with the Assistant Director of Nursing (ADON), the ADON stated her expectation was for staff to follow EBP practices and wear a gown for high contact care. The ADON stated if staff did not practice EBP precautions, there was an increased risk to spread infection to other residents. (continued on next page)

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	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pacific Gardens Nursing and Rehabilitation Center	577 S. Peach Ave. Fresno, CA 93727

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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 job duties titled, Infection Preventionist, undated, the job duties indicated, . participates in clinical meeting . to coordinate compliance with infection control policies and practices . directs compliance with . Infection Control Policies and Procedures . stays current on, and has working knowledge of regulatory standards for infection prevention and control; and accreditation standards . complies with training infection control standards in accordance with state and federal requirements - New hire and annual training . works with various departments to identify proper types of PPE, and proper use and fit procedures in accordance with IIPP and standards . 48430 6. During a concurrent observation and interview on 2/3/25 at 8:51 a.m. with Resident 505 in the resident's room, Resident 505 was sitting upright in bed wearing glasses, a dark blue sling cradled her right arm, and an oxygen nasal cannula and oxygen tubing were lying on the floor. Resident 505 was alert and oriented, able to state her name, date, location and was able to understand and answer questions. Resident 505 stated she did not use oxygen continuously and was not aware the tubing was on the ground. During a record review of Resident 505's Admission Record (AR), dated 2/6/25, the AR indicated, Resident 505 was admitted to the facility on [DATE] with diagnoses: fall with a left broken thigh bone surgically repaired with an artificial hip joint, uneven broken right collarbone, and difficulty breathing. During a review of Resident 505's Minimum Data Set (MDS-a federally mandated resident assessment tool), dated 2/4/25, the MDS section C indicated, Resident 505 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 14, which indicated Resident 505 was cognitively intact (without intellectual disability). During an interview on 2/3/25 at 09:01 a.m. with Certified Nurse Aide (CNA) 1 in Resident 505's room, CNA 1 stated the resident would decide when to use oxygen which was why the tubing was on the floor. CNA 1 stated the tubing should be kept in a bag and tied on the side of the oxygen concentrator (a medical device that extracts oxygen from air and filters it into a purer form for breathing) to keep it from getting contaminated and prevent the resident from getting an infection. During a concurrent observation and interview on 2/3/25 at 09:10 a.m. with Registered Nurse (RN) 1 in Resident 505's room, RN 1 stated the resident had an order for oxygen as needed. RN 1 stated the oxygen nasal cannula and tubing should not be on the floor due to the risk of cross contamination and infection. Observed RN 1 pick up and discard the tubing from the floor and replaced with a sealed package. During an interview on 2/5/25 at 10:29 a.m. with CNA 2 in a Resident 64's room, CNA 2 stated if a resident was on oxygen, the staff should ensure the tubing was properly placed in a plastic bag when not in use. CNA 2 stated if the oxygen tubing fell on the floor, staff should throw it away as the floor was dirty and germs could contaminate the tubing. CNA 2 stated if germs contaminated the tubing and was placed on the resident, it could put the resident at risk for infection. (continued on next page)

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	056207	A. Building B. Wing	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	056207	A. Building B. Wing	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pacific Gardens Nursing and Rehabilitation Center	577 S. Peach Ave. Fresno, CA 93727

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	056207	A. Building B. Wing	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/06/25 at 1:49 p.m. with the ADON, the ADON stated, staff personal belongings did not belong inside the utility supply room. The ADON stated, staff personal belongings were not sterile or clean and could have harbored germs and cross contaminated the clean supplies and caused infections to the residents. The ADON stated, the staff were given lockers in the employee breakrooms and a dedicated locker area to store their belongings. The ADON stated, no staff belongings should have been in any care area. During a review of the facility's P&P titled, Infection Prevention Manual For Long Term Care dated 05/2024, the P&P indicated, .Standard Precautions .include a group of infection prevention practices that apply to all patients .in any setting which healthcare is delivered .these practices include .environmental cleaning and disinfection .Compliance Monitoring .The Infection Preventionist and facility management will establish the methods for compliance monitoring for infection prevention .each new employee providing direct resident care shall be observed during observation .Specific compliance issues will be discussed with the individual employee involve [TRUNCATED]

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	02/07/2025

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 0924 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Put firmly secured handrails on each side of hallways. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48739 Based on observation and interview, the facility failed to ensure corridors were equipped with firmly secured handrails on each side of the corridor. This failure put residents at increased risk for falls when utilizing the handrail for assistance with walking. Findings: During an observation on 2/03/25 at 8:43 a.m. in the Station 2 Hallway, across from room [ROOM NUMBER], the handrail across the hall was observed to be broken and loose. The handrail next to room [ROOM NUMBER] on the west side of the doorway was observed to be missing a curved piece of wood exposing the metal bracket and screws. During an interview on 2/05/25 at 10:34 a.m. with the Maintenance Supervisor (MS), the MS stated the facility used the TELS System to notify his department of any issues that needed repair. The MS stated any staff could access the system for repairs. The MS stated he was notified of broken handrails, and they were repaired right away. The MS stated the curved ends of the handrails were obsolete and the facility could not replace them. The MS stated residents used the handrails for walking with the Rehabilitation Nursing Assistant (RNA). The MS stated broken and loose handrails placed residents at risk for injury. During a review of the facility's job description document titled, Supervisor, Maintenance, undated, the document indicated, . ensure timely and effective repairs to all systems, and equipment as required . ensure that all patient and resident rooms are properly maintained (furniture, wall covering, flooring, plumbing, lights, etc.) . During a review of the facility's policy and procedure (P&P) titled, Safe, Clean, Comfortable, and Homelike Environment, dated 6/2023, the P&P indicated, . in accordance with residents' rights, the facility will strive to provide a safe, clean, comfortable and homelike environment . that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk . refers to any environment in the facility that is frequented by residents, including (but not limited to) the residents' rooms, hallways . therapy areas . housekeeping and maintenance services will be provided as necessary . promptly reporting issues to maintenance department, such as . broken or unsafe facility equipment . ED, DON, and/or Maintenance/Housekeeping Supervisor should conduct regular facility rounds and provide general monitoring/oversight of efforts to maintain a safe, clean, comfortable environment . During a review of the facility's Maintenance Manual P&P titled, Scope of Services, dated 8/2014, the P&P indicated, .the Maintenance Department is responsible for the condition and function of the facility's physical plant, including all utilities, grounds, and equipment . all areas of the facility and equipment therein, are inspected and maintained in accordance with the TELS Preventive Maintenance Program .