STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056266	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fresno Nursing Center	3672 North First Street Fresno, CA 93726

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47205 Based on observation, interview and record review, the facility failed to ensure a physician obtained Informed Consents (a process in which residents are given important information of the possible risk and benefits of the use of psychoactive medications) for the use of psychotropic medications (medication capable of affecting mind, emotions, and behavior) was completed for four of ten sampled residents (Residents 2, 34, 41, and 50) when: 1. Resident 2 received Olanzapine (an antipsychotic medication that can treat several mental health conditions like schizophrenia (a mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions) and bipolar disorder (a mental health condition that affects your moods) without an informed consent. 2. Resident 34 received Quetiapine (an antipsychotic medication that treats several kinds of mental health conditions including schizophrenia and bipolar disorder) without an informed consent. 3. Resident 41 received Trazodone HCl (an antidepressant medication used to treat major depressive disorder, anxiety disorders, and insomnia) without an informed consent. 4. Resident 50 received Mirtazapine (an antidepressant medication used to treat major depressive disorder) without an informed consent. These failures resulted in Residents 2, 34, 41 and 50 to receive psychotropic medications without being fully informed of the risk and benefits of the medication being administered; preventing them from making an informed choice which placed the resident at risk of negative side effects. Findings: 1. During a review of Resident 2's Admission Record (AR-a document that provides resident contact details, a brief medical history, level of functioning, preferences, and wishes) dated 4/16/2024, the AR indicated, admitted [DATE] . Diagnosis Information . Schizophrenia (a mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions.) . During a review of Resident 2's Minimum Data Set Section C Cognitive Patterns (MDS-comprehensive, standardized assessment of residents' functional capabilities and health needs) indicated, .BIMS .13 [indicating normal cognitive level (related to thinking, learning and understanding)] . (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056266	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fresno Nursing Center	3672 North First Street Fresno, CA 93726

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 4/17/2024 at 1:15 p.m., in Resident 2's room, Resident 2 was propped up in bed and eating her lunch. Resident 2 stated she felt safe and gets good care. During a review of Resident 2's Order Summary Report (OSR) dated 3/1/2024, the OSR indicated . Olanzapine Give 10 mg (milligrams) by mouth at bedtime for paranoid delusions (reflect profound fear and anxiety along with the loss of the ability to tell what's real and what's not real) related to Schizophrenia .m/b (manifested by) screaming and yelling at others without purpose .order date 12/23/2023 . During a review of Resident 2's Medication Administration Record (MAR) dated 2/1/2024 through 2/29/2024, the MAR indicated .Olanzapine 10 mg by mouth at bedtime . was administered daily at 2100 hours (9 p.m.) during the month of February 2024. The MAR indicated resident refusal on 2/23/2024. During a review of Resident 2's Medication Administration Record (MAR) dated 3/1/2024 through 3/31/2024, the MAR indicated .Olanzapine 10 mg by mouth at bedtime . was administered daily at 2100 hours (9 p.m.) during the month of March 2024. During an interview on 4/19/2024 at 12:03 p.m , with Licensed Vocation Nurse (LVN) 2, LVN 2 stated when a psychotropic medication is ordered, a note is entered into the Electronic Medical Record (EMR), it is then printed out and signed by physician. LVN 2 stated they do not document the resident/RP choice on the form. LVN 2 stated the resident/RP does not sign anything. During a concurrent interview and record review on 4/23/24 at 2:39 p.m., with LVN 2 of Resident 2's Verification of Resident Informed Consent for Psychotherapeutic Drugs (VRICPD), dated 7/13/2022, the VRICPD indicated .Medications & Strength: Olanzapine 5 mg (milligrams-unit of measurement) 2 tabs (tablets) PO (by mouth) Q (every) HS (at bedtime) . LVN 2 stated the form is incomplete because Resident/RP and Physician signatures are not present on the form, there is no indication for use (Diagnosis) present on form. During a review of Resident 2's PMIC dated 8/3/2023, the PMIC indicated .3. Medication Name Olanzapine . Dose: 10 mg at bedtime .5. Indication for use Psychosis .6. Targeted behavior warranting the use of this medication M/B schizophrenia AEB (as evidenced by) screaming, yelling at others w/o (without) purpose . PMIC form indicated 9. Date consent obtained: 8/3/2023 . 11. Received Informed Consent From (Name) [brother] .Resident/RP and Physician signatures were not present on the PIMC. During an interview on 4/26/2024 at 10:05 a.m., with the Interim Director of Nursing (IDON), the IDON stated the current consents are missing physician documentation of the risks and benefits of the proposed antipsychotic medication has been had with either the resident or RP and current process is not requiring the resident/RP signs confirming their choice after being informed by the physician. IDON stated it is his expectation the form is filled out correctly, the provider should be obtaining consent and reviewing risk versus benefits with resident or RP and documenting that this task has been completed and filed/housed in EMR/paper chart. During a telephone interview on 4/26/2024 at 1:34 p.m., with Pharmacist (PharmD) 1, PharmD 1, stated any new or change in physician order for psychotropic medications requires a new [informed] consent to be signed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056266	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fresno Nursing Center	3672 North First Street Fresno, CA 93726

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 0552 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, Resident Rights, dated February 2021, the P&P indicated, .1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to .p. be informed of, and participate in, his or her care planning and treatment . During a review of the facility's P&P titled, Antipsychotic Medication Use, dated July 2022, the P&P indicated . 13. Residents (and/or resident representatives) will be informed of the recommendation, risks, benefits, purpose and potential adverse (negative) consequences of antipsychotic medication use. Residents (and/or representatives) may refuse medications of any kind . 2. During a review of Resident 34's Admission Record (AR-a document that provides resident contact details, a brief medical history, level of functioning, preferences, and wishes) dated 4/16/2024, the AR indicated, admitted [DATE] . Diagnosis Information . Delirium (a mental state in which you are confused, disoriented, and not able to think or remember clearly), adjustment disorder with depressed mood, bipolar disorder (a mental health condition that causes extreme mood swings that include emotional highs (mania or hypomania) and lows (depression) . During a review of Resident 34's Minimum Data Set Section C Cognitive Patterns (MDS-comprehensive, standardized assessment of residents' functional capabilities and health needs) indicated, .BIMS .12 [indicating moderate cognitive impairment] . During an observation on 4/16/24 at 3:53 p.m. in Resident 34's room, resident was lying in bed. Resident 34 states he has no concerns, is treated well, and has no complaints. During a review of Resident 34's Order Summary Report (OSR) dated 3/1/2024, the OSR indicated . Quetiapine 100 mg .give 10 mg by mouth one time a day related to bipolar disorder m/b angry outburst . order date 2/28/2024. During a review of Resident 34's MAR dated 2/1/2024 through 2/29/2024, the MAR indicated .Quetiapine 100 mg .give 1 tablet by mouth one time a day . was administered at 2100 hours (9 p.m.) on 2/1, 2/8, and 2/12/24. The MAR indicated resident refusal on 2/2 through 2/7, 2/9 through 2/11 and 2/13 through 2/15/24. During a review of Resident 34's MAR dated 3/1/2024 through 3/31/2024, the MAR indicated .Quetiapine 100 mg .give 1 tablet by mouth one time a day . was administered at 2100 hours (9 p.m.) on 3/1, 3/2, 3/5 through 3/9, 3/12 through 3/16, 3/20, 3/22, 3/23, 3/25, 3/28, and 3/29/2024. The MAR indicated resident refusal on 3/3, 3/4, 3/10, 3/11, 3/17, 3/18, 3/19, 3/21, 3/24, 3/26, 3/27, 3/30, and 3/31/2024. During an interview on 4/19/2024 at 12:03 p.m., with Licensed Vocation Nurse (LVN) 2, LVN 2 stated when a psychotropic medication is ordered, a note is entered into the Electronic Medical Record (EMR), it is then printed out and signed by physician. LVN 2 stated they do not document the resident/RP choice on the form. LVN 2 stated the resident/RP does not sign anything. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056266	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fresno Nursing Center	3672 North First Street Fresno, CA 93726

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 4/23/24 at 2:45 p.m., with LVN 2 of Resident 34's Psychoactive Medication: Informed Consent California v1 (PMIC), dated 2/28/2024, the PMIC indicated .3. Quetiapine 100 mg . 5. Indication for use (Diagnosis) bipolar disorder .6. Targeted behavior warranting the use of this medication manifested by (m/b) angry outburst .13. Prescriber signature: present. LVN 2 stated Resident 34 is his own RP and that there is no RP signature on the PMIC form indicating Resident 34's consent to be administered the ordered psychotropic medication ordered. During an interview on 4/26/2024 at 10:05 a.m., with the Interim Director of Nursing (IDON), the IDON stated the current consents are missing physician documentation of the risks and benefits of the proposed antipsychotic medication has been had with either the resident or RP and current process is not requiring the resident/RP signs confirming their choice after being informed by the physician. IDON stated it is his expectation the form is filled out correctly, the provider should be obtaining consent and reviewing risk versus benefits with resident or RP and documenting that this task has been completed and filed/housed in EMR/paper chart. During a telephone interview on 4/26/2024 at 1:34 p.m., with Pharmacist (PharmD) 1, PharmD 1, stated any new or change in physician order for psychotropic medications requires a new [informed] consent to be signed. During a review of the facility's policy and procedure (P&P) titled, Resident Rights, dated February 2021, the P&P indicated, .1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to .p. be informed of, and participate in, his or her care planning and treatment . During a review of the facility's P&P titled, Antipsychotic Medication Use, dated July 2022, the P&P indicated . 13. Residents (and/or resident representatives) will be informed of the recommendation, risks, benefits, purpose and potential adverse (negative) consequences. 3. During a review of Resident 41's Admission Record (AR-a document that provides resident contact details, a brief medical history, level of functioning, preferences, and wishes) dated 4/16/2024, the AR indicated, admitted [DATE] . Diagnosis Information . insomnia (inability to sleep), major depressive disorder (a common and serious mental disorder that negatively affects how you feel, think, act, and perceive the world.), alcohol dependence in remission (a decrease in or disappearance of signs and symptoms of) . During a review of Resident 41's Minimum Data Set Section C Cognitive Patterns (MDS-comprehensive, standardized assessment of residents' functional capabilities and health needs) indicated, .BIMS .14 [indicating normal cognitive level] . During an observation on 4/16/24 at 2:32 p.m. Resident 41 was seated at side of the bed wearing a hospital gown. Resident 41 stated he had no concerns; staff treat him well. During a review of Resident 41's Order Summary Report (OSR) dated 3/1/2024, the OSR indicated . Trazodone HCl give 50 mg by mouth at bedtime for inability to sleep . order date 12/19/2023. During a review of Resident 41's MAR dated 2/1/2024 through 2/29/2024, the MAR indicated .Trazodone HCl .give 50 mg by mouth one time a day . was administered at 2100 hours (9 p.m.) from 2/1/2024 to 2/29/2024. The MAR indicated resident refusal on 2/9, 2/10, 2/16, and 2/17/2024. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056266	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fresno Nursing Center	3672 North First Street Fresno, CA 93726

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 41's MAR dated 3/1/2024 through 3/31/2024, the MAR indicated .Trazodone HCl .give 50 mg by mouth one time a day . was administered at 2100 hours (9 p.m.) from 3/1/2024 to 3/31/2024. The MAR indicated resident refusal on 3/20/2024. During an interview on 4/19/2024 at 12:03 p.m , with Licensed Vocation Nurse (LVN) 2, LVN 2 stated when a psychotropic medication is ordered, a note is entered into the Electronic Medical Record (EMR), it is then printed out and signed by physician. LVN 2 stated they do not document the resident/RP choice on the form. LVN 2 stated the resident/RP does not sign anything. During a concurrent interview and record review on 4/23/24 at 2:52 p.m., with LVN 2 of Resident 41's VRICPD, dated 6/15/2023, .Medications & Strength: Trazodone HCl 50 mg tab .Dose to give 1 tab PO QHS . LVN 2 stated the form is incomplete because Resident/RP signature is not present on the form, and there is no indication for use (Diagnosis) present on form. During an interview on 4/26/2024 at 10:05 a.m., with the Interim Director of Nursing (IDON), the IDON stated the current consents are missing physician documentation of the risks and benefits of the proposed antipsychotic medication has been had with either the resident or RP and current process is not requiring the resident/RP signs confirming their choice after being informed by the physician. IDON stated it is his expectation the form is filled out correctly, the provider should be obtaining consent and reviewing risk versus benefits with resident or RP and documenting that this task has been completed and filed/housed in EMR/paper chart. During a telephone interview on 4/26/2024 at 1:34 p.m., with Pharmacist (PharmD) 1, PharmD 1, stated any new or change in physician order for psychotropic medications requires a new [informed] consent to be signed. During a review of the facility's policy and procedure (P&P) titled, Resident Rights, dated February 2021, the P&P indicated, .1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to .p. be informed of, and participate in, his or her care planning and treatment . During a review of the facility's P&P titled, Antipsychotic Medication Use, dated July 2022, the P&P indicated . 13. Residents (and/or resident representatives) will be informed of the recommendation, risks, benefits, purpose and potential adverse (negative) consequences of antipsychotic medication use. Residents (and/or representatives) may refuse medications of any kind . 4. During a review of Resident 50's Admission Record (AR-a document that provides resident contact details, a brief medical history, level of functioning, preferences, and wishes) dated 4/16/2024, the AR indicated, admitted [DATE] . Diagnosis Information . Schizophrenia . Psychosis (a collection of symptoms that affect the mind, where there has been some loss of contact with reality.) not due to a substance or known physiological condition . anxiety disorder (a condition in which a person has excessive worry and feelings of fear, dread, and uneasiness), major depressive disorder . During a review of Resident 50's Minimum Data Set Section C Cognitive Patterns (MDS-comprehensive, standardized assessment of residents' functional capabilities and health needs) indicated, .BIMS .6 [indicating severe cognitive impairment] . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056266	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fresno Nursing Center	3672 North First Street Fresno, CA 93726

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 4/16/2024 at 4:03 p.m., Resident 50 was seated in a wheelchair at doorway to his room, resident was smiling, and his hair was not combed. Resident denies any concerns with care. During a review of Resident 50's Order Summary Report (OSR) dated 3/1/2024, the OSR indicated . Mirtazapine Oral tablet 15 mg give 1 tablet by mouth at bedtime for depression . order date 12/9/2023. During a review of Resident 50's MAR dated 2/1/2024 through 2/29/2024, the MAR indicated .Mirtazapine Oral tablet 15 mg give 1 tablet by mouth at bedtime for depression . was administered at 2100 hours (9 p.m.) from 2/1/2024 to 2/29/2024. During a review of Resident 50's MAR dated 3/1/2024 through 3/31/2024, the MAR indicated .Mirtazapine Oral tablet 15 mg give 1 tablet by mouth at bedtime for depression . was administered at 2100 hours (9 p.m.) from 3/1/2024 to 3/31/2024. The MAR indicated resident refusal on 3/5/2024. During an interview on 4/19/2024 at 12:03 p.m , with Licensed Vocation Nurse (LVN) 2, LVN 2 stated when a psychotropic medication is ordered, a note is entered into the Electronic Medical Record (EMR), it is then printed out and signed by physician. LVN 2 stated they do not document the resident/RP choice on the form. LVN 2 stated the resident/RP does not sign anything. During a concurrent interview and record review on 4/23/24 at 2:59 p.m., with LVN 2 of Resident 50's PMIC, dated 12/9/2023, the PMIC indicated .3. Mirtazapine Dose 15 mg . 5. Indication for use (Diagnosis) Depression .6. Targeted behavior warranting the use of this medication m/b eating < (less than) 50% [of meals] . LVN 2 stated Resident 50 and Physician's signatures are not present on the PMIC. During an interview on 4/26/2024 at 10:05 a.m., with the Interim Director of Nursing (IDON), the IDON stated the current consents are missing physician documentation of the risks and benefits of the proposed antipsychotic medication has been had with either the resident or RP and current process is not requiring the resident/RP signs confirming their choice after being informed by the physician. IDON stated it is his expectation the form is filled out correctly, the provider should be obtaining consent and reviewing risk versus benefits with resident or RP and documenting that this task has been completed and filed/housed in EMR/paper chart. During a telephone interview on 4/26/2024 at 1:34 p.m., with Pharmacist (PharmD) 1, PharmD 1, stated any new or change in physician order for psychotropic medications requires a new [informed] consent to be signed. During a review of the facility's policy and procedure (P&P) titled, Resident Rights, dated February 2021, the P&P indicated, .1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to .p. be informed of, and participate in, his or her care planning and treatment . During a review of the facility's P&P titled, Antipsychotic Medication Use, dated July 2022, the P&P indicated . 13. Residents (and/or resident representatives) will be informed of the recommendation, risks, benefits, purpose and potential adverse (negative) consequences of antipsychotic medication use. Residents (and/or representatives) may refuse medications of any kind .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056266	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fresno Nursing Center	3672 North First Street Fresno, CA 93726

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 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** 48430 Based on observation, interview, and record review, the facility failed to provide a homelike environment for 10 of 16 sampled residents (Residents 1, 7, 26, 29, 35, 39, 45, 48, 53, and 271) when: 1. Residents 1, 7, 26 and 271's shared bathroom had blackened floor tiles with dirt on the floor, a loose doorknob with the doorknob plate hanging on the doorknob, missing paint and chipped areas on the lower bathroom door frame, and scattered black areas measuring one-half to two inches on the bathroom ceiling and a hole on the bathroom ceiling measuring two and one-half by two inches. Residents 1,7,26 and 271 2. Resident 29 and 53's joint bathroom had a discolored bathroom ceiling with bubbling and peeling paint. 3. Resident 35's wall guard protector (devices installed into walls made to stop beds and equipment from touching walls) was found to have peeling paint, and a large hole. 4. Resident 39's room had an exposed floor with missing tiles and visible dirt. 5. Resident 45's bathroom was observed to have dirt and a yellow spot on the floor. The toilet had yellow fluid in the bowl and there was a white substance on the toilet seat. The wooden lower door frame of the bathroom was chipped and had missing pieces of wood. The hole in the ceiling had a hardened yellow substance not fully covering the hole. 6. There was low water pressure, with water trickling out of the faucet in Resident 48's bathroom Resident 48. These failures resulted in Residents 1, 7, 26, 29, 35, 39, 45, 48, 53, and 271 not being provided a safe, comfortable, and clean homelike environment. Findings: 1. During an observation on 4/16/24 at 11:09 a.m. in Resident 1, 7, 26 and 271's shared bathroom, the bathroom floor was observed with dirt and black areas on the floor. The lower door frame to Resident 7's bathroom was chipped and missing paint. The doorknob was loose, with the doorknob plate hanging on the doorknob in Resident 7's bathroom. The bathroom ceiling was observed to have blackened areas measuring one-half to two inches, with a two and one-half by two-inch hole in the ceiling in Resident 7's bathroom. During a review of Resident 1's Admission Record (AR), dated 4/19/24, the AR indicated Resident 1 was admitted on [DATE] with diagnoses of acute respiratory failure acute respiratory failure (a serious condition that occurs when the lungs cannot get enough oxygen into the blood or remove enough carbon dioxide [a waste gas] from the blood) with hypoxia (absence of enough oxygen in the tissues to sustain bodily functions), pleural effusion (a buildup of fluid between the tissues that line the lungs and the chest) . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056266	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fresno Nursing Center	3672 North First Street Fresno, CA 93726

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/18/24 at 10:59 with the Infection Preventionist (IP), the IP stated the black spots on Resident 1, 7, 26, and 271's shared bathroom ceiling was possibly mold. The IP stated the black spots looked like they had been there a while. The IP stated the ceiling with black spots should not be that way. The IP stated the black spots were mold, it could cause respiratory issues and different illnesses for our clients. The IP stated it would need to be corrected right away. The IP stated the dirty floors and chipped doorway could cause abrasions and spread bacteria. The IP stated having dirty floors and chipped doorways was a dignity issue and not a homelike environment. The IP stated if residents used a dirty toilet, it could spread infections or bacteria. The IP stated a dirty toilet was not a homelike environment and residents could get sick. During a concurrent observation and interview on 4/18/24 at 11:11 a.m. with the IP and the Administrator (Admin.) in Resident 1, 7 26, and 271's shared bathroom, Resident 1, 7, 26 and 271's bathroom ceiling with black spots and a hole by the fire sprinkler was observed. The Admin. stated the bathroom ceiling was not acceptable. The Admin. stated the bathroom smelled like it needed to be aired out. The Admin. stated he suspected the black areas in the ceiling were due to standing water. The IP stated if there is water leakage, it could turn to mold if it continued. During a concurrent observation and interview on 4/18/24 at 11:32 a.m. with the Environmental Services Director (ESD) in Resident 1, 7, 26, and 271's bathroom, the bathroom and bathroom ceiling were observed. The ESD stated the facility had an Air Conditioner (AC) leak. The ESD stated he suspected the black areas on the ceiling were mold. The ESD stated he would bleach the area really well. The ESD stated he would not move the residents in the attached rooms when he bleached the ceiling but would close the bathroom door and have the bathroom fan on. The ESD stated he did not usually test for mold. The ESD observed the broken door handle in Resident 7 and 271's shared bathroom and reattached the door handle plate. The ESD observed the chipped edges on Resident 1, 7, 26, and 271's bathroom door frame. The ESD stated the chipped edges were not a homelike environment. The ESD stated residents could get injured if they bumped into the edges of the door frame. The ESD stated staff communicated repairs to him through an electronic maintenance system (TELS). The ESD stated if he was in the facility, staff would just tell him. The ESD stated there was no written logbook. During a review of the facility's policy and procedure (P&P) titled, Maintenance Service, dated 12/2009, indicated, . the Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times . maintaining the building in good repair and free from hazards . maintaining the heat/cooling system, plumbing fixtures, wiring, etc., in good working order . maintenance personnel shall follow the manufacturer's recommended maintenance schedule . the Maintenance Director is responsible for maintaining the following records/reports . inspection of building . work order requests . maintenance schedules . records shall be maintained in the Maintenance Director's office . maintenance personnel shall follow established safety regulations to ensure the safety and well-being of all concerned . During a review of the facility's policy and procedure (P&P) titled, Homelike Environment, dated 2/2021, indicated, . residents are provided with a safe, clean, comfortable and homelike environment . these characteristics include . clean, sanitary and orderly environment . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056266	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fresno Nursing Center	3672 North First Street Fresno, CA 93726

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled Cleaning and Disinfection of Environmental Surfaces, dated 8/2019, indicated, . non-critical items are those that come in contact with intact skin but not mucous membranes . non-critical environmental surfaces include bed rails, some food utensils, bedside tables, furniture and floors . housekeeping surfaces (e.g., floors, tabletops) will be cleaned on a regular basis, when spills occur, and when these surfaces are visibly soiled . 2. During a concurrent observation and interview on 04/16/24 at 10:12 a.m. with Licensed Vocational Nurse (LVN) 5 in Resident 29's and 53's joint bathroom, on the bathroom ceiling had yellow stains and peeling paint. LVN 5 stated, the ceiling had yellow and brown stains as well as peeling paint in the bathroom ceiling. LVN 5 stated, the stains could possibly be water stains. LVN 5 stated, this is not a home-like environment and needed to be repaired. During a concurrent observation and interview on 04/18/24 at 11:15 a.m. with the Administrator (ADM), inside Resident 29's and 53's joint bathroom, the ADM stated, stated the brown and yellow stains in the ceiling could be water leakage and agreed that it is not a homelike environment. During a concurrent observation and interview on 04/18/24 at 11:40 a.m. with the Environmental Service Director (ESD) in Resident 29's and 53 joint bathrooms, the ESD stated, the stains could be the result of water leakage. The ESD stated, this had to be repaired so the environment could more homelike. During an interview on 04/24/24 at 11:39 a.m., with the Interim Director of Nurses (IDON), the IDON stated, the water stains and leakage in the bathroom ceiling should have been fixed. The IDON stated, the stains and leaks do not make for a homelike environment. During a review of the facility's policy and procedure (P&P), titled, Homelike Environment, dated February 2021, the P&P indicated, The facility staff and management maximizes, to the extent possible .a .homelike setting. These characteristics include .clean .environment. During a review of the facility's P&P titled, Resident Rights, dated February 2021, the P&P indicated, Federal and state laws guarantee .a dignified existence. During a review of the facility's (P&P), titled, Maintenance Service, dated December 2009, the P&P indicated, Maintenance service shall be provided to all areas of the building, grounds, and equipment. The P&P indicated, .maintenance department is responsible for maintaining the building .and equipment in a safe and operable manner at all times. The P&P indicated, .maintaining the building in good repair and free from hazards. 3. During a concurrent observation and interview on 04/16/24 at 10:21 a.m. with Licensed Vocational Nurse (LVN) 4, in Resident 35's room, a wall guard protector had peeling paint and had a hole with sharp edges. LVN 5 stated, the wall guard had peeling paint as well having sharp edges from the hole which might cause a potential for injury for residents. LVN 5 stated, this is not a homelike environment and must be repaired. During an interview on 04/16/24 at 11:12 a.m. with the Environmental Service Director (ESD), the ESD stated, this [peeling paint and hole in the wall guard] isn't acceptable and needs to be repaired. The ESD stated, this doesn't add to a homelike environment. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056266	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fresno Nursing Center	3672 North First Street Fresno, CA 93726

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/24/24 at 11:39 a.m., with the Interim Director of Nurses (IDON), the IDON stated, the peeling paint and hole in Resident 35's room does not make for a homelike environment and needs to be repaired. During a review of the facility's policy and procedure (P&P), titled, Homelike Environment, dated February 2021, the P&P indicated, The facility staff and management maximizes, to the extent possible .a .homelike setting. These characteristics include: .clean .environment. During a review of the facility's (P&P), titled, Maintenance Service, dated December 2009, the P&P indicated, Maintenance service shall be provided to all areas of the building, grounds, and equipment. The P&P indicated, .maintenance department is responsible for maintaining the building .and equipment in a safe and operable manner at all times. The P&P indicated, .maintaining the building in good repair and free from hazards. 4. During a concurrent observation and interview on 4/16/24 at 11:26 a.m. with Certified Nursing Assistant (CNA) 3 in Resident 39's room, the floor was observed with missing tile and dirt in the untiled flooring areas by the sliding door. CNA 3 stated there is a build up of dirt on the floor where the tile is missing. CNA 3 stated the floor is dirty and it could have bacteria. During a review of the facility's policy and procedure (P&P) titled, Homelike Environment, dated 2/2021, indicated, . residents are provided with a safe, clean, comfortable and homelike environment . these characteristics include . clean, sanitary and orderly environment . 5. During a concurrent observation and interview on 4/17/24 at 9:00 a.m. with CNA 4 in Resident 45's, bathroom, Resident 45's bathroom floor was observed to have dirt on the floor, and a yellow spot on the floor in front of the toilet. Resident 45's toilet had yellow fluid in it and the toilet seat in Resident 45's bathroom had a white substance on the seat. The lower door frame in Resident 45's bathroom was chipped with paint missing. CNA 4 stated Resident 45's toilet chair needed to be cleaned due to possible body secretions. CNA 4 stated the CNAs clean the toilets. CNA 4 stated Resident 45's bathroom floor looked like it was stained. CNA 4 stated housekeeping cleaned the floors. CNA 4 stated the chipped door frame could cause a cut or injury if the resident rubs against it. During a review of Resident 45's AR, dated 4/17/24, the AR indicated Resident 45 was admitted on [DATE] with diagnoses of acute respiratory failure (a serious condition that occurs when the lungs cannot get enough oxygen into the blood or remove enough carbon dioxide [a waste gas] from the blood), cognitive communication deficit, heart failure, acute kidney failure . During a review of the facility's policy and procedure (P&P) titled, Maintenance Service, dated 12/2009, indicated, . the Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times . maintaining the building in good repair and free from hazards . During a review of the facility's policy and procedure (P&P) titled, Homelike Environment, dated 2/2021, indicated, . residents are provided with a safe, clean, comfortable and homelike environment . these characteristics include . clean, sanitary and orderly environment . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056266	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fresno Nursing Center	3672 North First Street Fresno, CA 93726

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled Cleaning and Disinfection of Environmental Surfaces, dated 8/2019, indicated, . non-critical items are those that come in contact with intact skin but not mucous membranes . non-critical environmental surfaces include bed rails, some food utensils, bedside tables, furniture and floors . housekeeping surfaces (e.g., floors, tabletops) will be cleaned on a regular basis, when spills occur, and when these surfaces are visibly soiled . 6. During a concurrent observation and interview on 4/16/24 at 4:19 p.m. with Resident 48, in Resident 48's room, Resident 48 was observed dressed in her wheelchair. Observed low water pressure with water trickling out in Resident 48's bathroom sink and peeling paint with exposed drywall in Resident 48's bathroom. Resident 48 stated she had told staff and the maintenance about the water pressure being low. Resident 48 stated it took a long time to get warm water . During an interview on 4/26/24 at 10:52 a.m. with the IDON, the IDON stated low water pressure in the resident's bathroom sink was not a homelike environment. The IDON stated residents would not be able to properly wash their hands. The IDON stated it could lead to potential infection. The IDON stated residents should have appropriate water pressure in their bathroom sinks. During a review of the facility's policy and procedure (P&P) titled, Maintenance Service, dated 12/2009, indicated, . the Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times . maintaining the building in good repair and free from hazards . During a review of the facility's policy and procedure (P&P) titled, Homelike Environment, dated 2/2021, indicated, . residents are provided with a safe, clean, comfortable and homelike environment . these characteristics include . clean, sanitary and orderly environment . 48739

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056266	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fresno Nursing Center	3672 North First Street Fresno, CA 93726

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 49769 Based on 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 four of 62 sampled residents (Resident 11, Resident 41, Resident 44, and Resident 45)) when: 1. Resident 45 did not have an individualized care plan developed and implemented for unintentional severe weight loss until 41 days after admission. This failure placed Resident 45 at risk for complications from not having care needs planned by licensed nurses to determine if nursing interventions needed to be added, changed, or completed. 2. Resident 11 did not have a person-centered CP to address his dental needs. This failure resulted in resident 11's dental and nutrition needs to go unmet. 3. Residents 41 and 44 did not have a person-centered CP to address the use of oxygen (O2) therapy. This failure resulted in Resident 41's oxygen needs to go unmet and caused Resident 44 to receive unnecessary oxygen therapy. Findings: 1. During a review of Resident 45's Admission Record (document containing resident demographic information and medical diagnosis) showed Resident 45 was admitted to the facility on [DATE], readmitted [DATE]. During a review of Resident 45's History and Physical (H&P-formal document that physicians produce through the interview with the patient, physical exam, and the summary of the testing either obtained or pending), undated, the H&P indicated, Resident 45 was admitted from a hospital for fall on 3/6/24 to the facility, with a diagnoses that included weakness, deconditioning (the decline in physical function of the body as a result of physical inactivity and/or bedrest or an extremely sedentary lifestyle), history of falling. The H&P indicated .Plan .The patient will be observed and monitored for progress and worsening of overall well-being .and plan will be modified accordingly . During a review of Resident 45's Minimum Data Set (MDS-tool for implementing standardized assessment and for facilitating care management in nursing homes), dated 3/27/24, the MDS Section K-Swallowing/Nutritional Status, K0300 Weight Loss, indicated Resident 34 had a 5% or more weight loss in the last month and was not on physician-prescribed weight-loss regimen. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056266	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fresno Nursing Center	3672 North First Street Fresno, CA 93726

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 45's Care Area Assessment Worksheet (CAA-provides guidance on how to focus on key issues identified during a comprehensive MDS assessment and serves as the link between the MDS and the Care Plan [CP]), dated 3/27/24, the CAA indicated through MDS assessment Patient 45 had a triggering condition due to a weight loss of 5% or more in the last month that was not on prescribed weight-loss regimen. The CAA indicated that nutritional status will be addressed in the care plan. During a review of Resident 45's Comprehensive Care Plans (CCP), Resident 45's CCP did not include a care plan for Resident 45's severe weight loss until 4/16/24. During a review of the facility's policy and procedure titled, Comprehensive Assessments (CA), dated 10/23, the P&P indicated, Comprehensive MDS assessments are conducted to assist in developing person-centered care plans .3. A comprehensive assessment includes .c. development of the comprehensive care plan . During a review of the facility's policy and procedure titled, Care Planning-Interdisciplinary Team, undated, the P&P indicated, .1. Resident care plan are developed according to the timeframe's and criteria established by S 483.21. S 483.21 indicated, .(2) A comprehensive care plan must be .(i) Developed within 7 days after completion of the comprehensive assessment. During a concurrent interview and record review on 4/18/24 at 11:39 a.m. with the Director of Nursing (DON), Resident 45's EMAR was reviewed. The DON verified the care plan should have been done before it was and the care plan was late. 47205 2. During a concurrent observation and interview on 4/16/2024 at 3:45 p.m., with Resident 11, in Resident 11's room, Resident 11 stated he has a hard time eating hard to chew foods like meat, so he does not eat it. Resident 11 stated that he has repeatedly asked facility staff for help with obtaining dentures to help him with eating his meals. During a review of Resident 11's Admission Record (AR-a document that provides resident contact details, a brief medical history, level of functioning, preferences, and wishes) dated 4/16/2024, the AR indicated, admitted [DATE] . Diagnosis Information . Dysphasia (swallowing difficulties), dependence on renal (kidney) dialysis (treatment that removes toxins [poison] from the blood . Diabetes (high blood sugar levels) . During a review of Resident 11's Minimum Data Set Section C -Cognitive Patterns (MDS-comprehensive, standardized assessment of residents' functional capabilities and health needs), dated 3/2/2024, the BIMS score indicated, .BIMS .15 [indicating normal level of cognition (related to thinking, learning and understanding)] . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056266	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fresno Nursing Center	3672 North First Street Fresno, CA 93726

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 4/18/2024 at 2:13 p.m., with Licensed Vocational Nurse (LVN) 3, LVN 3 stated she is aware that Resident 11 would like to have upper dentures. LVN 3 stated she is not able to find documentation of Resident 11's request for dentures in the Electronic Medical Record (EMR). LVN 3 stated that the facility Social Services Director (SSD) had set up dentist to come out to the facility, but Resident 11 has been out of facility when they have come out. LVN 3 stated the current CP for Resident 11 did not include dental needs. LVN 3 stated that once the Licensed Nurse (LN) learned of Resident 11's request a CP should have been initiated and a referral sent to the SSD to follow up on a dental evaluation appointment. During an interview on 4/18/24 at 2:17 p.m., with SSD, the SSD stated she had recently returned to the facility as the SSD and had not been made aware of Resident 11's request for dentures. During a concurrent interview and record review on 4/18/2024 at 2:32 p.m., with LVN 3, LVN 3 stated Resident 11 did not have a care plan (CP) for dentures or dental needs present in the Electronic Medical Record (EMR). LVN 3 stated a CP is the nurses plan for care of the resident, without a CP the nurse would not know how to meet the residents needs. During a review of the facility's policy and procedure (P&P), titled, Care Plans, Comprehensive Person-Centered, dated March 2022, the P&P indicated, Policy Statement A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implement for each resident .4. Each resident's comprehensive person-centered care plan is consistent with the resident's rights to participate in the development and implementation of his or her plan of care, including the right to: a. participate in the planning process; .d. request revisions to the plan of care; .g. receive the services and/or items included in the plan of care .7. The comprehensive, person-centered care plan . b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being . c. includes the resident's stated goals upon admission and desired outcomes .11. Assessments of residents are ongoing and care plans are revised as information about the resident's and the resident's conditions change .12. The interdisciplinary team (IDT) review and update the care plan . 3. During an observation on 04/16/2024 at 11:10 a.m., Resident 44 was wearing a nasal cannula (NC- while seated in a wheelchair in the facility television area. During a review of Resident 44's AR dated 4/16/2024, the AR indicated, admitted [DATE] . Diagnosis Information . Dependence on renal (kidney) dialysis (treatment that removes toxins [poison] from the blood . Anemia (too few red blood cells in the body) . Congestive Heart Failure (CHF- a long-term condition in which your heart can't pump blood well enough to meet your body's needs) . During a review of Resident 44's MDS, the MDS section C, dated 3/22/2024, indicated, .BIMS .14 [indicating normal level of cognition (related to thinking, learning and understanding)] . During a review of Resident 44's OSR, dated 2/27/2024, the OSR indicated, there was no physician order for oxygen therapy administration present in the Electronic Medical Record (EMR) from 3/1/2024 through date of record review 4/16/2024. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056266	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fresno Nursing Center	3672 North First Street Fresno, CA 93726

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 4/16/2024 at 2:28 p.m., in Resident 41's room, there was an oxygen (O2) concentrator (a medical device that gives extra O2) near Resident 41's bed with Nasal Cannula (NC- a device that delivers extra oxygen through a tube and into your nose) was draped over the concentrator. Resident 41 stated he uses O2 as needed when he gets short of breath (SOB). During a review of Resident 41's AR, dated 4/16/2024, the AR indicated, admitted [DATE] . Diagnosis Information . Personal History of Covid-19, Personal History of Nicotine Dependence . During a review of Resident 41's MDS Section C dated 3/2/2024, the BIMS score indicated, .BIMS .14 [indicating normal level of cognition (related to thinking, learning and understanding)] . During a review of Resident 41's Order Summary Report (OSR), dated 2/27/2024, the OSR indicated, there was no physician order for O2 therapy administration present in the Electronic Medical Record (EMR). During a concurrent observation and interview on 4/16/2024 at 4:23 p.m., Resident 44 was seated in a wheelchair with NC on resident face. Resident 44 was being wheeled back to her room by Registered Nurse (RN) 2, for medication administration. RN 2 stated the portable O2 tank on wheelchair indicated Resident 44's O2 was flowing at 1L/m (liter per minute). An O2 concentrator was observed on Resident 44's bedside. During an interview on 04/18/24 at 2:44 p.m., with LVN 3, LVN 3 stated Resident 44 will usually come back from dialysis wearing it [oxygen by NC] because Resident 44 reports she gets SOB while at dialysis. LVN 3 stated nurses send Resident 44 with an O2 tank and NC in case dialysis staff need to apply O2 for support during transportation back to the facility. During a concurrent interview and record review on 4/18/2024 at 2:32 p.m., with LVN 3, LVN 3 stated Resident 41 did not have a care plan (CP) for O2. LVN 3 stated if a resident is on O2, she would expect to see an O2 resident centered CP. LVN 3 stated a CP is the nurses plan for care of the resident, without a CP the nurse would not know how to meet the residents needs. During an interview on 4/26/2024 at 10:05 a.m., with the facility Interim Director of Nursing (IDON), IDON stated it is his expectation that all residents have a care plan. IDON stated a care plan should be initiated no later than 14 days after admission. IDON stated departments are expected to complete their portion within the first 14 days of admission and to update the care plan as needed. IDON stated the care plan is important because it gives the nurses guidelines on how to deliver person-centered care to each resident. IDON stated not having a care plan can lead to resident harm and risk for either unnecessary treatment or not receiving essential 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
	056266	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fresno Nursing Center	3672 North First Street Fresno, CA 93726

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 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, Care Plans, Comprehensive Person-Centered, dated March 2022, the P&P indicated, Policy Statement A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implement for each resident .4. Each resident's comprehensive person-centered care plan is consistent with the resident's rights to participate in the development and implementation of his or her plan of care, including the right to: a. participate in the planning process; .d. request revisions to the plan of care; .g. receive the services and/or items included in the plan of care .7. The comprehensive, person-centered care plan . b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being . c. includes the resident's stated goals upon admission and desired outcomes .11. Assessments of residents are ongoing and care plans are revised as information about the resident's and the resident's conditions change .12. The interdisciplinary team (IDT) review and update the care plan .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056266	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fresno Nursing Center	3672 North First Street Fresno, CA 93726

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47205 Based on observation, interview and record review, the facility failed to provide care and services in accordance with professional standards of practice for three of seven sampled residents (Residents 11, 41, and 44) when: 1. Licensed Nurses (LNs) did not have physician orders for oxygen therapy (treatment intended to relieve or heal a disorder) administration for Resident 41 and Resident 44. 2. Oxygen tubing was not labeled with date/time and stored in a protective covering (such as a bag) when not in use to prevent contamination for Residents 11, 41, and 44. These failures resulted in residents receiving unnecessary oxygen treatment and the potential for infection from contaminated oxygen tubing. Findings: 1. During a review of Resident 41's Admission Record (AR-a document that provides resident contact details, a brief medical history, level of functioning, preferences, and wishes) dated 4/16/2024, the AR indicated, admitted [DATE] . Diagnosis Information . Personal History of Covid-19, Personal History of Nicotine Dependence . During a review of Resident 41's Minimum Data Set Section C Cognitive Patterns (MDS-comprehensive, standardized assessment of residents' functional capabilities and health needs) indicated, .BIMS .14 [indicating normal level of cognition (related to thinking, learning and understanding)] . During a review of Resident 41's Order Summary Report (OSR), dated 2/27/2024, the OSR indicated, there was no physician order for oxygen therapy administration present in the Electronic Medical Record (EMR). During an observation on 04/16/2024 at 2:28 p.m., in Resident 41's room, there was an oxygen concentrator (a medical device that gives extra oxygen) near Resident 41's bed, with unlabeled Nasal Cannula (NC-device used to deliver oxygen that is placed in a resident's nose) at 4L/min (liters per minute- units of measurement) tubing draped over the oxygen concentrator. Oxygen tubing was not labeled. Resident 41 stated that he uses oxygen as needed when he gets short of breath. During a review of Resident 44's AR dated 4/16/2024, the AR indicated, admitted [DATE] . Diagnosis Information . Dependence on renal (kidney) dialysis (treatment that removes toxins [poison] from the blood . Anemia (too few red blood cells in the body) . Congestive Heart Failure (CHF- a long-term condition in which your heart can't pump blood well enough to meet your body's needs) . During a review of Resident 44's MDS, the MDS section C indicated, .BIMS .14 [indicating normal level of cognition (related to thinking, learning and understanding)] . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056266	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fresno Nursing Center	3672 North First Street Fresno, CA 93726

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 44's OSR, dated 2/27/2024, the OSR indicated, there was no physician order for oxygen therapy administration present in the Electronic Medical Record (EMR) from 3/1/2024 through date of record review 4/16/2024. During an observation on 04/16/2024 at 11:10 a.m., Resident 44 was wearing NC while in wheelchair. During an interview on 04/18/24 at 2:44 p.m., with LVN 2, LVN 2 stated that Resident 44 will usually come back from dialysis wearing it, Resident 44 reports she gets SOB while at dialysis. Staff here send her with oxygen tank and NC and dialysis staff apply as needed (PRN) for support during transportation back to the facility. During an observation on 04/16/2024 at 4:23 p.m., Resident 44 was seated in a wheelchair being wheeled back to her room for medication administration by Registered Nurse (RN) 2. O2 concentrator was at bedside with a portable O2 tank on wheelchair with oxygen flowing at 1L/m (liter per minute) with NC on resident face. During a review of the facility's policy and procedure (P&P) titled, Oxygen Administration dated October 2012, the P&P indicated .1. Verify that there is a physician's order for this procedure . 2. During a review of Resident 11's AR dated 4/16/2024, the AR indicated, admitted [DATE] . Diagnosis Information . Chronic Obstructive Pulmonary Disease (COPD-condition involving constriction of the airways and difficulty or discomfort in breathing) . Chronic Respiratory Failure . During a review of Resident 11's MDS, the MDS section C dated 3/1/2024, the MDS indicated, .BIMS (Brief Interview for Mental Status) Summary Score .15 [indicating normal level of cognition (related to thinking, learning and understanding)] . During a review of Resident 11's OSR, dated 2/27/2024, the OSR indicated, .O2 [Oxygen] via NC every shift for Shortness of Breath related . During an observation on 04/16/24 at 3:45 p.m., in Resident 11's room, there was an oxygen concentrator (a medical device that gives extra oxygen) near Resident 11's bed, with unlabeled breathing treatment mask and tubing laying on top of Resident 11's nightstand. During an observation on 04/16/2024 at 2:28 p.m., in Resident 41's room, there was an oxygen concentrator (a medical device that gives extra oxygen) near Resident 41's bed, with unlabeled nasal canula tubing draped over the oxygen concentrator. Oxygen tubing was not labeled, Resident 41 stated the oxygen tubing at his bedside (Resident 41 points to oxygen concentrator and NC tubing) was his and was used as needed for when he is short of breath. During a concurrent observation and interview on 4/16/24 at 4:23 p.m., with Resident 44 and RN 1, in Resident 44's room, an oxygen concentrator was at bedside. A NC was draped across the oxygen concentrator which hung down toward the floor. RN 1 stated it was not supposed to be like that, [it was] supposed to be in a bag for prevention of bacteria on the tubing. RN 1 stated tubing should be dated. RN 1 stated usually NOC [Night] shift, on Saturday's, is supposed to change and label tubing. RN 1 stated the oxygen tubing is supposed to be kept in a black bag to protect from possible contamination. Resident 44 stated she wanted the tubing changed for her safety from germs. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056266	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fresno Nursing Center	3672 North First Street Fresno, CA 93726

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/18/2024 at 2:29 p.m. with LVN 1, LVN 1 stated the LN is responsible for dating tubing and dating oxygen humidifier fluid bottle (a refillable plastic bottle that infuses the normal flow of oxygen with water droplets). LVN 1 stated NOC shift LNs change and label tubing. LVN 1 stated dating the tubing helps with infection control. During an interview on 4/26/2024 at 10:00 a.m., with the Interim Director of Nursing (IDON), the IDON stated if the oxygen tubing is not being used it should be kept in a bag. IDON stated his expectation is that nurses are following physician orders and storing oxygen supplies (tubing) by labeling tubing and placing tubing in a black bag when not in use. IDON stated these expectations keep the resident safe from inappropriate use of oxygen and from infection. During a professional reference review retrieved from https://www.emphysemafoundation.org/index.php/about-uss/privacy/97-therapeutic-toolbox-articles/519-managing-supplemental-oxygen-supplies#:~:text=Clean%20oxygen%20concentrator%20filters%20weekly,replace%20the%20nasal%20cannula%20immediately. titled, Managing Supplemental Oxygen Supplies, dated 2023, .For people living with chronic obstructive pulmonary disease (COPD), supplemental oxygen is one of the most important therapies available when they experience reduced oxygen levels. But effectively managing oxygen can be challenging. To help, the National Heart, Lung, and Blood Institute (NHLBI), part of the National Institutes of Health (NIH), has published tips for doing so, including managing tubing, keeping supplies clean, and practicing oxygen safety . Keeping it clean . Ideally, nasal cannulas should be replaced every two weeks and the long oxygen tubing attached to stationary equipment every three months . During a review of the facility policy and procedure (P&P) titled Oxygen Administration, dated October 2010, the P&P indicated .Preparation 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration 2. Review the resident's care plan to assess for any special needs of the resident . During a review of the facility P&P titled Medication and Treatment Orders, dated July 2016, the P&P indicated .Policy Statement Orders for medications and treatments will be consistent with the principles of safe and effective order writing .1. Medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications in this state [California] . 3. Drug and biological orders must be recorded on the physician's order sheet in the resident's chart .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056266	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fresno Nursing Center	3672 North First Street Fresno, CA 93726

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49769 Based on observation, interview, and record review, the facility failed to implement a comprehensive systemic approach to ensure effective monitoring and systems to maintain acceptable parameters of nutritional status for one of five sampled Residents (Resident 45) reviewed for nutrition care when Resident 45 experienced a severe unplanned weight loss of 22 pounds (lbs-measurement of weight) or 11.2 % of admitting weight in 41 days from 3/6/24 to 4/16/24 when the Nutrition Assessment was not completed in a timely manner. As a result of these failures, Resident 45's compromised nutritional status was not addressed timely by the Registered Dietitian which could lead to further medical complications including but not limited to dehydration, loss of muscle mass with decreased mobility and negatively affect the diagnoses for Resident 45 and the reasons for admission to the facility. Findings: During an observation, on 4/16/24 10:35 a.m., Resident 45 stated food is good, but no appetite. Resident 45 stated she is losing weight. During a meal observation on 4/16/24 at 12:09 p.m., Resident 45 was feeding herself. Review of the meal ticket showed soft and bite sized food, extra gravy and sauce. Resident 45 ate all pudding, half of green beans and the resident stated only a couple of bites of corn dressing. Resident 45 stated the food didn't taste good and she was done eating. During an observation on 4/17/24 12:23 p.m. in Resident 45's room, Resident 45 stated she is not feeling well today again and didn't want to eat much. Resident 45 stated she had a banana and a couple bites of pudding. Resident 45's bed was not elevated to eating height, bed approximately at a 45-degree angle. CNA 16 at bedside and stated she would classify the meal tray as 0-25%. During a review of Resident 45's Admission Record (document containing resident demographic information and medical diagnosis) showed Resident 45 was admitted to the facility on [DATE], readmitted [DATE]. During a review of Resident 45's History and Physical (H&P-formal document that physicians produce through the interview with the patient, physical exam, and the summary of the testing either obtained or pending), undated, the H&P indicated, Resident 45 was admitted from a hospital for fall on 3/6/24 to the facility, with a diagnoses that included weakness, deconditioning (the decline in physical function of the body as a result of physical inactivity and/or bedrest or an extremely sedentary lifestyle), history of falling. The H&P indicated .Plan .The patient will be observed and monitored for progress and worsening of overall well-being .and plan will be modified accordingly . During a review of Resident 45's Minimum Data Set (MDS-tool for implementing standardized assessment and for facilitating care management in nursing homes), dated 3/27/24, the MDS Section K-Swallowing/Nutritional Status, K0300 Weight Loss, indicated Resident 34 had a 5% or more weight loss in the last month and was not on physician-prescribed weight-loss regimen. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056266	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fresno Nursing Center	3672 North First Street Fresno, CA 93726

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 45's Care Area Assessment Worksheet (CAA-provides guidance on how to focus on key issues identified during a comprehensive MDS assessment and serves as the link between the MDS and the Care Plan [CP]), dated 3/27/24, the CAA indicated through MDS assessment Patient 45 had a triggering condition due to a weight loss of 5% or more in the last month that was not on prescribed weight-loss regimen. The CAA indicated that nutritional status will be addressed in the care plan. During a review of Resident 45's Comprehensive Care Plans (CCP), Resident 45's CCP did not include a care plan for Resident 45's severe weight loss until 4/16/24. Cross Reference F656 During a review of Resident 45's Weights and Vitals Summary (WVS), dated 4/18/24, the WVS indicated Resident 45's weight were: 3/7/24 10:15 a.m. 195 lbs 3/12/24 2:15 p.m. 191 lbs 3/22/24 8:45 p.m. 190.4 lbs 3/26/24 8:46 a.m. 185 lbs .-5% change [Comparison weight 3/7/24, 195.0 lbs, -5.1%, -10.0lbs] 4/3/24 3:41 p.m. 175 lbs .-10% change [Comparison weight 3/7/24, 195.0 lbs, -10.3%, -20.0 lbs], -3% change from last weight [Comparison weight 3/26/24 185.0 lbs, -5.4%, -10.0 lbs], -5% change [Comparison weight 3/7/24, 195.0 lbs, -10.3%, -20.0 lbs], -7.5% change [Comparison weight 3/7/24, 195.0 lbs, -10.3.%, -20.0 lbs] 4/16/24 7:58 a.m. 173 lbs .-10% change [Comparison weight 3/7/24,195.0 lbs, 11.3%, -22lbs], -5% change [Comparison weight 3/22/24, 190.4 lbs, -9.1%, 17.4 lbs], -7.5% change [Comparison weight 3/7/24, 195.0 lbs, -11.3%, -22 lbs] During a review of Resident 45's Weekly Weight List (WWL), dated 3/11/24 to 4/8/24, the WWL indicated Resident 45's weight were: 3/11/24 Previous weight-195, Weight Not Documented 3/18/24 Previous weight -191, Weight -LOA 3/25/24 Previous weight-LOA, Weight-185 (-5) 4/1/24 No Record Found 4/8/24 Previous weight-175, Weight 171 (-4) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056266	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fresno Nursing Center	3672 North First Street Fresno, CA 93726

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 45's Progress Notes (PN), dated 4/5/24, the PN indicated, .Resident is noted with insidious weight loss of 10 lbs x1 week with total weight loss of 20 lbs x1 month since admission . Primary Care Provider Feedback .resident to have the following labs done: CBC (complete blood count-used to look at overall health and find a wide range of conditions), CMP (comprehensive metabolic panel-to look at body's fluid balance, levels of electrolytes like sodium and potassium, and how well the kidneys and liver are working), LFT (liver function test-used to help find the cause of your symptoms and monitor liver disease or damage), Prealbumin (a protein that is made mainly by your liver and a blood test that may be used to see if you are getting enough nutrition in your diet) level and also to start on four ounces (oz)(unit of measurement for weight) of house supplement (nutrition supplement - a liquid drink with calories and protein and can also help you meet your daily requirements of essential nutrients) TID (it is an abbreviation for ter in die which in Latin means three times a day) and follow up ST(Speech Therapy) evaluation for any significant changes . The progress note did not contain if this was an interdisciplinary team meeting note and what members were present, if any. During a review of Resident 45's Change in Condition Evaluation (CIC), dated 4/5/24, the CIC indicated Resident 45 had a change in condition regarding weight loss. CIC indicated, Resident is noted with insidious weight loss of 10lbs (pounds) x (times) 1 week with total wt (weight) loss of 20lbs x1 month is since admission . CIC indicated physician ordered Resident 45 to start four oz. on house supplement three times a day. During a review of Resident 45's Clinical Report (CR), undated, the CR indicated the following physician orders: Dated 3/6/24, a Regular diet, regular texture, thin consistency, and with an end date of 3/11/24. Dated 3/11/24, a Regular diet, soft and bite size texture, thin consistency, extra gravy/sauce/syrup, and with an end date of 3/21/24. Dated 3/22/24, a Regular diet, pureed texture, thin consistency, extra gravy/sauce/syrup, with an end date of 4/5/24. Dated 4/5/24, a Regular diet, soft and bite size texture, thin consistency regular bread ok, with an end date of 4/17/24. Dated 4/5/24, House supplement after meals for insidious weight loss. Dated 4/17/24, Regular diet, soft and bite size texture, thin consistency regular bread ok. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056266	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fresno Nursing Center	3672 North First Street Fresno, CA 93726

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 45's Nutrition Assessment (NA), dated 4/16/24, the RD documented, Resident 45 was receiving a soft and bite size diet and regular bread was okay, extra gravy/sauce/syrup with all meals and nutrition supplements between meals TID. The most Recent Weight of 173 lbs on 4/16/2024. RD documented Resident 45's admitting weight was 195 lbs RD documented the recent significant weight changes-Comparison wt 3/7/24, 195 lbs, -11.3%, -22 lbs over 40 days since admission. Comparison wt on 3/2/24. 207lbs, -5.6%, -11.6lbs from hospital wt to admission wt. The RD documented Resident 45's estimated nutrition needs to be 1700 to 1900 calories, 85 to 95 grams (1.2 grams per kilogram body weight) of protein per day and 2375 milliliters of fluid per day. The RD documented prealbumin was 16 and low. The RD documented Resident 45 had a fair appetite and had some missing teeth and swallowing difficulties. The RD documented the summary: Hospital weight:206.6lbs (3.4.24) usual body weight 187lbs. She was discharged return anticipated 3/12/24 and reentered 3/22/24 weighing 190.4 lbs. Significant/severed unplanned weight loss related to both fluid status and inadequate oral intake. RD documented the resident stated, My appetite isn't good. I haven't been wanting to eat like normally eat. Denied difficulty chewing or swallowing. Resident mentioned water (Edema) on her things. Partial upper dental plate is at her home . encourage her to eat . Nutrition Assessment completed 41 days after admission and 26 days after readmission. During a concurrent interview and record review on 4/18/24 at 10:14 a.m. with the Registered Dietitian (RD), Resident 45's Electronic Medical Record (EMR) was reviewed. The EMR indicated first intervention for weight loss was a house supplement beginning on 4/5/24 initiated by a registered nurse (RN). The RD stated there is no timeframe for assessments to be completed. The RD stated she personally evaluates the weights weekly and Point Click Care (PCC-charting system used by facility) alerts patients who have a triggered weight loss/gain. PCC does not require a sign off to verify the weight loss/gain of the triggers. RD validated in EMR that Resident 45 had a triggered alert for weight loss on 3/26/24, 4/3/24, and 4/16/24. RD stated after the 5% weight loss triggered by PCC on 3/26/24, there was not an absolute need for a care plan for patient 45. The RD stated she likes to wait until the third week after admission before doing a nutritional assessment and implementing care plans to see the baseline for the patient. The RD validated only intervention for Resident 45 from 3/6/24 (admission) to 4/16/24 (nutrition assessment) was a house supplement and lab work on 4/5/24. RD stated the change in condition note on 4/3/24 was nursing notes and that it was not an Interdisciplinary note. RD stated she was involved in that note however it was on an internal document that was deleted. During a concurrent interview and record review on 4/18/24 at 11:39 a.m. with the Director of Nursing (DON), Resident 45's EMR was reviewed. The DON verified nutritional assessment and care plan should have been done before they were, and nutritional assessment and care plan were late. The DON confirmed nutritional assessments are done 7 days after completion of comprehensive assessment. The DON stated this was not an acceptable practice and the expectation is for all staff to do all assessments as outlined in policy. The DON acknowledged the documentation on 4/5/24 did not show if it was an Interdisciplinary team note and what members were present during the weight meeting. The DON stated the old process was internal charting and not in the record. During a review of the facility's policy and procedure (P&P) titled, Nutritional Assessment (NA), undated, the P&P indicated, As part of the comprehensive assessment, a nutritional assessment, including current nutritional status and risk factors for impaired nutrition, shall be conducted for each resident .2. As part of the comprehensive assessment, the nutritional assessment will be a systematic, multidisciplinary process that includes gathering and interpreting data and using that data to help define meaningful interventions for the resident at risk for or with impaired nutrition. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056266	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fresno Nursing Center	3672 North First Street Fresno, CA 93726

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure titled, Weight Assessment and Intervention ([NAME]), dated March 2022, the P&P indicated, .Resident weight are monitored for undesirable or unintended weight loss or gain .2. Weights are recorded in each unit's weight record chart and in the individual's medical record . 3. Any weight change of 5% or more since the last weight assessment is retaken the next day for confirmation. A. IF the weight is verified, nursing will immediately notify the dietitian in writing .5. A. 1 month-5% weight loss is significant, greater than 5% is severe .Evaluation 1. Undesirable weight change is evaluated by the treatment team whether or not the criteria for significant weight change has been met .b. the resident's calorie, protein, and other nutrient needs comparted with the resident's current intake; c. the relationship between current medical condition or clinical situation and recent fluctuations in weight; and d. whether and to what extent weight stabilization or improvement can be anticipated. During a review of professional reference titled, Involuntary Weight Loss can lead to Muscle Wasting . Depression and an increased rate of Disease Complications (www.aafp.org/afp American Family Physician). Dated 2/15/02, indicated, . Various studies demonstrated a strong correlation between weight loss and morbidity (the condition of suffering from a disease or medical condition) and mortality. One study showed that nursing home patients had a significantly higher mortality rate in the six months after losing 10 percent of their body weight, irrespective of diagnoses or cause of death. In another study, institutionalized elderly patients who lost five percent of their body weight in one month were found to be four times more likely to die within one year . During a review of a professional reference publication titled, Nutrition Care of the Older Adult from the Academy of Nutrition and Dietetics, dated 2016, indicated, . The goal of Medical Nutrition Therapy is to maintain or restore the individual's usual body weight . During a review of professional reference titled, The Academy of Nutrition and Dietetics Evidence Analysis Library regarding Unintended Weight Loss for Older Adults Evidence-Based Nutrition Practice Guidelines dated 2007-2009, indicated, . The Registered Dietitian should monitor and evaluate weekly body weights of older adults with unintended weight loss, until body weight has stabilized, to determine effectiveness of medical nutrition therapy (MNT) .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056266	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fresno Nursing Center	3672 North First Street Fresno, CA 93726

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48430 Based on observation, interview, and record review, the facility failed to ensure 16 of 16 Residents (Residents 6, 8, 25, 27, 29, 32, 35, 37, 38, 41, 43 44, 45, 48, 53, 270) were assessed for the risk of entrapment (resident caught, trapped, or entangled in the space in or about the bed and side rail) from bed (side) rails (adjustable metal or rigid plastic bars in various sizes that attach to the bed, and can be placed in a guard [raised] or lowered position) and bed assist rails (a bed rail used to assist the resident with repositioning or getting in and out of bed) prior to installation, had consent (form signed by resident or family explaining the risks of bed rail use), used appropriate alternatives, and followed the manufacturers' recommendations and specifications for installing and maintaining bed rails prior to the use of the bed (side) rails when: 1. Resident 6, 8, 27, 38 had bed assist rails (U-Rail) up on one side of the bed and did not have a bed rail risk assessment, consent, physician orders, and no care plan (an individualized plan of care) prior to the use of the bed rails. 2. Resident 25, 29, 32, 37, 41, 43, 45, 48, 53, 270 had 1/4 bed rails up both sides of the bed in the guard position and did not have a physician's order, consent, bed rail risk assessment, and no care plan prior to the use of the bed rails. 3. Residents 35 and 44 had bed assist rails up on both sides of the bed and did not have a bed rail risk assessment, consent, physician orders, and no care plan prior to the use of the bed rails. These failures had the potential to cause entrapment, serious harm, injury, or death to Residents 6, 8, 25, 27, 29, 32, 35, 37, 38, 41, 43 44, 45, 48, 53, 270. Findings: 1. During an observation on 04/16/24, at 9:38 a.m., in Resident 6's room, Resident 6 was asleep in bed. Resident 6's bed had one bed assist rail on left side of the bed. During a review of Resident 6's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment) Section C, dated 02/22/24 was reviewed. The MDS Section C indicated Resident 6 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 13 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact) indicating Resident 8 had severe cognitive impairment. During a review of Resident 6's Admission Record (AR), dated 04/18/24, the AR indicated, Resident 6 had a diagnosis (process of identifying a disease) of, Morbid (severe) obesity (very overweight), difficulty walking, and muscle weakness (generalized. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056266	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fresno Nursing Center	3672 North First Street Fresno, CA 93726

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation on 4/16/24 at 10:18 a.m. in Resident 8's room, Resident 8 was observed dressed, and sitting in her wheelchair. Resident 8's bed was observed to have a U-rail on the right side of the bed. The left side of Resident 8's bed was against the wall. During a review of Resident 8's Admission Record (AR), dated 4/23/24, the AR indicated Resident 8 was admitted on [DATE] with diagnoses of cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area), cognitive communication deficit (difficulty with thinking and how someone uses language), and major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). During a review of Resident 8's MDS Section C, dated 03/08/24, the MDS Section C indicated, Resident 8 had a score of 6 indicating Resident 8 had severe cognitive impairment. During an observation on 04/16/24 at 3:57 p.m. in Resident 38's room, Resident 38 was observed sleeping. Resident 38's bed was observed to have a bed assist rail on the right side. During a review of Resident 38's MDS Section C, dated 02/17/24, the MDS Section C indicated, Resident 38 had a BIMS of 15, indicating Resident 38 was cognitively intact (no mental impairment). During a review of Resident 38's AR, dated 04/23/24, the AR indicated Resident 38 had a diagnosis of, Rheumatoid Arthritis (a disease affecting the joints causing inflammation and pain), Osteopathy after poliomyelitis (gradual muscle weakness and atrophy after being infected with polio [highly infectious disease caused by a virus]), and Muscle weakness. During an interview on 4/19/24 at 11:56 a.m. with Licensed Vocational Nurse (LVN) 3, LVN 3 stated, restraints were not used in the facility. LVN 3 stated having a side rail up on a resident's bed would be considered a restraint and the facility would need to get a consent for the use of bed rails. LVN 3 stated the resident could get injured with a bed rail. LVN 3 stated if the resident had a non-mobile upper extremity, it could get stuck in the bed rail. During an observation on 04/22/24, at 10:25 a.m., in Resident 27's room, Resident 27's bed was observed to have a single bed assist rail installed on the left side of the bed. During a review of Resident 27's MDS Section C, dated 02/24/24, the MDS Section C indicated, Resident 27 had a BIMS of 11, indicating Resident 27's cognition (ability to think, reason and problem solve) was moderately impaired. During a review of Resident 27's AR, dated 04/23/24, the AR indicated Resident 27 had a diagnosis of, Intervertebral disc degeneration (breakdown of the tissue between the bones of the spine) Muscle weakness. During a concurrent interview and record review on 4/22/24 at 2:09 p.m., with the with the Assistant Administrator (AADM) of Resident 38's Electronic Medical Record (EMR) dated April 2024, was reviewed. The EMR indicated no records of bed rail assessments, consents, or physician orders. The AADM stated, there were no physician orders for Resident 38 prior to 04/16/24. The AADM stated, there were no consents for Resident 38 prior to 4/16/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056266	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fresno Nursing Center	3672 North First Street Fresno, CA 93726

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 4/22/24 at 4:21 p.m. with the Interim Director of Nurses (IDON), the IDON stated the facility did not have documentation of bed rails being installed according to manufacturer's recommendations, which would include assessing the resident's bed for the correct size and weight accommodation of Resident 8, or the date the bed rails were installed. During a concurrent interview and record review on 04/22/24 at 4:39 p.m., with the Assistant Administrator (AADM), Resident 6's physician orders, dated April 2024 was reviewed the AADM stated, yes she's got bed rails. The AADM stated, bed rail orders, and assessments and consent for the rails were put in on 4/16/24. The AADM stated, these should have been done prior to the use of the rails. During a concurrent interview and record review on 4/22/24 at 4:46 p.m., with the Minimum Data Set Coordinator (MDSC), Resident 8's Siderail Enabler Assessment (Assessment), dated 11/29/22 was reviewed. The MDSC stated the Assessment was not signed by Resident 8. The MDSC stated the Assessment was not completed. The MDSC stated no consent for the use of bed rails was found in resident 8's chart. During a concurrent interview and record review on 04/22/24 at 5:30 p.m. with the AADM, Resident 27's EMR dated April 2024 was reviewed. The AADM stated, Resident 27 did not have signatures for consents for the rails. The AADM stated, there was no physician order for the use of bed rails, I don't see an order for him. The AADM stated, there were no care plans for the side rails, I don't see a care plan. The AADM stated, Resident 27 should have had orders and care plans. During an interview on 4/22/24 at 6:18 p.m., with the MDSC, the MDSC stated the importance of using alternative methods prior to using bed rails was bed rails were also used as a restraint. The MDSC stated if the facility could use something else that was less invasive than a bed rail, which could restrict the resident's free space, then we should have done that first. The MDSC stated a risk assessment for bed rail use was to let the resident or responsible party (RP) know what the risks versus the benefits of using a bed rail was. The MDSC stated the risk assessment would let the resident or Responsible Party (RP-an individual who makes final decisions regarding a certain individual) know what we were trying to obtain with using the bed rail. The MDSC stated the risk assessment was the consent for using bed rails. The MDSC stated the resident or RP would need to sign the risk assessment prior to using bed rails. During a concurrent interview and record review on 04/23/24 at 2:18 p.m., with the Physical Therapist (PT), Resident 6's Bed Rail Assessments, dated 04/16/24 was reviewed. The PT stated, the Bed Rail Assessment was done on 04/16/24. The PT stated, there should be an assessment before placing a bed rail to determine the resident's functional needs and the type of rail that is appropriate. During a concurrent interview on 04/24/24 at 11:15 a.m., with the IDON, the IDON stated, the process for the bed rails were not being followed. The IDON stated, there should have been consents and orders prior to the rails being installed. During an interview on 04/24/24 at 3:00 p.m. with the Administrator (ADM), the ADM stated, bed rails must have assessments, consents, orders and care plans must be in place if a bed rails were needed for a resident. The ADM stated, orders are important so the staff knows what the resident is ordered to have so that it can be followed safely and effectively as well as their rights are being honored. The ADM stated, if there are no orders, there are no orders, there are potential harm to the residents because their rights are not being honored and safety concerns are not properly addressed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056266	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fresno Nursing Center	3672 North First Street Fresno, CA 93726

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 04/26/24 at 10:00 a.m., with the IDON, the IDON stated, before a resident receives bed rails, they must be evaluated by the PT. The IDON stated once that evaluation is done, there needs to be a consent, orders and care plans put in [the resident's EMR. The IDON stated, without consents, orders, and care plans risk assessments, and orders, there is a potential risk for injury such as the resident getting stuck or trapped if bed rails are put in without following the process. the IDON stated, if there are no care plans, improper use of the bed rails can happen because there would be no instructions or monitoring when the rails are being used. During a review of the facility's policy and procedure (P&P) titled, Bed Safety and Bed Rails, dated 8/2022, indicated, . the use of bed rails is prohibited unless the criteria for use of bed rails have been met . the residents sleeping environment is evaluated by the interdisciplinary team . consideration is given to the resident's safety, medical conditions, comfort, and freedom of movement, as well as input from the resident and family regarding previous sleeping habits and bed environment . bed frames, mattresses and bed rails are checked for compatibility and size prior to use . bed dimensions are appropriate for the resident's size . bed rails are properly installed and used according to the manufacturer's instructions, specifications and other pertinent safety guidance to ensure proper fit .additional safety measures are implemented for residents how have been identified as having a higher than usual risk for injury including bed entrapment (e.g. , altered mental status, restlessness, etc.) . the use of bed rails or side rails (including temporarily raising the side rails for episodic use during care) is prohibited unless the criteria for use of bed rails have been met, including attempts to use alternatives, interdisciplinary evaluation, resident assessment and informed consent . before using bed rails for any reason, the staff shall inform the resident or representative about the benefits and potential hazards associated with bed rails and obtain informed consent . During a review of the facility's P&P titled, Safety and Supervision of Residents, dated July 2017, the P&P indicated, The interdisciplinary care team shall analyze information obtained from assessments and observations to identify any specific accident hazards or risks for individual residents. The P&P indicated, The care team shall target interventions to reduce individual risks related to hazards in the environment, including .assistive devices. The P&P indicated, .certain risk factors .are addressed in dedicated policies and procedures. These risk factors .and hazards include the following: .bed safety . During a review of the facility's P&P titled, Care Planning-Interdisciplinary Team, dated March 2022, the P&P indicated, Resident care plans are developed according to the timeframes established by S483.21 . Comprehensive, person-centered care plans are based on resident assessment . During a review of the facility's P&P titled, Resident Rights, dated February 2021, the P&P indicated, Federal and sate laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: .be informed of .his or her care planning and treatment. 2. During an observation on 04/16/24 at 9:31 a.m. in Resident 32's room, Resident 32's bed had rails on both sides of the bed, both in the guard position (side rails are up). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056266	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fresno Nursing Center	3672 North First Street Fresno, CA 93726

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During review of Resident 32's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment) Section C, dated 03/08/2024 indicated Resident 32 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 9 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact) indicating moderate cognitive impairment. During a review of Resident 32's Admission Record (AR), dated, 04/18/2024, the AR indicated Resident 32 had a diagnosis of, Hemiplegia [severe or complete loss of strength on side of the body] and Hemiparesis [weakness or the inability to move on one side of the body], Muscle weakness. During an observation on 4/16/24 at 10:28 a.m. in Resident 29's room, Resident 29 bed had rails on both sides of the bed, both in the guard position. During a review of Resident 29's MDS Section C, dated 04/01/24, the MDS Section C indicated, Resident 29 had a BIMS of 14, indicating Resident 29 was cognitively intact (no mental impairment). During a review of Resident 29's AR, dated 04/23/24, the AR indicated Resident 29 had a diagnosis of, Muscle weakness, and Difficulty in walking. During an interview on 4/19/24 at 11:56 a.m. with Licensed Vocational Nurse (LVN) 3, LVN 3 stated, having a side rail up on a resident's bed would be considered a restraint and the facility would need to get a consent for the use of bed rails. LVN 3 stated for phone consents staff would notify the RP of the risks and benefits of using bed rails. If the RP gave consent over the phone, we would print out the consent and the doctor would sign, or we would send the consent by facsimile (FAX) to the doctor to sign and send back to us. LVN 3 stated the nurse would sign the note in the electronic medical record. LVN 3 stated the resident could get injured with a bed rail. LVN 3 stated if the resident had a non-mobile upper extremity, it could get stuck in the bed rail. During an observation on 4/22/24 at 9:34 a.m. in Resident 45's room, Resident 45 was observed sleeping in her bed. Resident 45's bed had two bed rails up at the head of the bed, one on the right side of the bed and one on the left side of the bed. During a review of Resident 45's AR, dated 4/17/24, the AR indicated Resident 45 was admitted on [DATE] with diagnoses of acute respiratory failure (a serious condition that occurs when the lungs cannot get enough oxygen into the blood or remove enough carbon dioxide [a waste gas] from the blood), cognitive communication deficit, heart failure, acute kidney failure, and spondylosis of thoracic spine (wearing down of bones, cartilage and ligaments of the spine in the mid-back area). During a review of Resident 45's MDS Section C, dated 3/27/24, the MDS Section C, indicated Resident 45 had a BIMS score of 8, which indicated Resident 45 was moderately impaired. During an observation on 4/22/24 at 9:35 a.m. in Resident 48's room, Resident 48 was observed in bed sleeping. Resident 48's bed had two bed rails up, one on the right side of the bed and one on the left side of the bed, in the guard position. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056266	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fresno Nursing Center	3672 North First Street Fresno, CA 93726

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of Resident 48's AR dated 4/17/24, the AR indicated Resident 48 was admitted on [DATE] with diagnoses of heart failure, Type 2 Diabetes, and acquired absence of left leg below the knee. During a review of Resident 48's MDS Section C, dated 3/14/24, the MDS Section C indicated Resident 48 had a BIMS score of 15, which indicated Resident 48 was cognitively intact. During a concurrent observation and interview on 04/22/24 at 9:35 a.m. with Resident 53, in Resident 53's room, Resident 53 was observed in bed. Resident 53's bed had bed rails up on both sides of the bed. Resident 53 stated, the rails have been on the bed since admission. During a review of Resident 53's MDS Section C, dated 03/16/24, the MDS Section C indicated, Resident 53 had a BIMS of 15, indicating Resident 53 was cognitively intact (no mental impairment). During review of Resident 53's AR, dated 04/23/24, the AR indicated Resident 53 had a diagnosis of, Muscle weakness, and Difficulty in walking. During a concurrent observation and interview on 4/22/24 at 9:59 a.m. with Resident 43 in Resident 43's room, Resident 43 was observed dressed, sitting in his wheelchair in the doorway of his room. Resident 43's bed was observed with two bed rails up; one on the right side of the bed, and one on the left side of the bed in the guard position. Resident 43 stated staff did not talk to him about safety with using the bed rails. During a review of Resident 43's AR, dated 4/23/24, the AR indicated Resident 43 was admitted on [DATE] with diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, congestive heart failure, major depressive disorder, and cognitive communication deficit. During an observation on 4/22/24 at 10:00 a.m. in Resident 270's room, Resident 270's bed was observed with two bed rails up at the head of the bed, one on the right side and one on the left side, in the guard position. During a review of Resident 270's AR, dated 4/23/24, the AR indicated Resident 270 was admitted on [DATE] with diagnoses of heart failure and cognitive communication deficit. During a review of Resident 270's MDS Section C, dated 2/19/24, the MDS Section C indicated Resident 270 had a BIMS score of 15, which indicated Resident 270 was cognitively intact. During an observation on 4/22/24 at 10:00 a.m. in Resident 25's room, Resident 25's bed had two bed rails up, one on the upper left and one on the upper right side of the bed. During a review of Resident 25's AR, dated 4/23/24, the AR indicated, Resident 25 was admitted on [DATE] with diagnoses of acute kidney failure (a condition when the kidneys suddenly are unable to filter waste products from the blood), congestive heart failure (a condition when the heart muscle doesn't pump enough blood to meet the body's needs which can cause fatigue and shortness of breath), and Type 2 Diabetes Mellitus (when the blood sugar levels in the body are too high) and cognitive communication deficit. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056266	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fresno Nursing Center	3672 North First Street Fresno, CA 93726

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of Resident 25's MDS Section C, dated 3/8/24, the MDS Section C indicated Resident 25 had a BIMS score of 14, which indicated Resident 25 was cognitively intact. During a concurrent observation and interview on 4/22/24 at 10:55 a.m. in Resident 37's room, Resident 37 was observed in bed watching TV with Resident 37's Caregiver (CG) present. Resident 37's bed had bed rails up on the upper left and upper right side of the bed in the guard position with the left side of the bed against the wall. The CG stated Resident 37 had limited movement with his arms and hands but was able to put his hands through the rails to help him move in bed. Resident 37 stated he used the bed rails to help reposition himself in bed. Resident 37 was observed placing his hand through each grab bar to demonstrate how he turned himself. Resident 37 stated staff had not talked to him about using the bed rail safely. During a review of Resident 37's AR, dated 4/16/24, the AR indicated Resident 37 was admitted on [DATE] with diagnoses of fracture of upper end of left humerus (a break in the bone of the upper arm), fracture of upper end of right humerus, fracture of shaft of right tibia (a break in the lower leg bone below the knee and above the ankle), fracture of shaft of left fibula (a break in the lower leg bone from below the knee to the outside of the ankle), traumatic subdural hemorrhage (a rapidly developing brain bleed, caused by a significant head injury) without loss of consciousness, and cognitive communication deficit. During a review of Resident 37's MDS Section C, dated 1/27/24, the MDS Section C indicated Resident 37 had a BIMS score of 13, which indicated Resident 37 was cognitively intact. During an interview on 4/22/24 at 4:21 p.m. with the IDON, the IDON stated the facility did not have documentation of bed rails being installed according to manufacturer's recommendations on Resident 25, Resident 37, Resident 43, Resident 45, Resident 48 bed and Resident 270, which would include assessing Resident 45 and Resident 48 bed for the correct size and weight accommodation of Resident 45, or the date the bed rails were installed. During a concurrent interview and record review on 04/22/24 at 4:39 p.m. with the Assistant Administrator (AADM), Resident 32's Electronic Medical Record (EMR), dated April 2024 was reviewed. The AADM stated, the EMR did not indicate orders for the rails prior to 04/16/24. The AADM stated, the orders should have been in place prior to the use of the rails. During a concurrent interview and record review on 4/22/24 at 4:46 p.m. with the Minimum Data Set Coordinator (MDSC), Resident 25's Assessment, dated 4/17/24 was reviewed. The MDS stated the Assessment in Resident 25's chart was not signed by Resident 25, the physician or nurse. The MDSC stated the Assessment was not completed. The MDSC reviewed Resident 25's Consent, dated 4/17/24 for the use of bed rails signed by the MDSC dated 4/17/24. During a concurrent interview and record review on 04/22/24 at 4:55 p.m. with the AADM, Resident 29's EMR, dated April 2024 was reviewed. The AADM stated, the EMR did not indicate a bed rail assessment, consent, orders, or care plans for Resident 29's rails. The AADM stated, assessments consents, orders, and care plans are needed to have the bed rails in place. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056266	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fresno Nursing Center	3672 North First Street Fresno, CA 93726

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent interview and record review on 4/22/24 at 4:56 p.m. with the MDSC, Resident 37's Assessment, dated 4/17/24 was reviewed. The MDSC stated the Assessment in Resident 37's chart was not signed by Resident 37, the physician or nurse. The MDS stated the Assessment was not completed. The MDSC stated there was no Consent, for the use of bed rails in Resident 37's chart and the MDSC stated she was unable to find any documentation regarding alternative methods used prior to the resident using bed rails. During a concurrent interview and record review on 4/22/24 at 5:00 p.m. with the MDSC, Resident 43's Assessment, dated 4/17/24 was reviewed. The MDSC stated the Assessment in Resident 43's chart was not signed by Resident 43, the physician or nurse. The MDSC stated the Assessment was not completed. The MDSC stated there was a Consent dated 4/17/24 for the use of bed rails in Resident 43's chart signed by two nurses and the MDS coordinator but was not signed by Resident 43. The MDSC stated she was unable to find any documentation regarding alternative methods used prior to the resident using bed rails. During a review of Resident 43's MDS Section C, dated 3/8/24, the MDS Section C indicated Resident 43 had a BIMS score of 14, which indicated Resident 43 was cognitively intact. During a concurrent interview and record review on 4/22/24 at 5:10 p.m. with the MDSC, Resident 48's Assessment, dated 4/16/24 and Resident 270's Assessment, dated 4/17/24 were reviewed. The MDSC stated the Assessment in Resident 48's chart was signed by Resident 48, the MD and nurse. Resident 48's Consent dated 4/16/24 for the use of bed rails was observed in Resident 48's chart signed by Resident 48 and the MDS coordinator. The MDSC stated the Assessment in Resident 270's chart was not signed by Resident 270, the MD and nurse. The MDSC stated Resident 270's Assessment was not completed. Resident 270's Consent dated 4/17/24 for the use of bed rails was observed in Resident 270's chart signed by Resident 270 and the MDS coordinator. The MDSC stated she was unable to find any documentation regarding alternative methods used prior to the resident using bed rails for either Resident 48 or Resident 270. During an interview on 4/22/24 at 5:19 p.m. with the MDSC, the MDSC stated the assessment of the residents would involve all departments, and the resident or RP would be educated on the recommendations. The MDSC stated the importance of education for bed rails was if side rails were in place, then it would be considered a restraint. Education would be provided to inform the resident or RP how to properly use the bed rails. The MDSC stated the resident could injure them self if they did not use the bed rails appropriately. During a concurrent interview and record review on 04/22/24 at 5:50 p.m. with the AADM, Resident 41's EMR, dated April 2024, was reviewed. The AADM stated, the EMR did not indicate consents, orders, or care plans for the Resident 41's bed rails. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056266	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fresno Nursing Center	3672 North First Street Fresno, CA 93726

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 4/22/24 at 6:18 p.m. with the MDSC, the MDSC stated the importance of using alternative methods prior to using bed rails was bed rails were also used as a restraint. The MDSC stated if the facility could use something else that was less invasive than a bed rail, which could restrict the resident's free space, then we should have done that first. The MDSC stated a risk assessment for bed rail use was to let the resident or RP know what the risks versus the benefits of using a bed rail was. The MDSC stated the risk assessment would let the resident or RP know what we were trying to obtain with using the bed rail. The MDSC stated the risk assessment was the consent for using bed rails. The MDSC stated the resident or RP would need to sign the risk assessment prior to using bed rails. During an interview on 04/26/24 at 10:00 a.m., with the IDON, the IDON stated, before a resident receives bed rails, they must be evaluated by the Physical Therapist (PT). Once that evaluation is done, there needs to be a consent, orders, and care plans put in. The IDON stated, without consents, orders, and care plans risk assessments, and orders, there is a potential risk for injury such as the resident getting stuck or trapped if bed rails are put in without following the process. He stated, if there are no care plans, improper use of the rails can happen because there would be no instructions or monitoring when the rails are being used. During an interview on 04/24/24 at 3:00 p.m. with the Administrator (ADM), the ADM stated, bed rails must have assessments, consents, orders and care plans must be in place if a bed rail(s) were needed for a resident. The ADM stated orders are important so the staff knows what the resident is ordered to have so that it can be followed safely and effectively as well as their rights are being honored. The ADM stated, if there's no orders, there are no orders, there are potential harm to the residents because their rights are not being honored and safety concerns are not properly addressed. During a review of the facility's P&P titled, Bed Safety and Bed Rails, dated 8/2022, indicated, . the use of bed rails is prohibited unless the criteria for use of bed rails have been met . the residents sleeping environment is evaluated by the interdisciplinary team . consideration is given to the resident's safety, medical conditions, comfort, and freedom of movement, as well as input from the resident and family regarding previous sleeping habits and bed environment . bed frames, mattresses and bed rails are checked for compatibility and size prior to use . bed dimensions are appropriate for the resident's size . bed rails are properly installed and used according to the manufacturer's instructions, specifications and other pertinent safety guidance to ensure proper fit .additional safety measures are implemented for residents how have been identified as having a higher than usual risk for injury including bed entrapment (e.g., altered mental status, restlessness, etc.) . the use of bed rails or side rails (including temporarily raising the side rails for episodic use during care) is prohibited unless the criteria for use of bed rails have been met, including attempts to use alternatives, interdisciplinary evaluation, resident assessment and informed consent . before using bed rails for any reason, the staff shall inform the resident or representative about the benefits and potential hazards associated with bed rails and obtain informed consent . During a review of the facility's P&P titled, Safety and Supervision of Residents, dated July 2017, the P&P indicated, The interdisciplinary care team shall analyze information obtained from assessments and observations to identify any specific accident hazards or risks for individual residents. The P&P indicated, The care team shall target interventions to reduce individual risks related to hazards in the environment, including .assistive devices. The P&P indicated, .certain risk factors .are addressed in dedicated policies and procedures. These risk factors .and hazards include the following: .bed safety . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056266	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fresno Nursing Center	3672 North First Street Fresno, CA 93726

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of the facility's P&P titled, Care Planning-Interdisciplinary Team, dated March 2022, the P&P indicated, Resident care plans are developed according to the timeframes established by S483.21 . Comprehensive, person-centered care plans are based on resident assessment . During a review of the facility's P&P titled, Resident Rights, dated February 2021, the P&P indicated, Federal and sate laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: .be informed of .his or her care planning and treatment. 3. During an observation on 4/22/24 at 9:36 a.m. in Resident 35's room, Resident 35's bed bilateral (both sides) bed rail assist bars, one on the right and one on the left side of the bed. During a review of Resident 35's Admissions Record (AR), dated 4/23/24, the AR indicated, Resident 35 was admitted on [DATE] with diagnoses of traumatic subdural hemorrhage (a rapidly developing brain bleed, caused by a significant head injury) with loss of consciousness, Aphasia (a language disorder that affects a person's ability to speak) following cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area), hemiplegia (paralysis [the loss of the ability to move and sometimes to feel anything] of one side of the body) and hemiparesis (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles) following cerebral infarction affecting right dominant side, dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), and cognitive communication deficit. During a review of Resident 35's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment) Section C, dated 3/30/24, the MDS Section C indicated Resident 35 had a Brief Interview for M [TRUNCATED]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056266	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fresno Nursing Center	3672 North First Street Fresno, CA 93726

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 48739 Based on interview and record review, the facility failed to provide sufficient staff with the appropriate competencies and skill sets to provide nursing services and ensure residents receive services to maintain their highest practicable physical, mental, and psychosocial well-being when: 1. One of seven Licensed Vocational Nurses (LVN)s did not receive a blood glucometer (a small portable device used to check sugar levels in the blood) competency skills check off after being hired. This failure had the potential to place residents at risk of being exposed to the spread of infections. 2. Four of seven LVNs did not complete their required mandatory annual competency trainings. 3. One of five Certified Nursing Assistants (CNA)s did not receive a competency skills check off after being hired. 4. Two of five CNAs did not complete their required mandatory annual competency trainings. These failures had the potential to place residents at risk for care not provided in a safe and competent manner. Findings: 1. During an interview on 4/23/24 at 2:29 p.m. with the DSD, the DSD stated all staff go through mandatory competency training upon hire and annually. During an interview on 4/23/24 at 4:21 p.m. with the IDON, the IDON stated competencies and annual trainings should be completed on time. The IDON stated he was ultimately responsible for making sure staff had completed their competencies and training. During a concurrent interview and record review on 4/24/24 at 11:35 a.m. with the DSD, LVN 8's Personnel File (PF), dated (undated) was reviewed. The PF indicated, LVN 8 had not completed her blood glucometer competency. The DSD stated if LVN 8 did not complete the blood glucometer competency, LVN 8 would not be able to perform blood sugar testing on residents until the competency was completed. 2. During a concurrent interview and record review on 4/23/24 at 11:16 a.m. with the Director of Staff Development (DSD), Licensed Vocational Nurse (LVN) 4's PF, dated (undated) was reviewed. The DSD stated LVN 4 had no competency training for 2024. The DSD stated LVN 4 should have completed her competency training for dementia, falls, communication, customer service and resident rights in January 2024. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056266	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fresno Nursing Center	3672 North First Street Fresno, CA 93726

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 4/23/24 at 4:00 p.m. with the DSD and the IDON, the Minimum Data Set (MDS) Coordinator's PF, dated (undated) was reviewed. The PF indicated the MDS's orientation packet was not completed. The DSD stated the MDS's orientation packet was not completed. The IDON stated the orientation packet should have been completed the first week of employment with the facility. The DSD stated the MDS had not completed her abuse and dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life) training. During an interview on 4/23/24 at 4:10 p.m. with the DSD, the DSD stated the importance of dementia training was to give knowledge and training to staff on how to deal with residents with a dementia diagnosis. The DSD stated the importance of abuse training was to prevent abuse, to identify abuse, and know how to report abuse. The DSD stated abuse training was to educate staff on the process of being a mandated reporter and to know how to provide safety for the resident. During an interview on 4/23/24 at 4:21 p.m. with the IDON, the IDON stated the importance of annual staff competencies was it kept staff educated and trained on their skills to provide care for the residents. The IDON stated knowing how to care for residents with dementia, and knowing how to approach them to see what assistance they needed was very important, since the facility had a large population of residents with a diagnosis of dementia. The IDON stated abuse training was important for staff to know how to report abuse. The IDON stated all staff were mandated reporters. The IDON stated competencies and annual trainings should be completed on time. The IDON stated he was ultimately responsible for making sure staff had completed their competencies and training. During a concurrent interview and record review on 4/24/24 at 11:35 a.m. with the DSD, LVN 8's PF, dated (undated) was reviewed. The PF indicated, LVN 8 had not completed her annual competency training since 8/2022. The DSD stated she could not find documentation of competency training for 2024. The DSD stated LVN 8 was overdue for her yearly competency training. During a concurrent interview and record review on 4/24/24 at 11:45 a.m. with the DSD, LVN 9's PF, dated (undated) was reviewed. The PF indicated LVN 9's last competency training was 8/2022. The DSD stated LVN 9 was overdue for her yearly training. During an interview on 4/24/24 at 12:32 p.m. with the DSD, the DSD stated she did not keep track of CNA hours of training. 3. During a concurrent interview and record review on 4/23/24 at 3:33 p.m. with the DSD and Interim Director of Nursing (IDON), Certified Nursing Assistant (CNA) 18's PF, dated (undated) was reviewed. The PF indicated CNA 18 did not have an initial skills check off in her personnel folder. The DSD stated there was no current training documented in CNA 18's PF. During an interview on 4/23/24 at 4:21 p.m. with the IDON, the IDON stated competencies and annual trainings should be completed on time. The IDON stated he was ultimately responsible for making sure staff had completed their competencies and training. During an interview on 4/24/24 at 12:32 p.m. with the DSD, the DSD stated she did not keep track of CNA hours of training. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056266	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fresno Nursing Center	3672 North First Street Fresno, CA 93726

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. During a concurrent interview and record review on 4/23/24 at 3:33 p.m. with the DSD and Interim Director of Nursing (IDON), Certified Nursing Assistant (CNA) 18's PF, dated (undated) was reviewed. The PF indicated CNA 18 did not have mandatory annual training for 2024. The DSD stated there was no current training for dementia, abuse, falls, communication, resident rights or infection control documented in CNA 18's PF. During an interview on 4/23/24 at 4:21 p.m. with the IDON, the IDON stated competencies and annual trainings should be completed on time. The IDON stated he was ultimately responsible for making sure staff had completed their competencies and training. During a concurrent interview and record review on 4/23/24 at 5:03 p.m. with the DSD, CNA 9's PF, dated (undated) was reviewed. The PF indicated, CNA 9's annual skills check and evaluation was last completed in 2018. The DSD stated the annual skills check for CNA 9 was due in July 2024 to correspond with her hire date in July. During an interview on 4/24/24 at 12:32 p.m. with the DSD, the DSD stated she did not keep track of CNA hours of training. During a review of the facility's policy and procedure (P&P) titled, In-Service Training, Nurse Aide, dated 8/2022, indicated, .all personnel are required to participate in regular in-service education . annual in-services address the special needs of the residents . include training that addresses the care of residents with cognitive impairment . include training in dementia management and resident abuse prevention . required training topics for all staff (including nurse aides) include . communication resident rights and facility responsibilities . abuse, neglect and exploitation of residents . quality assurance and performance improvement (QAPI) . infection control . compliance and ethics . behavioral health . nurse aid participation in training is documented by the staff development coordinator, or his or her designee and includes . the hours of training completed . During a review of the facility's P&P titled, In-Service Training, All Staff, dated 8/2022, indicated, . all staff must participate in initial orientation and annual in-service training . [staff] means all new and existing personnel . the primary objective of the in-service training is to ensure that staff are able to interact in a manner that enhances the resident's quality of life and quality of care and can demonstrate competency in the topic areas of the training . required training topics include . effective communication with residents and family (direct care staff) . resident rights and responsibilities . preventing abuse, neglect, exploitation, and misappropriation of resident property including . activities that constitute abuse, neglect, exploitation or misappropriation of resident property . procedures for reporting incidences of abuse, neglect, exploitation or misappropriation of resident property . dementia management and resident abuse prevention . elements and goals of the facility QAPI program . the infection prevention and control program standards, policies and procedures . behavioral health . the compliance and ethics program standards, policies and procedures . training requirements are met prior to staff providing services to residents, annually, and as necessary . training is documented by the staff development coordinator, or his or her designee and includes . the hours of training completed . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056266	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fresno Nursing Center	3672 North First Street Fresno, CA 93726

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's document titled, Job Title: Staff Development Coordinator/Director of Staff Development, dated 5/2019, indicated, . this position will ensure proper identification, planning, development, organization, implementation, evaluation of educational needs including in-services . identify in-service needs and ensure proper in-services are presented to staff and accurately documented . keep and record in-service attendance records on all personnel . During a review of the facility's document titled, Job Title: Director of Nursing, dated 5/2019, indicated, . training and development duties include . develop and participate in planning, implementing, conducting and scheduling orientation, training and in service educational activities for nursing services personnel . maintain professional competence . through participation in continuing education programs, seminars and training programs . quality assurance activities duties include . in-service tracking system . During a professional reference review retrieved from https://casetext.com/regulation/california-code-of-regulations/title-22-social-security/division-5-licensing-and-certification-of-health-facilities-home-health-agencies-clinics-and-referral-agencies/chapter-25-certified-nurse-assistant-program/article-4-continuing-education-and-in-service-training/section-71847-in-service-training-program titled, In-Service Training Program, dated 4/26/24, professional reference indicated, . each facility shall complete a performance review of every nurse assistant employed by the facility at least once every 12 months and must provide regular in-service training based on the outcome of these reviews . a nursing facility shall keep all records of in-service training programs on file for a period of four years starting from the date the first classes were offered . During a professional reference review retrieved from https://pubmed.ncbi.nlm.nih.gov/27059825/ titled, CNA Training Requirements and Resident Care Outcomes in Nursing Homes, dated 6/2017, the professional reference indicated, . a higher ratio of clinical to didactic (to teach or lecture) hours was related to better resident outcomes . total and in-service training hours also were related to outcomes .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056266	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fresno Nursing Center	3672 North First Street Fresno, CA 93726

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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 48739 Based on interview and record review, the facility failed to ensure a registered nurse was designated as the Director of Nursing (DON) on a full time basis when the facility did not have a designated DON from 3/13/24 to 4/16/24. This failure resulted in the lack of guidance, direction and leadership to all nursing staff, and had the potential to impact the quality of care, quality of life and medical treatment and services for all facility residents. Findings: During an interview on 4/16/24 at 9:27 a.m. with the Administrator (ADM), the ADM stated the Director of Nursing (DON) was out on medical leave. The ADM stated the facility has an Interim DON (IDON) filling in full-time as the DON. During an interview on 4/23/24 at 4:16 p.m. with the IDON, the IDON stated he was hired with the facility on 1/31/24 as the Minimum Data Set (MDS) Coordinator. The IDON stated he started as on-call (available by phone) IDON on 3/18/24. The IDON stated he transferred to the full-time DON on 4/16/24. During an interview on 4/24/24 at 4:45 p.m. with the ADM, the ADM stated the DON went on leave of absence (LOA) on 3/13/24. During an interview on 4/25/24 at 8:28 a.m. with the ADM, the ADM stated the nurses would go to the IDON when he was working in the capacity as the MDS Consultant when the DON was not present. The ADM stated the MDS Consultant filled in as the IDON on an on-call basis when the DON went on leave. The ADM stated when the IDON was on-call, nurses could reach him by phone if they needed to speak with him. During a review of the facility's document titled, .Job Description .Director of Nursing, dated 5/2019, the Job Description indicated, . the primary purpose of the position is to ensure the highest quality of resident care available, support staff . Director of Nursing will plan, organize, develop and direct the overall operation of the Nursing Services Department . to ensure that the highest degree of quality care can be provided to the residents at all times .assist in developing and implementing methods for coordinating nursing services with other resident services .assist in planning, developing, implementing and maintaining resident discharge procedures and plans, monitor resident's treatment and medications to ensure residents are receiving proper care .develop and participate in planning, implementing, conducting and scheduling orientation training and in service educational activities for nursing services personnel . must work in an office and other areas of the facility as needed .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056266	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fresno Nursing Center	3672 North First Street Fresno, CA 93726

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41166 Based on observation, interview, and record review the facility failed to ensure ten out of .residents (Residents 37, 17, 7, 50, 41, 34, 16, 11, 26, 2) were free from unnecessary psychotropic (drugs that affect brain activities associated with mental processes and behavior) medications when: 1. Resident 37 was administered fluoxetine (an antidepressant medication) and did not implement adequate behavior monitoring and side effect monitoring for the use of fluoxetine. 2. Resident 17 was administered buspirone and trazodone (antidepressant medications) and did not implement resident specific non-pharmacological (behavioral) interventions and adequate behavior monitoring for the use of buspirone and trazodone. 3. Resident 7 was administered duloxetine (antidepressant medication), alprazolam (antianxiety medication), and olanzapine (antipsychotic medication that alters brain chemistry to help reduce symptoms of the mind where there has been some loss of contact with reality) and did not implement resident specific non-pharmacological interventions and adequate behavior monitoring for the use of duloxetine, alprazolam and olanzapine, and appropriate use of olanzapine. 4. Resident 50 was administered mirtazapine (antidepressant medication) and did not implement adequate behavior monitoring and non-pharmacological interventions for the use of mirtazapine. 5. Resident 41 was administered trazodone and sertraline (antidepressant medication) and did not implement adequate behavior monitoring, resident specific non-pharmacological interventions for the use of trazodone and sertraline, and appropriate dose increase for the use of sertraline. 6. Resident 34 was administered quetiapine (antipsychotic medication) and did not implement adequate behavioral monitoring, resident specific non-pharmacological interventions, and manufacturer specified monitoring for the use of quetiapine. 7. Resident 16 was administered quetiapine and lorazepam (antianxiety medication), and did not implement adequate behavioral monitoring, resident specific non-pharmacological interventions for the use of quetiapine and lorazepam and did not implement adequate side effect monitoring for the use of lorazepam. 8. Resident 11 was administered clonazepam (antianxiety medication), and sertraline (antidepressant medication), and did not implement resident specific non-pharmacological interventions and adequate behavior monitoring for the use clonazepam and sertraline. 9. Resident 26 was administered alprazolam (antianxiety medication) and mirtazapine and did not implement resident specific non-pharmacological interventions, adequate side effect monitoring and adequate behavior monitoring for the use of alprazolam and mirtazapine. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056266	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fresno Nursing Center	3672 North First Street Fresno, CA 93726

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	10. Resident 2 was administered olanzapine and did not implement adequate side effect monitoring and manufacturer specified monitoring for the use of olanzapine. These failures resulted in the potential for unnecessary psychotropic medications for Residents 37, 17, 7, 50, 41, 34, 16, 11, 26, and 2, which increased the potential for medical interactions, adverse reactions, and unidentified risks associated with the use of psychotropic medications including but not limited to sedation, respiratory depression, constipation, anxiety, agitation, memory loss, and death. Findings: 1. During a concurrent interview and record review on 4/25/24 at 11:02 a.m., with Licensed Vocational Nurse (LVN) 4, Resident 37's Admission Record (AR), undated, Physician Order (PO) dated 2/27/24, and Medication Administration Record (MAR) dated 4/1/24 to 4/30/24 were reviewed. Resident 37's AR indicated that Resident 37 was admitted to the facility on [DATE], with diagnoses including depression. Resident 37's PO indicated fluoxetine 10 mg (milligrams- unit of measure) daily for depression manifested by sad facial expression. When asked to describe Resident 37, LVN 4 stated Resident 37 was verbal and able to communicate needs. During a review of Resident 37's MAR, Resident 37's MAR indicated, Monitor for depression m/b [manifested by] sad facial expression . LVN 4 acknowledged Resident 37 was verbal and able to communicate needs. LVN 4 stated nursing staff would ask resident how he's feeling but it was not being monitored. LVN 4 stated Resident 37 was non-verbal when he arrived at the facility and had progressed and was now alert and verbal. LVN 4 acknowledged monitoring sadness by facial expression was not adequate. During a review of Resident 37's MAR, LVN 4 was unable to provide documentation of monitoring of side effects related to the use of fluoxetine prior to 4/25/24. LVN 4 acknowledged that prior to 4/24/24, nursing staff did not monitor Resident 37 for side effects related to the use of fluoxetine. LVN 4 stated it was important to monitor side effects for patient safety and also to be able to notify doctor if any changes from baseline. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056266	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fresno Nursing Center	3672 North First Street Fresno, CA 93726

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. During a concurrent interview and record review on 4/25/24 at 11:45 a.m. with LVN 4, Resident 17's AR, undated, PO dated 8/3/23, 1/27/24, MAR dated 4/1/24 to 4/30/24 and Care Plan (CP) were reviewed. Resident 17's AR indicated Resident 17 was admitted to the facility on [DATE], with diagnoses including lack of expected normal physiological development in childhood, insomnia, chronic pain, and cognitive communication deficit. Resident 17's PO indicated buspirone 15 mg three times daily for anxiety manifested by yelling, screaming even after all needs met, starting 1/27/24 and trazodone 25 mg at bedtime for inability to sleep starting 8/3/23. During a review of Resident 17's CP for anxiety initiated 4/24/24, Resident 17's CP indicated non-pharmacological interventions as, Goal . Will have improvement of episodes of anxiety disorder & [and] behaviors through the review date . Interventions . 1) 1:1 [one on one supervision] 2) TV (Walker Texas Ranger) 3) Backrub 4) Give Fluids 5) Give Food 6) Redirect 7) Remove Resident from Environment take resident outside 8) Return to room [ROOM NUMBER]) Toilet . During a review of Resident 17'a CP for insomnia (inability to sleep) initiated 4/24/24, Resident 17's CP indicated non-pharmacological interventions as, Goal . Will have improvement of episodes of insomnia through the review date . Interventions . 1)1:1 2)TV (Walker Texas Ranger) 3) Backrub 4) Give Fluids 5) Give Food 6)Redirect 7) Remove Resident from Environment take resident outside 8) Return to room [ROOM NUMBER]) Toilet . LVN 4 acknowledged Resident 17's CP for anxiety and insomnia non-pharmacological interventions CP were initiated the day prior on 4/24/24, and did not have resident specific non-pharmacological interventions and measurable objective goals for anxiety and insomnia. LVN 4 stated nursing staff was unable to determine number of episodes for anxiety and insomnia established for Resident 17's goal. LVN 4 stated having an objective goal was important to help determine effectiveness of Resident 17's anxiety and insomnia medications and whether to increase or decrease medication dose. When asked about the monitoring of Resident 17's yelling and crying to get attention even after all needs met, LVN 4 stated Resident 17 was non-verbal and uses yelling and crying to get attention. LVN 4 stated when staff asks questions, Resident 17 nods yes or to have needs met. LVN 4 was unable to provide information on how nursing staff was able to determine whether Resident 17 was having anxiety or wanting needs met. 3. During a concurrent interview and record review on 4/25/24 at 12:22 p.m. with LVN 4, Resident 7's AR, undated, MAR dated 4/1/24 to 4/30/24 and CP were reviewed. Resident 7's AR indicated Resident 7 was admitted to the facility on [DATE], with diagnoses including psychosis, generalized anxiety, depression, insomnia, and cognitive communication deficit. Resident 7's MAR indicated, duloxetine 90 mg once daily for depression manifested by negative statements regarding health status with a start date of 2/27/24, olanzapine 5 mg at bedtime related to unspecified psychosis manifested by history of responding of internal stimuli, starting 2/26/24, alprazolam 0.5 mg every 12 hours for anxiety manifested by feelings of panic, causing self-distress, starting 3/3/24. During a review of Resident 7's MAR, Resident 7's MAR indicated for monitoring of Resident 7's behavior of anxiety, depression, and psychosis, nursing staff documented no. LVN 4 acknowledged nursing staff was expected to document the number of episodes of behavior per shift. When asked about Resident 7's combativeness to care for use of olanzapine, LVN 4 stated, I haven't found specific documentation for combativeness of care, she came in on Zyprexa [olanzapine]. During a review of Resident 7's MAR, Resident 7's MAR indicated non-pharmacological interventions to manage behaviors for the use of alprazolam, duloxetine, and olanzapine, starting 4/25/24, as, 1) 1:1 2) Activity 3) TV 4) Backrub 5) Change Position 6) Give Fluids 7) Give Food 8) Redirect 9) Keep room quiet. LVN 4 acknowledged Resident 7's non-pharmacological interventions were generalized and not resident specific. LVN 4 stated non-pharmacological interventions should be specific for each behavior pertinent to resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056266	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fresno Nursing Center	3672 North First Street Fresno, CA 93726

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	4. During a concurrent interview and record review on 4/25/24 at 2:26 p.m., with LVN 4, Resident 50's AR, undated, MAR dated 4/1/24 to 4/30/24 and CP were reviewed. Resident 50's AR indicated Resident 50 was admitted to the facility on [DATE] with diagnoses including depression. Resident 50's PO dated 12/9/23, indicated mirtazapine 15 mg at bedtime for depression manifested by less than 50 percent. During a review of Resident 50's MAR, LVN 4 was unable to provide documentation for the monitoring of Resident 50's behavior of eating less than 50 percent for the behavior of depression. LVN 4 stated nursing staff was not monitoring and documenting the appropriate behavior. During a review of Resident 50's CP for depression initiated 4/24/24, Resident 50's CP indicated, 1)1:1 2) Activity 3) Adjust Room Temperature 4) Watch TV In room [ROOM NUMBER]) Change Position 6) Give Fluids 7) Give Food 8) Redirect 9) Other -Refer to Progress note 10) Remove Resident from Environment take outside. 11)Return to room [ROOM NUMBER]) Toilet LVN 4 was unable to provide documentation of measurable objective goal for Resident 50's behavior manifested by depression, and stated non-pharmacological interventions for depression were not specific to address the behavior related to depression Resident 50 was having. 5. During a concurrent interview and record review on 4/25/24 at 3:39 p.m., with LVN 4, Resident 41's AR, undated, MAR dated 4/1/24 to 4/30/24, Progress Note (PN) dated 12/23/23, and CP were reviewed. Resident 41's AR indicated Resident 41 wad admitted to the facility on [DATE], with diagnoses including insomnia, depression, diabetes, and hyperlipidemia. Resident 41's MAR indicated, sertraline 50 mg daily for depression manifested by extreme irritability with start date 12/24/23, trazodone 25mg at bedtime for inability to sleep with start date 4/12/24. During a review of Resident 41's MAR, Resident 41's MAR indicated for monitoring of Resident 41's behavior of depression, nursing staff documented no. LVN 4 acknowledged nursing staff was expected to document the number of episodes of behavior per shift. During a review of Resident 41's PN dated 12/232/3 at 11:57 a.m., Resident 41's PN indicated for sertraline 25 mg daily to be discontinued and to start sertraline 30 mg daily. LVN 4 was unable to provide documentation for clarification of sertraline dose to 50 mg daily. During a review of Resident 41's CP for depression initiated 4/18/24 and insomnia initiated 4/24/24, Resident 17's CP indicated non-pharmacological interventions as, Interventions . 1)1:1 2) Activity 3) Watch TV 4) Backrub 5) Change Position 6)Give Fluids 7)Give Food 8)Redirect 9)Let me sleep 10) Remove Resident from Environment take resident outside . LVN was unable to provide documentation for measurable objective goal for monitoring of behavioral episodes for insomnia and depression, and acknowledged Resident 41's non-pharmacological interventions for depression and insomnia were generalized and not resident specific. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056266	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fresno Nursing Center	3672 North First Street Fresno, CA 93726

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	6. During a concurrent interview and record review on 4/25/24 at 4:17 p.m., with LVN 4, Resident 34's AR, undated, MAR dated 4/1/24 to 4/30/24, PO dated 4/5/24, and CP were reviewed. Resident 34's AR indicated Resident 34 was admitted to the facility on [DATE], with diagnoses including adjustment disorder with depressed mood and bipolar disorder. Resident 34's PO indicated quetiapine 25 mg daily for bipolar disorder for two weeks manifested by angry outburst. During a review of Resident 34's MAR, Resident 34's MAR indicated nursing staff documented yes and no. LVN 4 acknowledged nursing staff was expected to document the number of episodes of behavior per shift. During a review of Resident 34's CP for bipolar disorder initiated 4/24/24, Resident 34's CP indicated non-pharmacological interventions as, Interventions .1) repositioning 2) dim lights 3) quiet environment 4) relaxation techniques . LVN was unable to provide documentation of objective goal for behavior manifested by bipolar disorder and acknowledged Resident 34's non-pharmacological interventions were general and not resident specific. When asked for Resident 34's annual lipid and TSH (thyroid stimulating hormone) monitoring as specified by the manufacturer for quetiapine, LVN was unable to provide documentation and stated the physician did not order annual monitoring for Resident 34's lipid and TSH. During a review of Lexicomp, a nationally recognized reference, the manufacturer for quetiapine indicated, . frequency of antipsychotic monitoring . TSH . annually . lipid panel . 4 months after initiation; annually. 7. During a concurrent interview and record review on 4/25/24 at 4:43 p.m., with LVN 4, Resident 16's AR, undated, MAR dated 4/1/24 to 4/30/24, PO dated 9/1/23, 9/20/23 and CP were reviewed. Resident 16's AR indicated Resident 16 was admitted to the facility on [DATE] with diagnoses including hypoglycemia, depression, dementia with behavioral disturbance, cognitive communication deficit and anxiety. Resident 16's PO indicated, quetiapine 25 mg twice daily for unspecified psychosis related to agitation and combativeness and 50 mg at bedtime for agitation with a start date of 9/1/23, and lorazepam 0.5 mg every 12 hours for anxiety with a start date of 9/20/23. LVN 4 stated Resident 16's lorazepam was for exit seeking behaviors, and acknowledged Resident 16 also had a diagnosis of dementia. During a review of Resident 16's MAR, Resident 16's MAR indicated nursing staff documented no for episodes of refusal of care and combativeness, and for episodes of exit seeking behaviors related to anxiety. LVN 4 acknowledged nursing staff was expected to document the number of episodes of behavior per shift. LVN 4 was unable to provide documentation of monitoring for side effects related to the use of lorazepam prior to 4/24/24. During a review of Resident 16's CP for anxiety and unspecified psychosis, Resident 16's CP indicated non-pharmacological interventions as, Goal . Will have improvement in anxiety disorder & behaviors through the review date . Interventions . NON-PHARMACOLOGICAL INTERVENTIONS TO MANAGE BEHAVOIRS AS APPLICABLE FOR Lorazepam and quetiapine: 1) Adjust Room Temperature 2) Backrub 3) Change Position 4) Give Fluids 5) Give Food 6) Redirect 7) Remove Resident from Environment 8) Take outside accompanied by staff 9) Toilet . LVN 4 acknowledged Resident 16's non-pharmacological interventions were generalized and not resident specific. During a review of Lexicomp, a nationally recognized reference, the manufacturer for quetiapine indicated, Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056266	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fresno Nursing Center	3672 North First Street Fresno, CA 93726

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	8. During a concurrent interview and record review on 4/26/24 at 10:13 a.m., with LVN 6, Resident 11's AR, undated, MAR dated 4/1/24 to 4/30/24, and CP were reviewed. Resident 11's AR indicated Resident 11 was admitted to the facility on [DATE] with diagnoses including cognitive communication deficit, diabetes, and depression. During a review of Resident 11's MAR dated 4/1/24 to 4/30/24, Resident 11's MAR indicated physician orders for sertraline 50 g at bedtime for depression manifested by withdrawal from activity with a start date of 4/4/24, and clonazepam 1 mg twice daily for anxiety manifested by repetitive health complaints or concerns with a start date of 3/22/24. LVN 6 was unable to provide documentation of resident specific non-pharmacological interventions. During a review of Resident 11's MAR, Resident 11's MAR indicated nursing staff documented no for episodes of withdrawal from activities of interest and repetitive health complaints or concerns. During a review of Resident 11's CP for depression and anxiety, Resident 11's CP indicated non-pharmacological interventions for sertraline and clonazepam as, . Interventions . NON-PHARMACOLOGICAL INTERVENTIONS TO MONITORFOR BEHAVIORS AS APPLICABLE FOR .: 1) 1:1 2) Activity 3) Give Fluids 5) Give Food 3) Provide with quiet room . LVN 6 acknowledged Resident 11's CP did not have objective measurable goal to reassess behaviors related to the use of clonazepam and sertraline. 9. During a concurrent interview and record review on 4/26/24 at 10:56 a.m., with LVN 6, Resident 26's AR, undated, MAR dated 4/1/24 to 4/30/24, and CP were reviewed. Resident 26's AR indicated Resident 26 was admitted to the facility on [DATE] with diagnoses including cognitive communication deficit, Alzheimer's disease (memory disorder), and depression. During a review of Resident 26's MAR dated 4/1/24 to 4/30/24, Resident 26's MAR indicated physician orders for alprazolam 0.25 mg in the evening for anxiety, manifested by verbalizing fear of being alone with a start date of 9/8/23 and mirtazapine 7.5 mg at bedtime for depression manifested by poor oral intake with a start date of 9/9/23. During a review of Resident MAR, LVN 6 was unable to provide documentation for side effect monitoring for alprazolam and mirtazapine prior to 4/24/24. Resident 26's MAR also indicated nursing staff documented no for episodes of verbalizing fear of being alone. LVN 6 acknowledged nursing staff was expected to document number of behavioral episodes per shift and not yes or no. During a review of Resident 2's6 CP for anxiety and depression, Resident 26's CP indicated goals for alprazolam as, Resident 26's CP indicated non-pharmacological interventions for alprazolam and mirtazapine as, Goal . Will have improvement in anxiety disorder & behaviors through the review date. Interventions . NON-PHARMACOLOGICAL INTERVENTIONS TO MANAGE BEHAVIORS AS APPLICABLE FOR Mirtazapine: 1) 1:1 2) Activity 3) Change Position 4) Give Fluids 5) Give Food 6) Redirect and provide baby doll 7) Remove Resident from Environment 8) Return to room [ROOM NUMBER]) Toilet. LVN 6 acknowledged Resident 26's CP did not have objective measurable goals for Resident 26's behaviors related to the use of alprazolam and mirtazapine. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056266	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fresno Nursing Center	3672 North First Street Fresno, CA 93726

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	10. During a concurrent interview and record review on 4/26/24 at 11:29 a.m., with LVN 6, Resident 2's AR, undated, MAR dated 4/1/24 to 4/30/24, and CP were reviewed. Resident 2's AR indicated Resident 2 was admitted to the facility on [DATE] with diagnoses including cognitive communication deficit, diabetes, schizophrenia, and hyperlipidemia. During a review of Resident 2's MAR dated 4/1/24 to 4/30/24, Resident 2's MAR indicated a physician order for olanzapine 10 mg at bedtime for schizophrenia related to paranoid delusions manifested by screaming and yelling at others without purpose with a start date of 12/23/23. LVN 6 started Resident 2's olanzapine was initiated on admission on 7/13/22. When asked about a gradual dose reduction for Resident 2's olanzapine, LVN 6 was unable to provide documentation. For side effect monitoring related to the use of olanzapine, Resident 2's MAR indicated tardive dyskinesia (abnormal and involuntary facial, tongue movement), cognitive impairment, akathisia (inability to sit still), and parkinsonism (tremors, drooling, stiffness). LVN 6 acknowledged the side effects being monitored for the use of olanzapine was inadequate. When asked for Resident 2's TSH monitoring as specified by the manufacturer for quetiapine, LVN was unable to provide documentation and stated the physician did not order annual monitoring for Resident 2's TSH. During a review of Lexicomp, a nationally recognized reference, the manufacturer for olanzapine indicated, . frequency of antipsychotic monitoring . TSH annually. Monitor for and instruct patient to report signs of extrapyramidal symptoms [group of involuntary muscle movements], constipation, suicide ideation, sedation, CNS changes, and neuroleptic malignant syndrome (fever, muscle rigidity, confusion). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056266	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fresno Nursing Center	3672 North First Street Fresno, CA 93726

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 4/26/24 at 12:02 p.m., with Interim Director of Nursing (IDON), IDON stated he was aware Residents 37, 17, 7, 50, 42, 34, 16, 1, and 26's non-pharmacological interventions were general, and the facility was working on them. IDON stated non-pharmacological interventions should be personalized for each individual resident to help with their mood and behaviors. IDON acknowledged nursing staff did not appropriately monitor behavioral episodes for Residents 37, 17, 7, 50, 4, 34, 16, 11, 26, and 2. IDON stated the expectation was for nursing staff to count and document the number of episodes so staff will know if medications were working and to give staff a better goal. IDON acknowledged the facility was not able to assess the effectiveness of the psychotropics if staff was not documenting the number of behavioral episodes related to each psychotropic medication. IDON also acknowledged inadequate side effect monitoring related to the use of psychotropics for Residents 37, 16, 26 and 2, and stated the expectation was for nursing staff to be able to adequately monitor the side effects of the psychotropics so immediate action could be taken to treat side effect if identified. IDON acknowledged Residents 17, 7, 50, 41, 34, 16, 11, and 26's CP did not have objective goals for behavioral monitoring related to the use of psychotropic medications. IDON stated it was important to have a measurable goal for the number of behavioral episodes on each resident's CP in order to see if the medication was effective. IDON stated if a resident's CP did not have an objective goal for the number of behavioral episodes, then the team will not be able to assess if a resident is meeting goal. When asked about documentation of combativeness for Resident 7's use of olanzapine, IDON was unable to provide documentation. IDON stated the facility should have documentation of combativeness in notes prior to olanzapine being given. For Resident 16, when asked how nursing staff was able to differentiate if exit seeking behavior was due to Resident 16's dementia or having anxiety, IDON was unable to provide documentation. IDON stated he was aware of the black box warning related to the use of quetiapine, increasing the risk of death in dementia patients. IDON acknowledged the facility did not obtain manufacturer specified TSH, lipid labs for Residents 34 and TSH lab for Resident 2. IDON stated, If manufacturer specifies lab, we would follow the specification, we would draw lab to ensure there are no potential side effects. IDON acknowledged Resident 37 was verbal and stated the expectation was for nursing staff to change Resident 37's monitoring for depression to verbal expression of sadness. For Resident 17's use of buspirone for yelling and screaming after needs met, IDON was unable to provide documentation of how nursing staff was able to differentiate if yelling/screaming was for anxiety or wanting a need met. During a telephone interview on 4/26/24 at 12:51 p.m., with Doctor of Nursing Practice (DNP), DNP acknowledged nursing staff was expected to collect behavioral data, DNP stated, How can you treat if no behavior documented? For Resident 16, DNP stated nursing staff was expected to identify if Resident 16 had other causes of exit seeking behavior and acknowledged Resident 16's exit seeking behavior could be related to dementia. During a telephone interview on 4/26/24 at 1:33 p.m. with consultant pharmacist (CRPH), CRPH acknowledged nursing staff was expected to implement resident specific non-pharmacological interventions. CRPH stated, Each resident responds to different things and if you find out what the resident responds best to, then that's where you focus. For appropriate monitoring of behaviors, CRPH stated the expectation was for nursing staff to appropriately track the number of behavioral episodes so they can report to the doctor how many times the resident is having the behavior. For monitoring of side effects, CRPH stated the expectation was for nursing staff to appropriately monitor side effects and be able to differentiate an adverse event from disease so action can be taken if needed. CRPH acknowledged the importance to have objective measurable goal for behaviors in each resident's CP and stated it gave nursing staff an idea of what to aim for the resident's therapy. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056266	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fresno Nursing Center	3672 North First Street Fresno, CA 93726

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of the facility's Policy and Procedure (P&P), titled, Antipsychotic Medication Use dated 2022, the P&P indicated, Residents who are admitted from community or transferred from a hospital and who are already receiving antipsychotic medications will be evaluated for the appropriateness and indications for use . diagnosis of a specific condition for which antipsychotic medications are necessary to treat will be based on a comprehensive assessment of the resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056266	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fresno Nursing Center	3672 North First Street Fresno, CA 93726

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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** 49769 Based on observation, interview, record review, the facility failed to ensure food and ice were stored in accordance with professional standards for food service safety for all residents eating and drinking at the facility when: 1. The ice machine was not sanitized according to the manufacturer's directions 2. The dishes in dish machine were not sanitized according to the manufacturer's directions and the facility policy and procedure These failures had the potential to result in the growth of microorganisms and could lead to foodborne illnesses for the 63 residents eating food and drinking in the facility. Findings: 1. During an observation on 4/16/21 at 11:21 a.m., Kitchen Aid 1 (KA) as filling up a tray of cups of punch with ice from the kitchen ice machine and 35 cups water with ice. During a concurrent observation and interview on 4/16/24 at 4:16 p.m. with the Environmental Services Director (ESD) in the kitchen, MS stated he had responsibility for cleaning and sanitizing the ice machine. MS stated he cleans the ice machine two months in a row and a third-party vendor cleans it quarterly on the third month. MS stated he follows the manufacturer's recommendations which were on the door when he opened the top of the ice machine. MS stated he uses one gallon to one ounce cleaner for sanitizing of the bin compartment of the ice machine. When the ice machine was opened, and the curtain was removed there was brown/black substance on the bottom lip where water was present. The Surveyor wiped the substance with a clean glove and the substance came off. MS validated the substance and stated the substance should not be there. During a concurrent interview and record review on 4/16/24 at 4:35 p.m. with ESD, the Manufacturer's Recommendations titled Cleaning/Sanitizing Procedure (CP), was reviewed. The CP indicated, .Step 16. When water trough has refilled (approximately 1 minute) and the display indicates; add the proper amount of ice machine sanitizer to the water trough by pouring between the water curtain and evaporator.model 1000 . Amount of Sanitizer .3 ounces . ESD stated step 16 was missed when cleaning of the ice machine was performed. ESD validated step 16 on the CP was not followed per the manufactures recommendation for cleaning and sanitizing of the ice machine. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056266	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fresno Nursing Center	3672 North First Street Fresno, CA 93726

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a phone interview with the Contract Company that services the facility ice machine on 4/17/24 2:59 p. m. Contract employee (CE) 1, stated they come to facility for the ice machine every 3-4 months to do deep clean and every other month change filters. CE 1 stated the facility office person gets emails with invoice accounts payable. CE 1 stated the service technician who went to this facility frequently was recently got laid off. CE 1 stated there is another service technician who has done it in the past and she would put him through on the line. Contract Service Technician (CST) stated he would wash coils with water and empty bin, wipe it down look for signs of mold or mildew, then tear down clean and change out water filter every 6 months. CST stated he would use the chemical Nu-Calgon nickel safe food grade cleaner when cleaning the ice machine. He stated they were last there on [DATE]; and in January 2024 for a repair and clean. CST stated they come out every 4-6 months. CST confirmed they just wipe with hot water only. CST confirmed that they do not use or put in ice machine sanitizer in the ice machine. CST stated he was looking up that manufacturer's directions for the facility ice machine and confirmed that a sanitizer should be used, and they had not been doing that. CST stated they would start following manufacturer's directions and use the sanitizer as recommended by the manufacturer since they want to do a good job. During a review of the facility's policy and procedure titled, Ice Machines and Ice Storage chests, dated January 2012, the P&P indicated, .3. Our facility has established procedures for cleaning and disinfecting ice machines and ice storage chests which adhere to manufacturer's instructions . 2. During a concurrent observation and interview on 4/17/24 at 8:34 a.m. with KA 2 in the kitchen, KA 2 stated the temperatures of the dish machine needed to be 150 degrees Fahrenheit (F) for the wash cycle and 180 degrees F for the rinse cycle. It was noted that through multiple machine-wash cycles, the dishwasher thermometer did not reach the manufactures specifications of 180 degrees F for the rinse cycle. The surveyor's thermometer was placed inside the dish machine cycle during dishwashing and the thermometer indicated a temperature of 156.8 degrees F. KA2 did not check the temperature of each dishwashing cycle. The temperature on the rinse cycle through multiple cycles on the machine was 160-178 degrees F. KA2 validated the rinse temperature on the washing machine did not reach manufacture specification of 180 degrees F on the rinse cycle when asked to check temperature. KA2 stated this was not an acceptable temperature for rinse cycle. Additional rinse cycles revealed similar temperatures. During a concurrent observation and interview on 4/17/24 at 8:46 a.m. with the Dietary Supervisor (DS) in the kitchen, the DS observed the dishwasher did not reach manufactures specifications of 180 F on the rinse cycle. The DS validated the temperature did not reach 180 F. The DS stated this was not an acceptable practice. The DS stated they do not validate temperature of the dishwasher with thermometer going through the dishwasher, just by outside thermometer of the dishwasher. During a review of the Dish Machine Temperature Log (DMTL), dated April 2024, the DMTL indicated, .April 11th Wash-145 .Final Rinse-147 .April 17th Wash-151 .Final Rinse-180 . During a review of the facility's P&P titled, Dishwashing Machine Use, dated March 2010, the P&P indicated, . 3. Dishwashing machine hot water sanitation rinse temperatures may not be more than 194 F, or less than .b. 180 F .7. The operator will check temperatures using the machine gauge with each dishwashing machine cycle .the operator will monitor the gauge frequently during dishwashing machine cycle .8. The supervisor will check the calibration of the gauge weekly by: a. Running a secondary thermometer through the machine to compare temperatures . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056266	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fresno Nursing Center	3672 North First Street Fresno, CA 93726

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of AM15 Dishwasher Technical Manual 208-240V/60/3 (TM) (undated), indicated on page 18, .Operating temperature for all models are as follows: Rinse Temperature .Minimum Rinse 180 F .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056266	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fresno Nursing Center	3672 North First Street Fresno, CA 93726

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 medical records were complete and accurately documented in accordance with accepted professional standards of practice for two of eight sampled residents (Residents 23 and 31) when Resident 23 and 31's copy of Physician Orders for Life-Sustaining Treatment (POLST - a medical order signed by both the patient and medical provider that specifies the types of medical treatment a patient wishes to receive toward the end of life) were incomplete. This failure had the potential for Resident 23 and 31's decisions regarding treatment options and end of life wishes to not be honored. Findings: During a review of Resident 23's Admission Record (AR), dated [DATE], the AR indicated Resident 23 was admitted on [DATE] with diagnoses of kidney failure (a condition when the kidneys are unable to filter waste products from the blood), Type 2 Diabetes Mellitus (when the blood sugar levels in the body are too high), and major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities). During a review of Resident 23's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated [DATE], the MDS Section C indicated Resident 23 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] indicates severe cognitive impairment, ,d+[DATE] indicates moderately impaired, ,d+[DATE] indicates cognitively intact), which indicated Resident 23 was cognitively intact. During a concurrent interview and record review on [DATE] at 9:56 a.m. with the Medical Records (MR) Director, Resident 23's POLST, dated [DATE] was reviewed. The MR stated the POLST was missing the date of the physician's signature. The MR stated Resident 23's POLST was incomplete. During a review of Resident 31's AR, dated [DATE], the AR indicated Resident 31 was admitted on [DATE] with diagnoses of heart failure (a condition when the heart muscle doesn't pump enough blood to meet the body's needs which can cause fatigue and shortness of breath), cognitive communication deficit (difficulty with thinking and how someone uses language), acute myocardial infarction (a blockage of blood flow to the heart muscle), major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities), and anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities). During a review of Resident 31's MDS, dated [DATE], the MDS section C indicated Resident 31 had a BIMS score of 15, which indicated Resident 31 was cognitively intact. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056266	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fresno Nursing Center	3672 North First Street Fresno, CA 93726

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on [DATE] at 10:27 a.m. with the MR coordinator, Resident 31's POLST, dated [DATE] was reviewed. The POLST indicated the physician, physician assistant's license number, or Nurse Practitioner Certification number and physician signature date were missing. The MR stated Resident 31's POLST was not complete. During an interview on [DATE] at 11:56 a.m. with Licensed Vocational Nurse (LVN) 3, LVN 3 stated the importance of a POLST is to know if the resident or family wants the resident to have cardiopulmonary resuscitation (CPR-lifesaving procedure done when someone's heart stops beating) in case of an emergency. LVN 3 stated if the resident is transferred out of the facility, staff will make a double-sided copy of the POLST and send it with the resident to the hospital. LVN 3 stated if the POLST was missing the physician phone number, license number, or date of the physician's signature, the POLST would not be complete. During an interview on [DATE] at 10:52 a.m. with the Interim Director of Nursing (IDON), the IDON stated the POLST is a physician order, so staff would know what life sustaining measures to perform on the resident. The IDON stated the facility would send the POLST with the resident when the resident would leave the facility. The IDON stated an incomplete POLST made it difficult to know the resident's wishes for life-sustaining treatment. The IDON stated if the POLST was missing the physician's phone number, it would be difficult for the next provider to contact the resident's physician. The IDON stated if the resident's POLST was not completed, it could affect the resident's wishes for end-of-life care. The IDON stated the Director of Nursing (DON) was responsible for making sure the resident's POLST was completed. The IDON stated Resident 23 and 31's POLST should have been completed. During a review of the facility's document titled, Job Description . Medical Records, dated ,d+[DATE], indicated, . medical records duties include . monitoring the resident charts to ensure that all entries are complete, and made in a timely manner as long as the resident resides in the care center . each open resident's chart should be audited at least monthly for possible deficiencies; a record of such audits should be kept and address any possible medical record problems .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056266	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fresno Nursing Center	3672 North First Street Fresno, CA 93726

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 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** 47205 Based on observation, interview, and record review, the facility failed to ensure a safe, and sanitary environment to help prevent diseases and infections when: 1. One of four residents sampled (Resident 32's) oxygen (O2) nasal cannula (NC-a tube that directs oxygen into the nose) was found on the floor and part of the tube was laying on top of a garbage can. 2. Three of four oxygen concentrators (a medical device that gives you extra oxygen) and filters sampled, were visibly soiled with dust and debris, and not cleaned according to manufacturer's recommendation. 3. One of one (central) nurses' station countertop was peeling, cracked and/or missing veneer (a thin decorative covering of fine wood applied to a coarser wood or other material) which exposed the porous, non-wipe-able countertop. 4. The facility did not have a Legionella (a microscopic organism that can cause disease) when there's an outbreak (sudden occurrence of disease) water testing protocol, nor did they perform Legionella water testing. 5. One of two medication (med) carts sampled were visibly soiled with drip marks on the outside back wall of the medication cart and on the sharps (used needles and other sharp instruments) container affixed to the medication cart. 6. Two of two brand name pill crushers were visibly soiled with white, yellow, and orange colored powder-like substance encrusted on the devices. These failures had the potential to result in the spread of germs and bacteria, contamination of resident water, oxygen equipment and surfaces that could result in infections and illness. Findings: 1. During a concurrent observation and interview on 04/16/24 at 9:31 a.m. with Certified Nursing Assistant (CNA) 11 in Resident 32's room, an oxygen cannula was observed on the floor and part of the tubing was on top of a garbage bin. CNA 11 stated, the tubing shouldn't be on the floor. During an interview on 04/17/24 at 4:14 p.m. with CNA 15, CNA 15 stated, the O2 tubing should not be touching the floor; this could potentially cause bacteria to get inside the resident. During an interview on 04/17/24 at 4:31 p.m. with Licensed Vocational Nurse (LVN 2), LVN 2 stated she was the nurse for Resident 32 today and stated the oxygen cannula shouldn't be on the floor or touching the garbage, no, it shouldn't. LVN 2 stated, pathogens on the floor could travel up the resident's nose and cause illness. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056266	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fresno Nursing Center	3672 North First Street Fresno, CA 93726

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/17/24 at 5:09 p.m. with the Infection Preventionist (IP), the IP stated, the O2 tubing shouldn't have been on the floor and it shouldn't have been touching the garbage can. The IP stated, when not in use, the cannula should be in a dated bag resting on the side of the O2 concentrator and never be touching the floor. The IP stated, the dirty cannula can cause bacterial growth inside the tubing which will go in the resident's lungs and cause respiratory or bloodstream infections. During an interview on 04/24/24 at 11:46 a.m. with the Interim Director of Nurses (IDON), the IDON stated, the tubing should not have been on the floor or touching the garbage can. The DON stated this could potentially cause infections in the resident. During a review of the facility's policy and procedure (P&P) titled, Infection Prevention and Control Program, dated Quarter 3 2021, the P&P indicated, Important facets of infection prevention include: . ensuring that they adhere to proper techniques and procedures . During a review of the facility's P&P, titled, Cleaning and Disinfection of Environmental Surfaces, dated August 2019, the P&P indicated, Semi-critical items consist of items that may come in contact with mucous membranes (the moist, inner lining of some organs and body cavities (such as the nose, mouth, lungs, and stomach) or non-intact skin (e.g., respiratory therapy equipment). Such devices should be free from all microorganisms (a living thing that on its own is too small to be seen without a microscope). 2. During an observation on 4/16/2024 at 10:15 a.m., during a tour of the unit, oxygen concentrators at Resident 2, Resident 41, and Resident 44's bedside, were visibly soiled with dust particles and debris on the machine and filters. During a review of Resident 2's Admission Record (AR-a document that provides resident contact details, a brief medical history, level of functioning, preferences, and wishes) dated 4/16/2024, the AR indicated, admitted [DATE] . Diagnosis Information . shortness of breath . During a review of Resident 2's Minimum Data Set Section C Cognitive Patterns (MDS-comprehensive, standardized assessment of residents' functional capabilities and health needs), dated 2/28/2024, the MDS indicated, .BIMS .13 [indicating normal level of cognition (related to thinking, learning and understanding)] . During a review of Resident 41's AR, dated 4/16/2024, the AR indicated, admitted [DATE] . Diagnosis Information . Personal History of Covid-19, Personal History of Nicotine Dependence . During a review of Resident 41's MDS, the MDS section C dated 3/2/2024. indicated, .BIMS .14 [indicating normal level of cognition (related to thinking, learning and understanding)] . During a review of Resident 44's AR dated 4/16/2024, the AR indicated, admitted [DATE] . Diagnosis Information . Dependence on renal (kidney) dialysis (treatment that removes toxins [poison] from the blood . Anemia (too few red blood cells in the body) . Congestive Heart Failure (CHF- a long-term condition in which your heart can't pump blood well enough to meet your body's needs) . During a review of Resident 44's MDS, the MDS section C, dated 3/22/2024, indicated, .BIMS .14 [indicating normal level of cognition (related to thinking, learning and understanding)] . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056266	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fresno Nursing Center	3672 North First Street Fresno, CA 93726

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 4/16/2024 at 4:23 p.m., with Resident 44 and Registered Nurse (RN) 2, in Resident 44's room, an oxygen concentrator was at bedside. NC is draped across the concentrator hanging down toward the floor, but not touching the floor. RN 2 stated it is not supposed to be like that, [it is] supposed to be in a bag for prevention of bacteria on the tubing. RN 2 stated tubing should be dated and filter for concentrator is supposed to be cleaned. RN 2 stated usually NOC [Night] shift, on Saturday's, changes and labels tubing. RN 2 stated the oxygen tubing is supposed to be kept in a black bag to protect from possible contamination. RN 2 stated the filter on concentrator should be cleaned monthly and he has not had an opportunity to clean or change since [he's] worked here. Resident 44 stated she wanted the tubing changed and machine [concentrator] to be kept clean for her safety from germs. During an interview on 4/18/2024 at 2:29 p.m. with LVN 5, LVN 5 stated the Licensed Nurse is responsible for dating tubing, dating oxygen humidifier fluid, and cleaning of the outside casing of concentrator weekly and as needed (PRN). LVN 5 stated she knows there are filters in the machine, which should be cleaned. LVN 5 stated she was not sure of frequency on cleaning. LVN 5 stated NOC shift LN's change tubing, and wipe machine [oxygen concentrator]. LVN 5 stated the Housekeeper will clean the concentrator when a patient discharges. LVN 1 stated machine cleaning and tubing dating helps with infection control. During an interview on 04/18/2024 at 02:29 p.m., with LVN 3, LVN 3 stated the LN's are responsible to ensure tubing is dated, O2 humidifier [bottle] is dated, and concentrator is cleaned weekly/PRN outside casing. LVN 3 stated she knows there are filters in the machine, that should be cleaned but is not sure of frequency on cleaning. During an interview on 04/19/2024 at 9:59 a.m., with the IP, IP stated her expectation is that Licensed Nurses (LN's) keep the oxygen concentrators clean, no visible debris, no drips, and no visible soiled state. IP stated the tubing (NC) should be in a bag and typically ties onto the concentrator, on a clean surface not touching the floor. IP stated that LN's should change the tubing weekly, and as needed (PRN) if it appears soiled, touches the floor or other soiled surface. IP stated the tubing should be labeled and dated with date when opened. IP stated the maintenance department is responsible for cleaning and replacing oxygen concentrator filters. IP stated the current condition of the oxygen concentrators and tubing places the resident at risk for infection and possibly not receiving the necessary/ordered oxygen therapy. During an interview on 4/26/2024 at 10:00 a.m., with the IDON, IDON stated it is his expectation that the LN change and/or clean the oxygen equipment weekly and as needed. IDON stated if the oxygen tubing is not being used it should be kept in a bag. IDON stated these expectations keep the resident safe. During a review of the manufacturer's instructions for [brand name] Concentrator Maintenance the instructions indicated Section 6-Maintenance .1. Remove the filter and clean at least once a week depending on environmental conditions . Cleaning the cabinet Clean the cabinet with a mild household cleaner and non-abrasive cloth or sponge . 3. During a concurrent observation and interview on 4/17/2024 at 12:34 p.m., with the IDON, at the central nurses' station, the IDON stated the peeling, cracked and missing veneer makes these surfaces non-wipe-able surfaces. IDON stated they should be wipe-able and non-porous, could have collection of bacteria. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056266	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fresno Nursing Center	3672 North First Street Fresno, CA 93726

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 4/18/2024 at 1:49 p.m., with LVN 3, at the central nurse's station and visitor reception desk, the counter tops had peeling and missing pieces of veneer. LVN 3 stated no, in its current condition, the countertops were not easily cleanable which could lead to potential cross contamination and illness. During a review of the facility's policy and procedure (P&P) titled, Infection Prevention and Control Program, dated Quarter 3 2021, the P&P indicated, Important facets of infection prevention include: . ensuring that they adhere to proper techniques and procedures . During a review of the facility's P&P, titled, Cleaning and Disinfection of Environmental Surfaces, dated August 2019, the P&P indicated, Semi-critical items consist of items that may come in contact with mucous membranes (the moist, inner lining of some organs and body cavities (such as the nose, mouth, lungs, and stomach) or non-intact skin (e.g., respiratory therapy equipment). Such devices should be free from all microorganisms (a living thing that on its own is too small to be seen without a microscope). 4. During an interview on 04/17/24 at 5:35 p.m. with the Infection Preventionist (IP), the IP stated, to prevent Legionella from developing in the water pipes, maintenance only runs hot water. The IP stated, maintenance only test the water for Legionella. During an interview on 04/18/24 at 2:04 p.m. with the Environmental Service Director (ESD), the ESD stated, the hot water is run every Friday. The ESD stated, we don't do any Legionella testing. The ESD stated, the facility has no testing protocols for Legionella. During an interview on 04/18/24 at 2:53 p.m. with the Administrator (ADM), the ADM stated, is unaware if maintenance has done any testing for Legionella at all. During an interview on 04/24/24 at 11:42 a.m. the IDON, the IDON stated, doesn't know when the last time the water was for Legionella. The IDON stated, not testing the water can cause Legionnaire's disease (a lung infection) which is life threatening. 5. During a concurrent observation and interview on 4/17/2024 at 8:20 a.m., with LVN 4, LVN 4 stated the medication cart is cleaned, daily in between patients and at start and end of shift. LVN 4 stated the LN is responsible to restock, wipe down the cart with disinfectant wipes, computer wipe down, trash, cups restocking. LVN 4 stated the medication cart drawers are cleaned weekly and as needed (PRN). LVN 4 stated NOC shift normally checks the carts and makes sure maintenance including deep cleaning. LVN 4 stated LN's change out sharp's containers. During a concurrent observation and interview on 4/17/2024 at 8:55 a.m., with LVN 4, on the unit at Medication Cart B, drip marks, orange in color were observed on the attached sharps container, and drip marks, brown in color, were observed on back of med cart. LVN 4 stated med carts are supposed to be cleaned at least once per shift and as needed. LVN 4 stated the potential harm to residents of not maintaining a clean medication administration work surface, such as the medication cart could be contamination of medications while being prepared at dirty station could cause infection, or allergic/adverse reaction. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056266	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fresno Nursing Center	3672 North First Street Fresno, CA 93726

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/17/2024 at 12:34 p.m., with IDON, IDON stated, it is his expectation that LN's wipe down of all med cart surfaces daily, at each shift at least, tabletop and other medication preparation an administration device. IDON states that monthly deep cleaning of the medication carts is coordinated with the housekeeping and maintenance departments. During an interview on 04/19/2024 at 9:59 a.m., with the IP, IP stated her expectation is that the LN passing med's takes responsibility of the cart, clean before and after shift and PRN that includes all surfaces that may be touched or items that are used to prepare the medications (pill crusher). 6. During a concurrent observation and interview on 4/16/2024 at 10:54 a.m., on the unit at Medication Cart A with LVN 5, LVN 5 stated the brand name pill crushers on the medication cart did not appear clean. LVN 5 stated the medication cart along with the pill crushers are cleaned every shift at the end of the shift. LVN 5 stated the whole cart should be cleaned every shift by LN. LVN 5 stated the powder, white in color with some brown spots and build up in the inside of the device does not look like it was cleaned by the prior (NOC) shift. During a concurrent observation and interview on 4/17/2024 at 8:55 a.m., with LVN 4 at Medication Cart B, brand name pill crusher had residue/powder build-up, brown/orange in color on the device. LVN 4 stated the possible harm to residents if not clean is contamination of medications while being prepared at a dirty station that could cause infection, or allergic/adverse reaction. During a concurrent observation and interview on 4/17/2024 at 12:34 p.m., with the IDON, IDON stated it is his expectation that the LN's are wiping down of all cart surfaces at each shift at least tabletop and other med devices, daily. IDON stated the medication carts undergo a monthly deep cleaning. IDON stated these cleanings are coordinated with the housekeeping and maintenance departments. IDON stated the main nurses station with missing or peeling veneer made the surfaces on counter non-wipe-able. IDON stated the surface should be wipe-able and non-porous, could have collection of bacteria. During an interview on 04/19/2024 at 9:59 a.m., with the IP, IP stated her expectation is that the LN passing med's takes responsibility of the cart, clean before and after shift and PRN that includes all surfaces that may be touched or items that are used to prepare the medications (pill crusher). During a review of the facility's P&P titled, Infection Prevention and Control Program, dated Quarter 3 2021, the P&P indicated, Important facets of infection prevention include: .ensuring that they [staff] adhere to proper techniques and procedures . During a review of the facility's P&P, titled, Cleaning and Disinfection of Environmental Surfaces, dated August 2019, the P&P indicated, Policy Statement Environmental surfaces will be cleaned and disinfected according to current CDC (Centers for Disease Control) recommendations for disinfection of healthcare facilities .14. Horizontal surfaces will be wet dusted regularly (e.g., daily, three times per week) .15. Spills of blood and other potentially infectious materials will promptly be cleaned and decontaminated .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056266	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fresno Nursing Center	3672 North First Street Fresno, CA 93726

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. 48430 Based on interview, and record review, the facility failed to ensure one of five residents (Resident 16) was offered or administered the pneumonia (infection that affects one or both lung) vaccine (a substance injected into the body to protect it against diseases). This failure placed Resident 16 at risk to develop pneumonia. Findings: During a concurrent interview and record review on 04/17/24 at 5:09 p.m. with the Infection Preventionist (IP), Resident 16 Electronic Medical Record (EMR) dated April 2024 was reviewed. The IP stated, there were no records the pneumonia vaccine being given since admission. The IP stated, there were no past records of the resident receiving or refusing a pneumonia vaccine. The IP stated a declination form the refusal of the Pneumonia Vaccine should have been signed if it was offered and refused. During a review of Resident 16's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment) Section C, dated 3/24/24, the MDS Section C indicated Resident 16 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 08 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact) indicating Resident 16 had moderate cognitive impairment. During an interview on 04/24/24 at 11:48 with the Director of Nurses (DON), the DON stated, consents that show acceptance or refusals for immunizations must be signed by the RP or the patient's themselves. During a review of the facility's policy and procedure (P&P) titled, Vaccination of Residents, dated October 2019, the P&P indicated, All residents will be offered vaccines that aid in preventing infectious diseases unless the vaccine is medically contraindicated, or the resident has already been vaccinated. The P&P indicated, All new residents shall be assessed for current vaccination status upon admission.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056266	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fresno Nursing Center	3672 North First Street Fresno, CA 93726

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49769 Based on observation, interview, record review), the facility failed to ensure physical environmental maintenance were maintained when: 1. There were multiple areas of the floor throughout the kitchen that had missing sections of epoxy (a type of synthetic resin floor system that is laid on top of concrete substrates as a form of protection and decoration). resulting in a build-up of food particles. This failure had the potential to result in the growth of pathogenic (an organism which can cause diseases in a host [person)] organisms and create an environment for pest harborage for the 62 residents eating food in the facility. 2. The heating, ventilation and air conditioning (HVAC) unit (an appliance or system used to control the humidity, ventilation, and temperature in a building) was not maintained to prevent water damage for four of eight Residents (Residents 1, 7, 26, and 271) that access the restroom. This failure had the potential for Residents 1, 7, 26, and 271's shared bathroom ceiling to develop mold (a fungal growth that forms and spreads on various kinds of damp or decaying organic matter), and cause Residents 1, 7, 26, and 271 to develop infections in their lungs. Findings: 1. It would be the standard of practice to ensure the materials for indoor floor, wall, and ceiling surfaces under conditions of normal use are maintained to ensure they are smooth, durable and easily cleanable. Additionally, the presence of food debris or dirt on nonfood contact surfaces may provide a suitable environment for the growth of microorganisms which employees may inadvertently transfer to food. If these areas are not kept clean, they may also provide harborage for insects, rodents, and other pests. (US Food and Drug Administration (FDA) Food Code, 2022). It is the standard of practice to ensure maintenance of the physical environment. Floors are to be smooth and of durable construction and are nonabsorbent for easy cleaning. Requirements and restrictions regarding floor coverings, utility lines, and floor/wall junctures are intended to ensure that regular and effective cleaning is possible, and that insect and rodent harborage is minimized (FDA Food Code Annex, 2022). During general food services observations on 4/16/24 beginning at 9:32 a.m. in kitchen, there were multiple sections of the floor with layers missing, deteriorated, pulled up. a. Large area approximately 40 inches by 15 inches with top layer of epoxy flooring missing in front and underneath the 3-compartment sink. This area also had second and third layer of flooring missing revealing cement like surface with old red remains of flooring attached to it. There appeared to be dark unidentifiable substances all around the missing floor. Dirt was visible and stuck to the jagged edges. This area was not smooth or easily cleanable. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056266	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fresno Nursing Center	3672 North First Street Fresno, CA 93726

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. A rectangular shape approximate size of 40 inches by 15 inches floor has been replaced with new flooring in front and underneath the steamer. There is a approximately 1/4 inch to 1/2 inch gap around the rectangular area that is not flush with old flooring allowing debris, dirt, possible harboring of vermin to reside. Debris, food, dirt visible in the gap. This area was not smooth or easily cleanable. c. Attached to the rectangular gap, there is a 4 inch by 4 inch by 4 inch triangular gap between the new and old flooring. The edge of one side of the triangle is raised up about 1 inch with duct tape attempting to hold it down. The duct tape is not successful holding down the piece of flooring. The duct tape is folded over on itself and coming off and has debris, dirt, and hair attached to it. In this triangle there is no covering or flooring. In the triangle it appears to be a dirt floor. There is debris, food, hair in the gap. This area was not smooth or easily cleanable. d. Multiple other areas including 14 inches by 5 inches near the back door; and area pulled up and can see pipes approximately 10 inches in length by 5 inches underneath the dish machine. There were multiple areas in the dry storage room by the reach in freezers that had areas with epoxy flooring missing; one was approximately 12 inches by 1 inch, two other spots were approximately 2 inches, there was a large space approximately 20 inches in length by 12 inches under the reach in freezer with no epoxy flooring. This area was not smooth or easily cleanable. During a concurrent observation and interview on 4/16/24 at 4:14 p.m. with Environmental Services Director (ESD) in the kitchen, ESD stated some areas of the kitchen floor had epoxy coming off due to draining and flooding in the past. ESD could not recall time of draining and flooding. ESD stated started process to get quotes to redo entire kitchen floor. ESD received one verbal quote of approximately 55 thousand dollars. ESD does not have any documentation of this quote. MS does not recall the vendor's name of the quote. ESD stated the quote was received approximately in February 2024. ESD stated he felt it was expensive and he didn't bring it up since there was a change of ownership of the facility that was in process. During an interview on 4/17/24 at 11:06 a.m. with Registered Dietitian (RD), RD stated she is doing kitchen sanitation inspections quarterly, but will be changing to monthly. During a review of Registered Dietitian Job Description (JD), undated, the JD indicated, .this individual is responsible for .the department is maintained in a clean, safe, and sanitary manner .14. Works with the corporate dietitian .to maintain the Dining Services Department in a clean, safe, and sanitary manner . During a review of the facility policy and procedure titled, Maintenance Service dated 2001 revised 12/09, showed maintenance service shall be provided to all areas of the building. It showed the functions of maintenance personnel include but are not limited to: a. maintaining the building in compliance with current federal, state and local laws, regulations and guidelines. b. maintaining the building in good repair. 48739 2. During an observation on 4/16/24 at 11:09 a.m. in Resident 1, 7, 26 and 271's shared bathroom, the bathroom ceiling was observed to have blackened areas measuring one-half to two inches, with a two and one-half by two inch hole in the ceiling in Residents 1, 7, 26, and 271's bathroom. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056266	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fresno Nursing Center	3672 North First Street Fresno, CA 93726

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's Admission Record (AR), dated 4/19/24, the AR indicated Resident 1 was admitted on [DATE] with diagnoses of acute respiratory failure acute respiratory failure (a serious condition that occurs when the lungs cannot get enough oxygen into the blood or remove enough carbon dioxide [a waste gas] from the blood) with hypoxia (absence of enough oxygen in the tissues to sustain bodily functions), pleural effusion (a buildup of fluid between the tissues that line the lungs and the chest), and schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 2/20/24, the MDS section C indicated Resident 1 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15 with 15 being the highest score) score of 12 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which indicated Resident 1 was moderately impaired. During a review of Resident 7's, AR, dated 4/17/24, the AR indicated Resident 7 was admitted on [DATE] with diagnoses of paraplegia (paralysis [the loss of the ability to move and sometimes to feel anything] that occurs in the lower half of the body), psychosis (a mental disorder characterized by a disconnection from reality), anxiety disorder (disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), cognitive communication deficit (difficulty with thinking and how someone uses language), and major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities). During a review of Resident 7's MDS, dated [DATE], the MDS Section C indicated Resident 7 had a BIMS score of 11, which indicated Resident 7 was moderately impaired. During a review of Resident 26's AR, dated 4/19/24, the AR indicated, Resident 26 was admitted on [DATE] with diagnoses of displaced fracture of second cervical vertebra (a broken bone in the neck region of the spine), Alzheimer's disease, (a brain disorder that slowly destroys memory and thinking skills, and eventually, the ability to carry out the simplest tasks), and major depressive disorder. During a review of Resident 26's MDS, dated [DATE], the MDS section C indicated Resident 26 had a BIMS score of 3, which indicated Resident 26 was severely cognitively impaired. During a review of Resident 271's AR dated 4/19/24, the AR indicated Resident 271 was admitted on [DATE] with diagnoses of Alzheimer's disease, dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), and major depressive disorder. During a review of Resident 271's MDS, dated [DATE], the MDS section C indicated Resident 271 had a BIMS score of 11, which indicated Resident 271 was moderately impaired. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056266	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fresno Nursing Center	3672 North First Street Fresno, CA 93726

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/18/24 at 10:59 with the Infection Preventionist (IP), the IP stated the black spots on Resident 1, 7, 26, and 271's shared bathroom ceiling was possibly mold. The IP stated the black spots looked like they had been there a while. The IP stated the ceiling with black spots should not be that way. The IP stated if the black spots were mold, it could cause respiratory distress and different illnesses for the residents. The IP stated the bathroom ceiling would need to be corrected right away. During a concurrent observation and interview on 4/18/24 at 11:11 a.m. with the IP and the Administrator (ADM) in Resident 1, 7 26, and 271's shared bathroom, Resident 1, 7, 26 and 271's bathroom ceiling with black spots and a hole by the fire sprinkler was observed. The ADM stated the bathroom ceiling was not acceptable. The ADM stated the bathroom smelled like it needed to be aired out. The ADM stated he suspected the black areas in the ceiling were due to standing water. The IP stated if there is water leakage, it could turn to mold if it continued. During a concurrent observation and interview on 4/18/24 at 11:32 a.m. with the Environmental Services Director (ESD) in Resident 1, 7, 26, and 271's bathroom, the bathroom and bathroom ceiling were observed. The ESD stated the facility had an HVAC leak. The ESD stated he suspected the black areas on the ceiling were mold. The ESD stated he would not move the residents in the attached rooms when he bleached the ceiling but would close the bathroom door and have the bathroom fan on. The ESD stated he did not usually test for mold. The ESD stated when he was in the facility, staff would just tell him if repairs were needed. The ESD stated there was no written logbook to track needed repairs in the facility. During an interview on 4/18/24 at 12:11 p.m. with the ESD, the ESD stated, the condensation (water which collects as droplets on a cold surface when humid air [air that contains extremely small drops of water] is in contact with it) pan from the HVAC unit could overflow and cause a leak if the condensation hose was backed up. The ESD stated Residents 1, 7, 26, and 271's shared bathroom had water leak over the condensation pan onto the resident's bathroom ceiling. The ESD stated he had an HVAC vendor who would go check the HVAC unit if the ESD could not do the repairs. The ESD stated he did not keep a maintenance log for the HVAC unit. The ESD stated there was not really anything to service on the HVAC unit. The ESD stated the black spots were discovered about three weeks to one month ago. The ESD stated he forgot to do the repairs to Resident 1, 7, 26, and 271's shared bathroom. A recommended maintenance schedule for the AC unit was not provided as requested. During a telephone interview on 4/18/24 at 3:31 p.m. with the HVAC Vendor (ACV) 1, ACV 1 stated, on 7/23/23 there was a water leak in the ceiling from the condensation pan which was similar to a service he performed on site earlier last week. No documentation for the service performed one week ago from ACV 1 or the ESD was provided as requested. During a review of the facility's job duties for the ESD titled, .Supervisor . Maintenance, dated 5/2019 indicated, .this position is responsible for maintaining the facility . follow the facility's written maintenance program to both prevent and correct problems of the facility in maintaining appliances, equipment, etc. perform regular inspections of resident rooms, halls and common areas for order, safety and any repairs that may be required . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056266	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fresno Nursing Center	3672 North First Street Fresno, CA 93726

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 0908 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, Maintenance Service, dated 12/2009, indicated, . the Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times .maintaining the heat/cooling system . in good working order . establishing priorities in providing repair service . the Maintenance Director is responsible for developing and maintaining a schedule of maintenance service to assure that the buildings, grounds, and equipment are maintained in a safe and operable manner . maintenance personnel shall follow the manufacturer's recommended maintenance schedule . the Maintenance Director is responsible for maintaining the following records/reports . inspection of building . work order requests . maintenance schedules . records shall be maintained in the Maintenance Director's office . During a review of the facility's P&P titled Inspection of Heat/Air-Conditioning Systems, dated 5/2008, indicated, . prior to the beginning of each heating/cooling season our facility's heating and air-conditioning systems shall be inspected for possible gas leaks, lines that have burst, etc. During a review of the facility's P&P titled, Construction and Renovation - Maintaining Air Quality and Safety, dated 12/2006, indicated, . this facility shall take environmental infection control measures pertaining to air quality and safety . ventilation systems are maintained by the Environmental Services Director (or designee) consistent with manufacturers' instruction and Centers for Disease Control and Prevention (CDC) and Healthcare Infection Control Practices Advisory Committee (HICPAC) recommendations to ensure optimal removal of particulates, elimination of excess moisture . During a review of the AC Brand Name Unit Maintenance Manual (Manual), dated (undated), the Manual indicated . on initial start-up and periodically during operation, it will be necessary to perform certain routine service checks . a recommended maintenance schedule is located at the end of this section .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056266	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fresno Nursing Center	3672 North First Street Fresno, CA 93726

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 - Few	Put firmly secured handrails on each side of hallways. **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 three hallways, handrail was firmly secured to the wall. This failure had the potential to result in injury to residents, visitors, and staff. Findings: During a concurrent observation and interview on 04/16/24 at 3:49 p.m. with Certified Nursing Assistant (CNA) 12, in the Hollywood BLVD hallway, the side handrail between rooms [ROOM NUMBERS] was loose and moved back and forth. CNA 12 stated, the handrail is lose and moved back and forth an inch. CNA 12 stated, the handrail is probably not safe for the residents to hold on to. During a concurrent observation and interview on 04/18/24 at 11:40 a.m. with the Environmental Service Director (ESD), in the hallway between rooms [ROOM NUMBERS], the ESD stated, the handrails are loose and needed to be tightened. The ESD stated, the loose handrails had the potential to cause injury if the rails come off while the residents were using it. During an interview on 04/24/24 at 11:42 a.m. with the Director of Nursing (DON), the DON stated, the loose handrails should have been fixed. DON stated, the loose rails had the potential to cause a resident to fall. During an interview on 04/25/24 at 3:00 p.m. with the Administrator (ADM), the ADM stated, loose handrails are not safe, they're not suitable to be called safe. The ADM stated, loose and unsecured handrails could lead to residents or staff losing their balance resulting in a fall. During a review of the facility's policy and procedure (P&P), titled, Maintenance Service, dated December 2009, the P&P indicated, Maintenance service shall be provided to all areas of the building, grounds, and equipment. The P&P indicated, .maintenance department is responsible for maintaining the building .and equipment in a safe and operable manner at al times. The P&P indicated, .maintaining the building in good repair and free from hazards. During a review of the professional standard (PS) from the Legal Information Institute titled, Cal. Code Regs. Tit. 22, S 72635-Handrails, undated, the PS indicated, Corridors shall be equipped with firmly secured handrails as required by Section T17-058I, Title 24.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056266	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fresno Nursing Center	3672 North First Street Fresno, CA 93726

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 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program for all new and existing staff members. 48739 Based on interview and record review, the facility failed to implement and maintain an effective training program for new and existing Licensed Nurses (LN's), Certified Nursing Assistants (CNAs), and ancillary (additional) support staff for demonstrated competency consistent with their expected roles in the areas of abuse, neglect and exploitation (the action of using someone or something unfairly for your own benefit) training, dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life) training, communication training, resident rights training, infection control training, and falls training, for six of 13 direct care staff. This failure had the potential to place residents at risk for care not provided in a safe and competent manner. Findings: During a concurrent interview and record review on 4/23/24 at 11:16 a.m. with the Director of Staff Development (DSD), Licensed Vocational Nurse (LVN) 4's Personnel File (PF), dated (undated) was reviewed. The PF indicated LVN 4 completed dementia training on 1/27/23, falls training completed on 1/27/23, communication/customer service training completed on 1/27/23, and resident rights training was completed on 1/27/23. The DSD stated LVN 4 had no competency training for 2024. The DSD stated LVN 4 should have completed her competency training for dementia, falls, communication/customer service and resident rights in January 2024. During a concurrent interview and record review on 4/23/24 at 3:33 p.m. with the DSD and Interim Director of Nursing (IDON), Certified Nursing Assistant (CNA) 18's PF, dated (undated) was reviewed. The PF indicated CNA 18 did not have an initial skills check in her personnel folder. CNA 18's dementia training was last completed on 8/21/2015, abuse training was last completed 8/18/2015, falls training was completed on 8/19/2015, resident rights training was last completed on 8/18/2015, infection control training was last completed on 3/3/2018, and communication/customer service training was not found in CNA 18's PF. The DSD stated there was no current training for dementia, abuse, falls, communication, resident rights or infection control documented in CNA 18's PF. During a concurrent interview and record review on 4/23/24 at 4:00 p.m. with the DSD and the IDON, the Minimum Data Set (MDS) Coordinator's PF, dated (undated) was reviewed. The PF indicated the MDS had not completed her abuse training and dementia training, and the MDS's orientation packet was not completed. The DSD stated the MDS's orientation packet was not completed. The IDON stated the orientation packet should have been completed the first week of employment with the facility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056266	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fresno Nursing Center	3672 North First Street Fresno, CA 93726

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 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/23/24 at 4:10 p.m. with the DSD, the DSD stated the importance of dementia training was to give knowledge and training to staff on how to deal with residents with a dementia diagnosis. The DSD stated the importance of abuse training was to prevent abuse, to identify abuse, and know how to report abuse. The DSD stated abuse training was to educate staff on the process of being a mandated reporter and to know how to provide safety for the patient. The DSD stated she does not do an exit interview when staff leave the facility to report to Quality Assurance and Performance Improvement (QAPI) (a systematic, comprehensive, and data-driven approach to maintaining and improving safety and quality in nursing homes while involving all nursing home caregivers in problem solving) During an interview on 4/23/24 at 4:21 p.m. with the IDON, the IDON stated the importance of annual staff competencies was it kept staff educated and trained on their skills to provide care for the residents. The IDON stated knowing how to care for residents with dementia, and knowing how to approach them to see what assistance they needed was very important, since the facility had a large population of residents with a diagnosis of dementia. The IDON stated abuse training was important in order for staff to know how to report abuse. The IDON stated all staff were mandated reporters. The IDON stated competencies and annual trainings should be completed on time. The IDON stated he was ultimately responsible for making sure staff had completed their competencies and training. During a concurrent interview and record review on 4/23/24 at 5:03 p.m. with the DSD, CNA 9's PF, dated (undated) was reviewed. The PF indicated, CNA 9's annual skills check/evaluation was last completed in July 2018. The DSD stated she did not see a documented current annual skills check/evaluation. The DSD stated she did not have the annual skills check for CNA 9 scheduled until July 2024 to correspond with her hire date. During an interview on 4/24/24 at 11:10 a.m. with the DSD, the DSD stated QAPI staff training was not completed. The DSD stated she was trained as a department head on QAPI. The DSD stated she did not give QAPI training to staff. The DSD stated education, including compliance and ethics training was provided to staff when a situation arose. During a concurrent interview and record review on 4/24/24 at 11:35 a.m. with the DSD, LVN 8's PF, dated (undated) was reviewed. The PF indicated, LVN 8 had not completed her blood glucometer (a small portable device used to check sugar levels in the blood) competency. The DSD stated she could not answer why her glucometer competency was not completed. The DSD stated she could not find documentation of training for dementia, abuse, falls, communication/customer service, resident rights, and infection control training completed in 2024 for LVN 8. The DSD stated the last training for LVN 8 was 3/9/23. The DSD stated LVN 8 was overdue for her yearly training. During a concurrent interview and record review on 4/24/24 at 11:45 a.m. with the DSD, LVN 9's PF, dated (undated) was reviewed. The PF indicated LVN 9's dementia training was last completed on 8/25/22, abuse training was last completed on 8/25/22, falls training was last completed on 8/25/22, communication/customer service training was last completed on 8/25/22, resident rights training was last completed on 8/25/22, and infection control training was last completed on 8/25/22. The DSD stated LVN 9 was overdue for her yearly training. During an interview on 4/24/24 at 12:32 p.m. with the DSD, the DSD stated she did not keep track of the required training hours for the Certified Nursing Assistants. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056266	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fresno Nursing Center	3672 North First Street Fresno, CA 93726

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 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's Resident Matrix (a listing of residents by medical conditions), dated 4/16/24, the Resident Matrix indicated there were 27 out of 62 residents with a diagnosis of Alzheimer's disease (an irreversible, progressive brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks) or Dementia. During an interview on 4/23/24 at 4:21 p.m. with the IDON, the IDON stated the importance of annual staff competencies was it kept staff educated and trained on their skills to provide care for the residents. The IDON stated knowing how to care for residents with dementia, and knowing how to approach them to see what assistance they needed was very important, since the facility had a large population of residents with a diagnosis of dementia. The IDON stated competencies and annual trainings should be completed on time. The IDON stated he was ultimately responsible for making sure staff had completed their competencies and training. During a review of the facility's policy and procedure (P&P) titled, In-Service Training, Nurse Aide, dated 8/2022, indicated, . all personnel are required to participate in regular in-service education . annual in-services address the special needs of the residents . include training that addresses the care of residents with cognitive impairment . include training in dementia management and resident abuse prevention . required training topics for all staff (including nurse aides) include . communication resident rights and facility responsibilities . abuse, neglect and exploitation of residents . quality assurance and performance improvement (QAPI) . infection control . compliance and ethics . behavioral health . nurse aid participation in training is documented by the staff development coordinator, or his or her designee and includes . the hours of training completed . During a review of the facility's P&P titled, In-Service Training, All Staff, dated 8/2022, indicated, . all staff must participate in initial orientation and annual in-service training . [staff] means all new and existing personnel . the primary objective of the in-service training is to ensure that staff are able to interact in a manner that enhances the resident's quality of life and quality of care and can demonstrate competency in the topic areas of the training . required training topics include . effective communication with residents and family (direct care staff) . resident rights and responsibilities . preventing abuse, neglect, exploitation, and misappropriation of resident property including . activities that constitute abuse, neglect, exploitation or misappropriation of resident property . procedures for reporting incidences of abuse, neglect, exploitation or misappropriation of resident property . dementia management and resident abuse prevention . elements and goals of the facility QAPI program . the infection prevention and control program standards, policies and procedures . behavioral health . the compliance and ethics program standards, policies and procedures . training requirements are met prior to staff providing services to residents, annually, and as necessary . training is documented by the staff development coordinator, or his or her designee and includes . the hours of training completed . During a review of the facility's P&P titled, Abuse and Neglect - Clinical Protocol, dated 3/2018, indicated, . the physician and staff will help identify risk factors for abuse within the facility, for example . issues related to staff knowledge and skill, or performance that might affect resident care . During a review of the facility's P&P titled, Dementia-Clinical Protocol, dated 11/2018, indicated, . nursing assistants will receive initial training in the care of residents with dementia and related behaviors. In-services will be conducted at least annually thereafter. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056266	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fresno Nursing Center	3672 North First Street Fresno, CA 93726

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 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's document titled, Job Title: Staff Development Coordinator/Director of Staff Development, dated 5/2019, indicated, . this position will ensure proper identification, planning, development, organization, implementation, evaluation of educational needs including in-services . identify in-service needs and ensure proper in-services are presented to staff and accurately documented . keep and record in-service attendance records on all personnel . During a review of the facility's document titled, Job Title: Director of Nursing, dated 5/2019, indicated, . training and development duties include . develop and participate in planning, implementing, conducting and scheduling orientation, training and in service educational activities for nursing services personnel . maintain professional competence . through participation in continuing education programs, seminars and training programs . quality assurance activities duties include . in-service tracking system . The professional reference document titled Center for Clinical Standards and Quality/Survey & Certification Group, dated 9/14/12, indicated . the Affordable Care Act: Section 6121 requires the Centers for Medicare & Medicaid Services (CMS) to ensure that nurse aides receive regular training on caring for residents with dementia and on preventing abuse. CMS created this training program to address the requirement for annual nurse aides training on these important topics . During a professional reference review retrieved from https://www.nursinghomeabuse.org/articles/nursing-home-abuse-training/ titled, Abuse and Neglect Training in Nursing Homes, dated 3/31/21, the professional reference indicated, . Nursing home abuse and neglect is unfortunately still a problem in nursing homes across the country. Nursing homes can significantly reduce the incidence of abuse and neglect in their facilities by investing in training and prevention. Nursing home facilities that do offer training have shown to have fewer cases of abuse and neglect .