

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/30/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056281	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/15/2026
NAME OF PROVIDER OR SUPPLIER Foundation Skilled Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 925 North Cornelia Fresno, CA 93706	
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 - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to maintain accurate documentation for one of three sampled residents (Resident 2) when LVN 1 documented Resident 2's wound care and bandage change was completed on 5/15/26. This failure resulted in inaccurate wound care documentation and had the potential to result in delayed wound healing, infection and sepsis. During a concurrent observation and interview on 5/15/26 at 11:45 am with Certified Nurse Assistant 1 (CNA 1), Resident 2 was observed in her bed. CNA 1 stated the facility was treating Resident 2's foot wounds with blue protective booties. When CNA 1 exposed Resident 2's feet, Resident 2 was wearing the booties on both feet. CNA 1 said they could not see any dressings and did not know whether any should have been present. During a concurrent observation and interview on 5/15/26 at 11:50 am with Licensed Vocational Nurse 1 (LVN 1), Resident 2 was observed in her bed. LVN 1 stated the treatment orders for Resident 2's wounds included hydrocolloid dressings and protective booties. LVN 1 exposed Resident 2's feet and removed the blue protective booties. LVN 1 stated she could not see any wound dressings on Resident 2's wounds. LVN 1 stated she had just finished giving medications to the residents and was about to start on dressing changes. When asked why there was no dressings currently on the wounds, LVN 1 stated it might have come off on the night shift and they forgot to replace it. During a concurrent interview and record review on 5/15/26 at 12:18 pm with the Director of Nursing (DON), Resident 2's medical records were reviewed. Resident 2's Physician's Order for wound care dated 4/24/26 at 6:34 pm, indicated Cleansed with NS (normal saline, a sterile salt solution), pat dry, apply [name of hydrocolloid dressing- a special type of bandage that promotes healing and protects the area from bacteria] to wound and cover with [name of bandage roll- a type of woven absorbent dressing] as needed AND every day shift every Tue, Fri. The DON reviewed the May 2026 TAR (Treatment Administration Record) and stated that LVN 1 had documented the wound care cleansing and dressing as completed that morning [5/15/2026]. During a concurrent observation and interview on 5/15/26 at 12:30 pm with the DON, Resident 2's feet were observed. The DON stated she could not find any dressings on Resident 2's foot wounds. During a concurrent interview and record review on 5/15/26 at 12:31 pm with LVN 1, LVN reviewed Resident 2's TAR for 5/15/26 and stated they had mistakenly documented the dressing change as completed. LVN 1 said they had been checking boxes and accidentally checked the wound care box before providing care. LVN 1 acknowledged that documenting care before completing it was poor practice because it could result in wound treatments not being completed timely which could cause infection, wound worsening, sepsis, or amputation. During a concurrent interview and record review on 5/15/26 at 12:40 pm with DON, the facility's Policy & Procedure (P&P) titled Charting and Documentation, dated July 2017, was reviewed. The DON stated that nurses sometimes document orders as completed before performing them, which the DON identified as not being best practice because it could lead to missed care. The DON said the facility had not followed its policy. During a concurrent interview and record review on 5/15/26 at 12:51 pm with the Administrator (ADM), the facility's Policy & Procedure (P&P) titled Charting and Documentation, dated July 2017, was reviewed. the ADM stated Licensed Nurses were (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 056281
		If continuation sheet Page 1 of 2

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	expected to follow orders and document only after completing them. The ADM stated documenting before performing care could cause treatments to be missed while appearing completed, leading to negative resident outcomes. During a review of Resident 2's medical records, Resident 2's Face Sheet (front page of the chart that contains a summary of basic information about the resident) (undated), the face sheet indicated Resident 2 was a [AGE] year old female who was admitted to the facility on [DATE] and had a medical history that included Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities), anemia (a condition where the body does not have enough healthy red blood cells), Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and local Infection of the skin and subcutaneous (fat layer under the skin) tissue. Resident 2's BIMS (Brief Interview for Mental Status-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) dated 4/21/26, indicated Resident 2 was Severely impaired - never/rarely made decisions. During a review of the facility policy and procedure titled, Charting and Documentation, dated July 2017 indicated, All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. 3. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. 5. All documentation shall be accurate, complete, timely, and reflective of the care and services provided. 6. When documentation errors are identified, the facility may enter an addendum or correction in accordance with facility policy to clarify the record while preserving the original entry. 9. Documentation of procedures and treatments will include care-specific details, including: a. the date and time the procedure/treatment was provided.		