

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

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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 06/09/2026
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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents received adequate supervision and assistance for one of three sampled residents (Resident 1) when Resident 1 who was assessed as needing a staff member to accompany her during medical appointments was transported to a doctor's appointment by herself without a staff member present. This failure resulted in Resident 1 not completing her appointment, delayed care, and placed her at risk for injuries. During a concurrent observation and interview on 6/9/26 at 10:40 a.m. with Resident 1, Resident 1 sat halfway on her bed with her feet on the floor, dressed in a facility gown, with a wheelchair nearby. Resident 1 stated she had a gynecology (GYN) appointment the previous week for evaluation of her cancer. Resident 1 stated she was dropped off at the appointment in her wheelchair, and no one accompanied her. She could not remember further details, including whether she completed the appointment. During an interview on 6/9/26 at 11 am with Certified Nurse Assistant (CNA) 1, CNA 1 stated she knew Resident 1 well. CNA 1 said Resident 1 previously assisted the CNAs with her ADLs but was now completely dependent, required a two-person assist for transfers, and was always incontinent. CNA 1 stated Resident 1 went alone only to dialysis appointments and required staff member to escort and assist her to all other medical appointments because she could not walk, use the bathroom independently, or manage her confusion. CNA 1 did not know whether an escort accompanied Resident 1 to the GYN appointment but stated she needed one. During a concurrent interview and record review on 6/9/26 at 11:37 a.m. with Licensed Vocational Nurse (LVN) 1, Resident 1's ERM was reviewed. LVN 1 stated Resident 1 was a maximum assist, two-person transfer and did not walk. LVN 1 stated the facility normally sent someone with her to medical appointments other than dialysis because she needed help with transferring and dressing/undressing. LVN 1 stated Resident 1 required assistance at a GYN appointment and not having an escort would put her at risk for injury. During a concurrent interview and record reviews on 6/9/26 at 11:45 a.m. with the Social Service Director (SSD), Resident 1's social service notes were reviewed. The SSD stated Resident 1's 6/2/26 GYN appointment was not completed because she had soiled herself and the GYN office said they could not complete the appointment without a care giver with Resident 1. SSD stated Resident 1 had a BIMS of 9, was incontinent, a heavy wetter, and he did not know how she went to the appointment without a responsible person. The SSD stated he and the Transportation Scheduler (TS) scheduled appointments and transportation, while nursing ensured residents had what they needed. The SSD said he had never seen and could not find a Policy and Procedure (P&P) for scheduling outside appointments for the residents. He recalled the GYN office reported Resident 1 arrived with a soiled adult diaper and an odor and they could not complete the exam. During an interview on 6/9/26 at 12:10 p.m. with the TS, the TS stated Licensed Nurses forwarded referrals to the SSD, the SSD schedules the appointment, and TS arranged for transportation. The TS stated the Director of Staff Development (DSD) scheduled extra staff when escorts were required. The TS stated Licensed Nurses knew which residents needed escorts and should have ensured Resident 1 had one. The TS reported never seeing a policy for scheduling appointments. During a concurrent interview and record (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	review on 6/9/26 at 12:30 p.m. with Registered Nurse (RN) 1, Resident 1's EMR was reviewed. RN 1 stated to schedule an outside appointment for residents, Licensed Nurses forwarded referrals to the SSD, the SSD schedules the appointment, and the TS arranges the transportation. RN 1 stated the SSD and the TS communicated when a resident needed an escort, or sometimes nursing did. RN 1 stated she based escort need on BIMS scores and would send an escort for residents with scores of 9 or below. RN 1 stated she spoke to GYN office while Resident 1 was there and the Medical Aide stated Resident 1 had soiled herself, could not clean her, and she would need to reschedule the appointment when she could have an escort. RN 1 acknowledged she did not document the incident or the need to reschedule in the EMR and stated she should have. RN 1 stated Resident 1 had a BIMS of 9, was dependent for toileting and dressing, and needed an escort to the GYN appointment. RN 1 stated she saw Resident 1's 6/2/26 appointment on the [NAME] Board but assumed it was a dialysis visit, which Resident 1 attended alone because aides assisted her there. RN 1 stated she had not seen a policy for scheduling appointments for the residents. During an interview on 6/9/26 at 1:00 p.m. with the DSD, the DSD stated she was told Resident 1 went alone to the appointment, was soiled, and the appointment needed to be rescheduled. The DSD stated the TS was responsible for staff scheduling and ensuring escorts for residents. The DSD stated she had not seen a policy for scheduling appointments for the residents. During a concurrent interview and record review on 6/9/26 at 1:30 p.m., with the Director of Nursing (DON), Resident 1's EMR was reviewed. The DON stated Resident 1 had a BIMS of 9 and required an escort for appointments. The DON stated Resident 1 could have fallen or injured without assistance. The DON stated the TS coordinated transportation and staffing for escorts. The DON stated the facility routinely sent escorts with residents who needed them. The DON reported she could not locate a facility policy for scheduling outside appointments for the residents. During a record review of Resident 1's electronic medical record (EMR), Resident 1's Face sheet and Minimum Data Set (MDS- a federally mandated resident assessment tool) dated 4/22/26 was reviewed. Resident 1's Face Sheet showed she was an 84-year-old female admitted on [DATE] with a history of encephalopathy (brain not working properly due to disease or injury); muscle weakness; abnormal gait and mobility; Type 2 diabetes; end-stage renal disease (ESRD); cancers of the frontal lobe, endometrium, thyroid gland, and right kidney; hypertension; anxiety; and dependence on renal dialysis. Her MDS Section C showed a BIMS score of 9, indicating moderate problems with thinking and memory. Section GG indicated she needed help with functional cognition, previously used a manual wheelchair and walker, required substantial/maximal assistance for toileting and upper-body dressing, and was dependent for lower-body dressing. ADL documentation for May 2026 showed she was often incontinent and usually required substantial/maximal assistance or was dependent for transfers, dressing, and wheeling her wheelchair.		