

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555352	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/05/2025
NAME OF PROVIDER OR SUPPLIER Grace Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2939 S. Peach Avenue Fresno, CA 93725	

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 - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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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(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 - Actual harm Residents Affected - Few	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the environment was free of accident hazards and residents received adequate supervision to prevent accidents for one of five residents (Resident 1) when, nursing staff were aware of Resident 1's behavior to self-propel in a wheelchair equipped with foot pedals and did not adequately supervise Resident 1 while propelling in a wheelchair. Staff did not assess the safety of the wheelchair for Resident 1's physical size and abilities. Resident 1 was not assessed and fitted for a wheelchair for personal use and instead Resident 1 used wheelchairs available for general use in the facility. Staff did not identify declining mobility in Resident 1's upper and lower extremities as identified in the Minimum Data Set (MDS - a resident assessment tool used to identify resident cognitive (the mental processes of perception, thinking, learning, memory, reasoning, judgment and physical function). These failures resulted in Resident 1 experiencing an unwitnessed avoidable accident on 8/17/25 where an internal investigation determined Resident 1's legs became entangled in the wheelchair while Resident 1 was self-propelling. The unwitnessed avoidable accident resulted in pain and tenderness to Resident 1's right lower leg and was sent to the local acute care hospital for evaluation which required hospitalization from [DATE] to 8/21/25. Resident 1 was diagnosed with acute (sudden and unexpected) right tibial (the larger of the two bones in the lower leg) fracture (a break or discontinuity in a bone) with only minimal displacement (broken bone fragments move out of alignment) and proximal (closer to the point of attachment or origin) fibular (thinner, outer bone of the lower leg) fracture. As a result of Resident 1's accident and injury he has pain, does not have the capability to self-propel and is isolated to his room. Findings: During an interview on 8/27/25 at 1:35 p.m. with Registered Nurse (RN) 1, RN 1 stated she was notified that Resident 1 had pain to the right lower leg and did not want to move his leg by the Certified Nursing Assistant (CNA) 1 on 8/18/25 around 11:00 a.m. RN 1 stated she went to Resident 1's room and did a physical assessment which included palpation (medical examination technique that involves using the hands to assess the body to detect abnormalities such as; tenderness/pain, temperature, size and shape, etc.) to the right lower leg. RN 1 stated Resident 1 had severe pain in the right lower leg when it was palpated and grimaced when palpated. RN 1 stated, Resident 1 does not complain about pain, and this complaint was unusual and new for him. RN 1 stated there was no physical deformity (a condition in which something is distorted from the usual or typical shape), no swelling or bruising, just pain. RN 1 stated she reported the condition of Resident 1 to the Director of Nursing (DON), offered pain medication to Resident 1 and notified the physician of Resident 1's condition. During a concurrent interview and record review on 8/27/25, at 1:45 p.m. with RN1, Resident 1's Situation, Background, Assessment, and Recommendation Communication Form (SBAR-a standardized communication tool used to convey patient status updates when a change occurs from baseline), dated 8/18/25 was reviewed. The SBAR indicated, . Situation. Resident has severed pain 9/10 (Pain scale from 0 to 10 with 0 representing pain free and 10 representing unspeakable bedridden pain) in the right lower limb. decreased mobility. 2. Functional Status Evaluation (compared to baseline; check all changes that you observe) Decreased mobility, Other (describe). severe pain on the [right] lower extremity (the body parts farthest from the center of the body). 9. Pain Evaluation. Does the resident have pain: yes (describe below), is the pain new: yes. Description/location of pain: Right lower leg pain, Intensity of Pain (rate on scale of 1-10, with 10 being the highest): 9. Appearance, CNA notified [charge nurse] regarding resident has severe pain in right lower limb. There is no swelling or redness, he claim[ed] it happened yesterday evening like he twisted his leg while propelling his wheelchair. He denied he had a fall. RN 1 stated CNA 1 informed her that Resident 1 was having pain in his right lower leg and RN 1 completed an assessment and did not find any deformity of the leg. RN 1 stated she administered acetaminophen (a drug used to relieve mild or chronic pain), informed the Medical Doctor (MD) and received an order for an in-house X-ray (a medical imaging tool used for diagnosing various conditions including bone fractures). RN 1 stated after Resident 1 twisted his legs while propelling his wheelchair on 8/17/25 she believes Resident 1 is sad because Resident 1 cannot roll around to different areas in the facility using a wheelchair anymore and he just lays in his bed and does not get up. During a review of Resident 1's Medication Administration Record (MAR), dated 8/25, the MAR indicated, . [acetaminophen] tablet. Give 325 mg (milligrams-unit of measure) by mouth every 8 hours as needed for mild pain. The MAR indicated medication was administered 8/18/25 at 10:58 a.m. and 8/19/25 at 8:13 a.m. both were after Resident 1 twisted his legs while propelling his wheelchair on 8/17/25 while</p>		