STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555352	A. Building B. Wing	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grace Healthcare Center	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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on observation, interviews and review of facility documents, the facility failed to ensure:1. The Certified Dietary Manager (CDM) met state requirements, California Code of Regulations (CCR), Health and Safety Code 1265.4 when the CDM did not complete the six hours of in-service training on the CCR, Dietetic Services Requirements of Title 22 and;2. The CDM received frequently scheduled consultation from the Registered Dietitian (RD). These failures had the potential to result in insufficient oversight and consultation with the CDM of food and nutrition services that resulted in a lack of the RD identifying system issues regarding hair restraint availability and use, prevention of wet stacking (when dishes/pans are stacked together while they are still damp, trapping moisture between surfaces and preventing air circulation and proper drying), and lack of food safety for dates and labeling of food items for the health and safety of the 61 residents admitted to the facility.Findings:1. During a review of the California Health and Safety Code 1265.4, indicated seven qualification pathways of the full-time position responsible for the day-to-day operation of dietetic services. Pathway four indicated the supervisor is a graduate of a dietetic services training program approved by the Dietary Managers Association and is a certified dietary manager credentialed by the Certifying Board of the Dietary Managers Association, maintains this certification, and has received at least six hours of in-service training on the specific California dietary service requirements contained in Title 22 of the California Code of Regulations prior to assuming full-time duties as a dietetic services supervisor at the health facility.During a review of the CDM personnel file, indicated a credential verification dated 11/4/25 that he is a certified dietary manager through 8/31/26.During an interview on 3/18/26 at 4:44 p.m. with the Certified Dietary Manager (CDM), the CDM stated he had been employed at the facility as the CDM since October 2025 and was not aware of the CCR additional six-hour requirement for CDM's in skilled nursing facilities (SNF). The CDM stated he worked for a hospital prior to this job and the hospital he worked for never mentioned any additional requirements. The CDM stated he would look into completing those requirements as soon as possible.During an interview on 3/19/26 at 11:15 a.m. with the Registered Dietitian Consultant (RDC), the RDC stated her expectation was the CDM follow state mandates for certifications/trainings for the position he is in and completed whatever requirements were necessary for that particular certification.During an interview on 3/20/26 at 8:55 a.m. with the Administrator (ADM), the ADM stated it was her expectation that the CDM met all credentials prior to employment to ensure the staff being hired was qualified to perform their job duties according to regulations. The ADM stated verifying credentials and certifications according to state regulations, it was important to ensure staff being hired were qualified for the position they were being hired. The ADM stated if the CDM did not have the appropriate certifications for his job title, then facility Policies and Procedures (P&P) were not followed.During a review of the facility's policy and procedure (P&P) titled, Dietary Services, (undated), the P&P indicated, .The facility shall provide organized, safe, and sanitary dietary services under the direction of a qualified Dietary Manager.Purpose To ensure.Compliance with Title 22 and survey requirements.Qualifications of Dietary Manager.Dietary Manager must meet one of the following: Certified Dietary Manager (CDM) with approved training.Required Title 22 in-service training (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
	555352	A. Building B. Wing	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grace Healthcare Center	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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	(minimum 6 hours) before assuming duties.2. A series of observations on 3/17/26 between 8:41 a.m. and 9:25 a.m. identified a dietary aid working in the kitchen did not have a hair net on, a wet quarter pan was stacked on top of another quarter pan, and ground beef was thawing in the refrigerator with no pull/thaw date on it (the date marked on a food item when it is removed from the freezer to thaw), and no use by date. (Cross Reference F812.)During an interview on 3/18/26 at 4:44 p.m. with the CDM, the CDM stated the RDC checked in with him periodically to see how things were going in the kitchen. The CDM stated if he had any questions relating to residents or kitchen concerns, he reached out to the RDC via telephone or email.During an interview on 3/19/26 at 11:00 a.m. with the RDC, the RDC stated she had been the RDC for the facility since the end of October 2025 and was located out of Los Angeles, California. The RDC stated she worked remotely and did not come physically into the facility. The RDC stated her duties included new resident/readmit assessments, significant weight changes, wounds, residents on dialysis and tube feeder assessments. The RDC stated she assessed patients via review of the medical record once or twice a week remotely. The RDC stated her and the other RDC that she worked with were in contact with the CDM via telephone conferences. The RDC stated the CDM was responsible for the day-to-day kitchen operations at the facility and the CDM was aware he could reach out at any time regarding resident concerns, menus, kitchen questions etc. During an interview on 3/19/26 at 3:21 p.m. with the RDC, the RDC stated her conversations with the CDM were not a scheduled consultation that was set weekly on a certain date and time but instead were based on the CDM's questions and RDC questions she had for him. The RDC stated consultations were provided on a weekly basis with the CDM and more often if needed. The RDC stated she did not keep documentation of the consultations, and conversations were done via a telephone call and were sometimes put in the RDC note on the resident record for all team members to see in Point Click Care (PCC-a computer charting system) if it was applicable depending on the resident concern or issue. The RDC stated she did not write down every single item discussed with the CDM and if it was a kitchen or nutrition related issue, conversations would be done through email as well. The RDC stated she does not keep a log or documentation on consultations provided and consultations were done either through phone or email.During an interview on 3/19/26 at 3:26 p.m. with the RDC, the RDC stated she relied strictly on the CDM to communicate and report any kitchen issues/concerns with food services to her because the CDM was the one at the facility full time. The RDC stated if the CDM had any questions, The CDM had both RDC's contact numbers and could call them at any time.During an interview on 3/20/26 at 11:03 a.m. with the ADM, the ADM stated she was aware the RDC was supposed to be visiting every week and knows this from working at her previous building. The ADM stated at her previous building, the RD would come in person to assess new admits, and then came on a regular basis every month and while they were in the facility, the RD would observe the kitchen tray line (meal service), do sanitation audits, review weights etc. and the ADM would get a copy of the evaluation/report including wt. loss recommendations etc. The ADM stated she had been actively looking for a RD that could come to the facility in person and stated she had not had any luck finding an in-person RD company that is willing to come to the facility. The ADM stated it was important for the RDC to be present at the facility to guide the staff and CDM with the functions of the kitchen and stated that having a RD present would be beneficial because it was a second person aside from the CDM looking at the kitchen service and giving recommendations. The ADM stated audits were important in order to provide a better food service and quality to the patient. ADM stated the current situation at the facility of RD's not coming in person to the facility, was making her uncomfortable with all the issues going on in the kitchen. The ADM stated having an RD present at the facility would be beneficial in providing a better kitchen service to the residents.During a review of the facility document titled, Registered Dietitian Job Description- Skilled Nursing Facility (SNF), (undated), the Registered Dietitian Job Description indicated, The Registered Dietitian (RD) is responsible for assessing, planning.care for residents in accordance with federal, state (e.g., Title 22).and facility regulations.Regulatory Compliance Ensure compliance with CMS, Title 22, and state (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555352	A. Building B. Wing	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grace Healthcare Center	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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	regulations Maintain accurate and timely documentation participate in audits and survey readiness. Food Service Oversight.monitor kitchen sanitation and safety.Monitoring & Education.Educate residents, families, and staff.During a review of the consultation agreement for dietetic consultation services document titled, SCM Nutrition and Diet Inc. [Name of RDC], MS RD., Consultant Dietitian, dated October 22, 2025, the consultation agreement for dietetic consultation services document indicated, .Facility provides skilled nursing and/or long-term care services and wishes to engage Consultant to provide dietary services to residents of the Facility in accordance with the provisions of this Agreement and applicable state and federal laws.DUTIES AND OBLIGATIONS OF CONSULTANT.Evaluate sanitation, safety, and food handling practices and meal service regulations in food service department.During a review of the facility business correspondences (the written or digital communications exchanged by a facility or organization to manage its operations, maintain relationships, and document activities) completed by RDCs dated 11/7/25 through 3/17/26, showed RDC recommendations for clinical nutrition and did not show any evaluation of food services. There was no documentation provided to show the RDC provided frequently scheduled consultation to the CDM. During a review of the facility's policy and procedure (P&P) titled, Dietitian, dated November 2022, the P&P indicated, .If a dietitian is not employed full time.a director of food and nutrition services will be designated. This individual will.receive frequently scheduled consultations from a qualified dietitian .Our facility's dietitian is responsible for.food preparation, service and storage.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555352	A. Building B. Wing	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grace Healthcare Center	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 0911 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure resident rooms hold no more than 4 residents; for new construction after November 28, 2016, rooms hold no more than 2 residents. Based on interviews and observations during the survey period from 3/17/26 through 3/20/26, the facility failed to ensure eight of eight sampled bedrooms, accommodated no more than four residents each.This failure had the potential for residents to not have reasonable privacy or adequate space.Throughout the survey period from 3/17/2026 through 3/20/2026, eight rooms in Building Two had more than four residents in each bedroom. The variations were in accordance to residents particular care needs and comfort. Wheelchairs and toilet facilities were accessible to residents. A reasonable amount of privacy was provided and adequate closet and storage space were available. There was sufficient space for residents to ambulate and staff to provide care to residents. Nursing care of the residents was not impacted. During Survey observations and residents and staff interviews, there was reasonable amount of privacy provided, storage closet was adequate and storage space was available. Wheelchairs and toilet facilities were accesible to residents. There was sufficient space for residents and staff to provide resident care. Nursing care of residents was not impacted.Building Room# # of Beds2 201 82 202 82 203 82 204 82 205 82 206 82 207 82 208 8Recommend waiver continue in effect._____Health Facilities Evaluator Supervisor Signature &DateRequest waiver continue in effect._____Administrator Signature & Date

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555352	A. Building B. Wing	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grace Healthcare Center	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 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** Based on observation, interview, and record review, the facility failed to establish and maintain an effective infection prevention and control program for four of eight sampled residents (Resident 5, Resident 6, Resident 11 and Resident 40) when:1. The facility did not follow their Policy and Procedure (P&P) for Enhanced Barrier Precautions (EBP - an infection control intervention designed to reduce transmission of resistant organisms [bacteria that have become resistant to certain antibiotics] that requires gown and glove use during high contact resident care activities) by placing EBP signage inside the room on the wall and EBP containers were below the EBP signage inside the room.2. Personal Protective Equipment (PPE) was not worn during care for Resident 11, Resident 40 and Resident 5. 3. The gastrostomy tube (G-tube- a surgical opening made through the abdominal wall into the stomach to insert a feeding tube for long-term nutritional support tube) for Resident 11 and Resident 40 had dried residue on the G-tube's medication and feeding port (the opening or access point on the outside of a feeding tube that allows formula, water, and medication to be delivered directly into the stomach).4. The connector end of the feeding bag tubing for Resident 40 did not have a tube cover cap, was left open to air and the exposed feeding bag tubing connector was available for use by Registered Nurse (RN) 4 to Resident 40's feeding port during enteral feeding (tube feeding- is a method of delivering liquid nutrients directly into the stomach or small intestine via a tube).5. Resident 6's yank [NAME] suction catheter (YSC-a rigid, oral suction instrument used to clear blood, saliva, and secretions from a patient's mouth and throat, primarily to prevent aspiration) was not dated to indicate the YSC's first use date, the YSC had yellow substance inside and at the tip of the YSC and the storage package had some dried yellow/brown substance.6. Resident 6's oxygen (O2- a colorless, odorless and tasteless gas essential for life) tubing was not labeled to indicate the O2 tubing's first use date.7. During an observation of medication administration on 3/18/26 at 4:00p.m., Registered Nurse (RN) 3 obtained blood pressure (a measurement that showed how hard the blood was pushing against the wall of the blood vessels when the heart pumped and when it rested) readings from Resident 26, 14 and 34 using the same blood pressure cuff without cleaning or disinfecting (the process of cleaning something to kill germs and make it safe to use) the equipment between residents. These failure had the potential to result in cross contamination (when germs were spread from one person, surface or object to another, which could make someone sick) and the transmission of infectious organisms (tiny living things, like germs or viruses that could enter the body and cause illness) between residents, placing residents at risk of infectionFindings: 1. During an observation on 3/17/2026 at 10:02 a.m. in Resident 11's room, there was EBP signage inside the room on the wall and EBP containers were below the EBP signage inside the room. During an observation on 3/17/26 at 10:10 a.m. during in Resident 5's room and Resident 40's room, there was EBP signage inside the room on the wall and EBP containers were below the EBP signage inside the room. During an interview on 3/18/26 at 3:37 p.m. with RN 4, RN 4 stated EBP is used when residents have communicable disease. RN 4 stated she wears PPE when caring for residents with G-tubes, catheter, and dialysis port. RN 4 stated this was important because there was an opening in the residents' body, and the PPE protected the residents from cross contamination. During a concurrent interview and record review on 3/20/26 at 8:50 a.m. with the Infection Preventionist (IP), the facility's P&P titled, Enhanced Barrier Precautions, dated 8/2022, and a picture of the EBP signage and EBP containers in Resident 5 and Resident 11's rooms were reviewed. The (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555352	A. Building B. Wing	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grace Healthcare Center	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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	P&P indicated, .Policy Statement- Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug-resistant organisms (MDROs) to residents.Policy Interpretation and Implementation.5. EBPs are indicated . for residents with wounds and/or indwelling medical devices regardless of MDRO colonization.10. Signs are posted in the door or wall outside the resident room indicating the type of precautions and PPE required. 11. PPE is available outside of the resident rooms. 12. Residents, families and visitors are notified of the implementation of EBPs throughout the facility. The IP stated the EBP signage was placed on the inside of residents' room by the door, and there was a 3-drawer container underneath the signage where the PPE equipment was stored. After a review of the P&P, the IP stated the facility did not have the EBP containers outside the residents' room. The IP stated it made more sense for the signage to be outside the room, along with the PPE to ensure family and staff were aware residents were on precaution. During a concurrent interview and record review on 3/20/26 at 10:56 a.m. with the Director of Nursing (DON), the facility's Policy and Procedure (P&P) titled, Enhanced Barrier Precautions, dated 8/2022, and the picture of the EBP signage and EBP containers in Resident 5 and Resident 11's rooms were reviewed. The DON stated the EBP containers should be outside the residents' room. The DON stated the facility did not follow the EBP policy. During a concurrent interview and record review on 3/20/26 at 11:56 a.m. with the Administrator (ADM), the picture of the EBP signage and EBP containers in Resident 5 and Resident 11's rooms were reviewed. The ADM stated the EBP containers should be outside the residents' room. The ADM stated the EBP policy was not followed. During a review of Centers for Disease Control and Prevention (CDC)'s website, Professional Reference titled, Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), dated 7/12/22, (found at https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html) the reference indicated, .Multidrug-resistant organism (MDRO) transmission is common in skilled nursing facilities, contributing to substantial resident morbidity and mortality and increased healthcare costs. Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employ targeted gown and glove use during high contact resident care activities. EBP may be indicated (when Contact Precautions do not otherwise apply) for residents with any of the following: Wounds or indwelling medical devices, regardless of MDRO colonization status, Infection or colonization with an MDRO. Effective implementation of EBP requires staff training on the proper use of personal protective equipment (PPE) and the availability of PPE and hand hygiene supplies at the point of care. 2. During an observation on 3/17/26 at 9:20 a.m. with Resident 11 in Resident 11's room, there was an EBP signage inside the room on the wall. The EBP signage indicated . Providers and staff must also: wear gloves and a gown for the following high contact resident care activities. device care or use: central line, ., feeding tube. Resident 11 was lying in bed with eyes opened, unable to communicate. Resident 11 had a G-tube with feeding pump by the bedside. During an observation on 3/17/26 at 12:22 p.m. in Resident 11's room, RN 3 was observed in Resident 11's room with gloves on and no gown worn, administering medication through Resident 11's G-tube. During a review of Resident 11's admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 3/18/26, the AR indicated, Resident 11, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555352	A. Building B. Wing	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grace Healthcare Center	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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was admitted to the facility on [DATE] from acute care hospital and had diagnoses that included . hemiplegia (form of paralysis that causes severe or complete loss of muscle function, weakness, or stiffness on only one side of the body), quadriplegia (paralysis affecting all four limbs- both arms and both legs- and usually the torso, caused by damage to the spinal cord in the neck), gastrostomy status, dysphagia (difficulty or discomfort in swallowing), gastrostomy infection, gastrointestinal hemorrhage (bleeding that occurs anywhere along the digestive tract- from the esophagus down to the rectum) . During a review of Resident 11's Minimum Data Set (MDS- a resident assessment tool used to identify resident cognitive (mental) and physical functional level) assessment, dated 12/29/25, the MDS section C1000 indicated, Resident 11's Staff Assessment for Mental Status- Cognitive skills for daily decision-making score was 3 (0. Independent- decision consistent/ reasonable, 1. modified independence- some difficulty in new situations only, 2. moderately impaired- decisions poor; cues/ supervision required, 3. severely impaired- never/ rarely made decisions). The score indicated Resident 11 was severely impaired During a review of Resident 11's Order Summary Report (OSR), the OSR indicated .Enteral Feed two times a day related to gastrostomy status .dysphagia, . G-tube: [named brand] feeding formula 1.5 kcal (kilocalorie- a unit of energy used to measure the amount of energy provided by food and drinks) at 40 mL (milliliter- unit of measure)/hour x 20 hours, providing 800 ml/1200kcal . order start date 1/21/26. During a review of Resident 11's Care Plan (CP), the CP indicated .Resident 11 is on Enhanced Barrier Precaution due to G-tube placement with interventions . Staff to use appropriate PPE equipment prior to providing direct care and/or handling resident's body fluids .start date 9/12/24. During an interview on 3/18/26 at 1:55 p.m. with RN 3, RN 3 stated EBP meant facility staff wear the PPE whenever care is provided for residents with G-tube, catheter care (thin, flexible, or rigid tube inserted into the body to drain fluids (like urine), inject fluids (like medicine), or keep passageways open), bedside dressing. RN 3 stated it is used to protect staff and the residents. When asked if she used the PPE when administering enteral feeding, RN 3 stated she did not use the PPE, RN 3 stated she was expected to use the PPE always when caring for residents with G-tube. RN 3 stated it was important to use the PPE to prevent infection from staff to residents. During an interview on 3/18/26 at 2:38 p.m. with CNA 8, CNA 8 stated EBP was used whenever any resident had a port, catheter or G-tube. CNA 8 stated the expectation was that staff should wear the gown and have all material to be used ready before resident care. CNA 8 stated this was important because if the staff was sick, the staff did not get the residents sick and if the residents were sick, the staff did not get sick. During an interview on 3/20/26 at 8:50 a.m. with the IP, the IP stated the expectation from the Licensed Nurse (LN)s was to wear the gown for G-tube feeding, to protect Resident 11. During an interview on 3/20/26 at 10:56 a.m. with the DON, the DON stated she expected RN 3 to use PPE during when handling Resident 11 feeding tube to prevent infection. During a concurrent observation and interview on 3/19/26 at 11:43 a.m. with RN 2 in Resident 40's room, RN 2 was observed operating the feeding tube on Resident 40. RN 2 did not wear a PPE gown. RN 2 stated there was no need for LNs to wear a PPE gown when handling a feeding tube. RN 2 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555352	A. Building B. Wing	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grace Healthcare Center	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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated feeding tube was not included in the list of devices that required EBP usage when residents are on EBP. During a review of Resident 40's AR, dated 3/20/26, the AR indicated, Resident 40, was admitted to the facility on [DATE] from acute care hospital and had diagnoses that included . Anoxic brain damage (a type of injury caused by a total lack of oxygen reaching the brain, leading to brain cell death within minutes), systemic inflammatory response syndrome (SIRS- a widespread, intense inflammatory reaction throughout the body, acting as a warning sign of severe stress, infection, or trauma), bacteremia (the presence of viable bacteria in the bloodstream), dysphagia, gastrostomy status . During a review of Resident 40's MDS, dated [DATE], the MDS section C was not completed. During a review of Resident 40's OSR, the OSR indicated .G-tube: NPO (nothing by mouth) . order start date 1/21/26. During a review of the facility's EBP signage, the EBP signage indicated . Providers and staff must also: wear gloves and a gown for the following high contact resident care activities. device care or use: central line, ., feeding tube. During an interview on 3/20/26 at 8:34 a.m. with RN 2, RN 2 stated EBP was used for residents that had wound dressing, dialysis residents, and feeding tubes. RN 2 stated she should have worn a gown on 3/19/26 when she attended to Resident 40 during initiation of feeding through the feeding tube. During an observation on 3/20/26 at 8:25 a.m. with RN 2 and CNA 12 in Resident 5's room, RN 2 was observed performing a wound dressing treatment while CNA 12 assisted by holding Resident 5's Right leg. RN 2 had gown, mask and gloves on. CNA 12 had gloves on but did not wear a gown. RN 2 applied the treatment as ordered to Resident 5's fifth toe on the right foot. During a review of Resident 5's AR, dated 3/20/26, the AR indicated, Resident 5, was admitted to the facility on [DATE] from acute care hospital and had diagnoses that included . pressure ulcer of sacral region (a localized injury to the skin and underlying tissue, typically over the tailbone (sacrum), caused by prolonged pressure, friction, or shear), urinary tract infection (an infection caused by bacteria entering the urinary system, commonly affecting the bladder), pressure induced deep tissue damage of left heel . During a review of Resident 5's MDS, dated [DATE], the MDS section C1000 indicated, Resident 5's Staff Assessment for Mental Status- Cognitive skills for daily decision-making score was 3. The score indicated Resident 5 was severely impaired During a review of Resident 5's OSR, the OSR indicated .Wound Treatment (Deep Tissue Pressure Injury on Right fifth toe) . order start date 3/18/26. During a review of Resident 5's CP, the CP indicated .Resident 5 was on Enhanced Barrier Precaution . with interventions . Wear PPEs during high contact activities/care to reduce the transmission of infection. During an interview on 3/18/26 at 3:37 p.m. with RN 4, RN 4 stated Resident 5 had a pressure ulcer on the fifth toe on the right foot. RN 4 stated the LNs were responsible for cleaning the PU site (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555352	A. Building B. Wing	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grace Healthcare Center	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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/20/26 at 8:34 a.m. with RN 2 outside Resident 5's room, RN 2 stated EBP was used for residents that had wound dressing, dialysis residents, and feeding tubes. RN 2 validated CNA 12 did not wear a gown during the wound treatment for Resident 5. RN 2 stated CNA 12 should have worn a gown to ensure there was precaution for herself and Resident 5. RN 2 stated the failure could bring about cross contamination, because CNA 12 was caring for so many residents. During an interview on 3/20/26 at 8:36 a.m. with CNA 12, CNA 12 stated EBP was used for any resident that had a catheter, colostomy bag (a lightweight, waterproof pouch worn over a surgically created opening in the abdomen), wound care. CNA 12 stated herself and RN 2 completed the wound treatment on Resident 5's right foot. CNA 12 stated, since she was involved in the wound care process, she should have worn a gown. CNA 12 stated it was important to avoid anything coming in contact with staff and the wound. CNA 12 stated the failure could have led to the spread of infection. During an interview on 3/20/26 at 8:50 a.m. with the IP, the IP stated the use of the EBP was for any resident with device in them, wounds, foley catheter, dialysis resident, residents with G-tube. The IP stated the expectation was for CNA 12 to wear a gown to keep Resident 5 safe, and to prevent infection spreading to other residents. During an interview on 3/20/26 at 10:56 a.m. with the DON, the DON stated she expected CNA 12 and RN 4 to wear PPE during wound treatment for Resident 5. During a review of the facility's P&P titled, Dressing, Dry/Clean dated 2001, the P&P indicated, Purpose: The purpose of this procedure is to provide guidelines for the application of dry, clean dressings.Equipment and Supplies.5. Personal protective equipment (e.g., gowns, gloves, masks.) . During a review of the facility's P&P titled, Enhanced Barrier Precaution dated 08/2022, the P&P indicated, Purpose: Enhanced barrier precautions (EBP) are utilized to prevent the spread of multidrug resistant organisms (MDROs) to residents. Policy interpretation and implementation 1. Enhanced barrier precautions (EBPs) are used as an infection prevention and control intervention to reduce the spread of multidrug resistant organisms (MDROs) to residents. 2. EBPs employ targeted gowns and gloves used during high contact resident care activities when contact precautions do not otherwise apply. a. Gloves and gowns are applied prior to performing the high contact resident care activity. 3. Examples of high contact resident care activities requiring the use of gown and gloves for EBPs include.g. device care or use (.feeding tube, .) . h. wound care (any skin opening requiring a dressing) .5. EBPs are indicated .for residents with wounds and/ or indwelling medical devices regardless of MDRO colonization. 9. Staff are trained to care for residents on EBPs. 3. During an observation on 3/17/26 at 12:22 p.m. in Resident 11's room, RN 3 was observed administering medication through Resident 11's G-tube. The G-tube port was observed to have brown substance at around the opening of the medication and feeding port. During an observation on 3/17/26 at 12:35 p.m. in Resident 40's room, RN 4 was observed during enteral feeding for Resident 40. Resident 40's G-tube port was observed to have brown /black substance at around the opening of the medication and feeding port. During a concurrent interview and record review on 3/20/26 at 8:50 a.m. with the IP, the picture of Resident 11 and Resident 40's the G-tube's medication and feeding ports were reviewed. The IP stated Resident 11's G-tube port looked like dark substance or dried formula. The IP stated Resident 40's G-tube tubing looked good but the G-tube ports did not. The IP stated the substances could be (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555352	A. Building B. Wing	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grace Healthcare Center	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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	really dried formula. The IP stated the G-tube port should not look that way. The IP stated the expectation from LNs would be to keep the ports clean and when there was so much build up then the G-tube should be replaced. During a concurrent interview and record review on 3/20/26 at 10:56 a.m. with the DON, the picture of Resident 11 and Resident 40's the G-tube's medication and feeding ports were reviewed. The DON stated the substance inside the G-tube ports for Resident 11 and Resident 40 were residuals. The DON stated the LNs were not flushing the G-tube properly. The [NAME] stated the LNs were not properly cleaning the port before and after feeding. The DON stated if the tube was not clean or the residuals could no longer come off, then the G-tube needed to be changed. The DON stated the expectation from the LNs was they flush the tube and clean the residuals. The DON stated the failure had the potential to cause gastrointestinal infection (GI- an infection/inflammation of the stomach and intestines caused by viruses, bacteria, or parasites) for the residents. During a concurrent interview and record review on 3/20/26 at 11:56 a.m. with the ADM, the picture of Resident 11 and Resident 40's the G-tube's medication and feeding ports were reviewed. The ADM stated the G-tube port was dirty. The ADM stated the G-tube port was not cleaned properly 4. During an observation on 3/17/26 at 10:56 a.m. during the initial tour in Resident 40's room, Resident 40 was in bed sleeping and there was a feeding pump with feeding formula set up. The connector end of the feeding bag tubing for Resident 40 did not have a tube cover cap and was left open to air. The inside of the feeding bag tubing was observed to be clogged with dried formula build up and around the tip of the connector end of the feeding bag tubing had dried formula build up. During a concurrent observation and interview on 3/17/26 at 12:35 p.m. in Resident 40's room, RN 4 was observed during enteral feeding for Resident 40. RN 4 was observed taking the exposed connector end of the feeding bag tubing that had dried formula buildup at the tip and was clogged on the inside of the feeding bag tubing for Resident 40's G-tube feeding port. RN 4 was asked if the tip of feeding tube should be opened and attached to Resident 40. RN 4 stated the tip of the feeding bag tubing should have been covered with a cap. RN 4 was observed cleaning around the end of feeding bag tubing and inside the feeding bag tubing with the hand glove she had removed. RN 4 stated I used the inside of the gloves to clean the tip of the tube. When asked if that was the correct process, RN 4 stated it should not be like that, I would use a gauze with normal saline. When asked if using the gauze with normal saline would remove the dried formula content partially obstructing the inside of the feeding bag tubing, RN 4 stated after cleaning with the gauze and normal saline, the tube would still have dried formula. During an interview on 3/18/26 at 3:37 p.m. with RN 4, RN 4 stated there was dried formula on the inside of the feeding bag tubing for Resident 40. RN 4 stated she should have inspected the feeding bag tubing before connecting it to Resident 40, and since the cap of the tubing was not there, she should have changed the whole feeding tube set. RN 4 stated attaching the feeding tube to Resident 40 was passing bacteria to the resident due to the tip of the feeding tube been opened to air for over 4 hours. RN 4 stated the last enteral feeding for Resident 40 was completed at 8 a.m. and the feeding was re-started at 12 p.m. RN 4 stated Resident 40 could have gotten GI infections due to this failure. During an observation on 3/18/26 at 8:02 a.m. in Resident 40's room, Resident 40 was in bed sleeping and the feeding bag tubing was observed to be on the floor. During a review of Resident 40's AR, dated 3/20/26, the AR indicated, Resident 40, was admitted to (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555352	A. Building B. Wing	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grace Healthcare Center	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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the facility on [DATE] from acute care hospital and had diagnoses that included . Anoxic brain damage, systemic inflammatory response syndrome, bacteremia, dysphagia, gastrostomy status . During a review of Resident 40's OSR, the OSR indicated .G-tube: NPO (nothing by mouth) . order start date 1/21/26. During a concurrent interview and record review on 3/20/26 at 8:50 a.m. with the IP, the picture of Resident 40's feeding bag tubing that had no cover cap and the picture of the feeding bag tubing lying on the floor were reviewed. The IP stated there was no cover cap at the end of the feeding bag tubing. The IP stated there should have been a cover cap, because without the cover cap, the feeding bag tubing was exposed, and anything could crawl up the inside of the feeding bag tubing. The IP stated if feeding bag tubing is not connected Resident 40, there should be a cap on the tip of the tubing. The IP stated the failure could lead to an infection, make the Resident 40 very sick and Resident 40 could end up in the hospital. The IP stated there was dried formula inside the tubing. The IP stated RN 4 using the inside of the glove to clean the tubing was wrong because the gloves were already contaminated with the RN 4's hand. The IP stated when RN 4 realized she did not cap the end of the tubing; she should have changed out the whole set to prevent any kind of infection to Resident 40. The IP stated the capped tubing lying on the floor should be on the pole. During a concurrent interview and record review on 3/20/26 at 10:56 a.m. with the DON, the picture of Resident 40's feeding bag tubing that had no cover cap and the picture of the feeding bag tubing lying on the floor were reviewed. The DON stated if feeding bag tubing is not connected to the resident it should be covered with a cap. The DON stated the tube should not be hanging or lying on the floor. The DON stated the whole tubing kit needed to be changed. During a concurrent interview and record review on 3/20/26 at 11:56 a.m. with the ADM, the pictures of Resident 40's feeding bag tubing that had no cover cap and the clogged inside of the feeding bag tubing were reviewed. The ADM stated Resident 40 would not be getting sufficient formula since the tubing was occluded. The ADM stated there should have been a cap on the tubing. 5. During an observation on 3/17/26 at 11:19 a.m. in Resident 6's room during the initial tour, Resident 6 was not in his room, the YSC was noted to have no label indicating the date Resident 6 started the use of the YSC. During a concurrent observation and interview on 3/17/26 at 12:09 p.m. with Resident 6 in his room, Resident 6 was sitting in a wheelchair, the YSC tip and inside were noted to have yellow substances and the inside of the storage package had some dried yellow/brown substance. Resident 6 stated the YSC was to help suck the extra saliva in his mouth. Resident 6 stated when there is a buildup of saliva in my mouth, I choke on it. Resident 6 stated the last time he used the YSC to suction was the day before which indicated 3/16/26. During a review of Resident 6's AR, dated 5/8/25, the AR indicated, Resident 6, was admitted to the facility on [DATE] from nursing home and had diagnoses that included . cerebral infarction (brain tissue death caused by a lack of blood supply), chronic obstructive pulmonary disease (COPD- is a progressive, long-term lung disease that makes it hard to breathe), dysphagia following cerebral infraction, Methicillin-resistant Staphylococcus aureus infections (MRSA-a type of staph bacteria resistant to many common antibiotics, causing serious, hard-to-treat infections) . During a review of Resident 6's MDS, dated [DATE], the MDS section C indicated Resident 6 had a (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555352	A. Building B. Wing	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grace Healthcare Center	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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	had a Brief Interview for Mental Status (BIMS-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 15 out of 15 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07 indicates severe impairment, 99 indicates unable to complete the interview. The BIMS score indicated Resident 6 was cognitively intact. During a review of Resident 6's OSR, the OSR indicated .May use oral suctioning PRN for increased sections. order start date 6/19/25. During a concurrent interview and record review on 3/18/26 at 2:38 p.m. with CNA 8, the picture of Resident 6's YSC was reviewed. CNA 8 stated Resident 6 used the YSC for both his nose and his mouth. CNA 8 stated the YSC did not have a label. CNA 8 stated the YSC should have a label and should be changed every week. CNA 8 stated the Respiratory Therapist (RT) was responsible for changing the YSC. CNA 8 stated the date label should be on the YSC tubing. CNA 8 stated it was important, so that LNs know when to change the YSC, there should be no cross contamination, and it prevented Resident 6 from getting sick. CNA 8 stated the inside of the YSC had probably phlegm (thick, sticky mucus produced in the lungs and throat, usually during illness) from inside the Resident 6's nose or mucous. CNA stated the package where the YSC was stored had dead skin and it was contaminated. CNA stated this could lead to a respiratory infection for Resident 6. During a concurrent observation, interview and record review on 3/18/26 at 2:55 p.m. with the RT, Resident 6's YSC was observed in Resident 6's room and Resident 6's OSR were reviewed. The RT stated the YSC should be changed weekly or as needed (PRN). The RT stated this was important for infection control purposes. The RT stated the facility staff want to prevent possible diseases entering Resident 6's lungs that could lead to pneumonia. The RT stated there should be 2 YSC for Resident 6, one for the mouth and one for the nose. The RT stated the label could be placed on the YSC itself or the manufacturer's package. The RT stated the manufacturer's package was what was used as storage for the YSC. The RT stated both the RT and the LNs were responsible for changing the YSC. During the observation in Resident 6's room, the Oral suction device, canister and tubing were observed. The RT stated there was hardened mucous in the YSC. The RT stated there was accumulated dust or old fluid from the secretion in the storage package. The RT stated there was no label on the tubing, device or the canister. The RT stated the YSC should have been labeled. The RT stated this was important, so the LN and RT know when to change the YSC and for infection prevention. The RT stated the whole process on the YSC was not properly implemented. The RT stated the substance in the YSC could lead to respiratory infection. During a concurrent interview and record review on 3/20/26 at 8:50 a.m. with the IP, the picture of Resident 6's YSC was reviewed. The IP stated disgusting material was inside the YSC. The IP stated the inside of the package had collected dust which should not be there. The IP stated her expectation was that the YSC should be cleaned and changed as needed. The IP stated this failure could lead to oral infection for Resident 6, and the infection could get to Resident 6's GI and Resident could have major issues. During a concurrent interview and record review on 3/20/26 at 10:56 a.m. with the DON, the picture of Resident 6's YSC was reviewed. The DON stated the YSC was dirty. The DON stated the YSC should be changed every 24 hours. The DON stated Resident 6 could develop infection. 6. During an observation on 3/17/26 at 10:13 a.m. with Resident 8 during the initial tour, Resident 8 was in bed sleeping and a nasal cannula (NC- thin plastic tube that delivers oxygen directly into the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555352	A. Building B. Wing	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grace Healthcare Center	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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	nose through two small prongs) in her nose, connected to a working oxygen concentrator (device that produces oxygen for breathing). The middle part of the O2 tubing was in a bag dated 2/7/26, and the O2 tubing itself has no date label indicating the date Resident 8 started the use of the O2 tubing. During a concurrent interview and record review on 3/18/26 at 1:55 p.m. with RN 3, the picture of Resident 8's O2 tubing was reviewed. RN 3 stated there was no label close to the connector or on any part of the O2 tubing. RN 3 stated the storage bag was dated 2/7/26. RN 3 stated the date on the bag was for the nebulizer set and Resident 8 uses the nebulizer every morning. RN 3 stated whenever the O2 tubing is changed, it should be labeled with the date. RN 3 stated the label was expected to be attached close to the connector. During a concurrent interview and record review on 3/18/26 at 2:38 p.m. with CNA 8, t

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555352	A. Building B. Wing	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grace Healthcare Center	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 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have policies on smoking. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility failed to follow its own policy and procedure to complete quarterly smoking assessments when three out of four sampled residents (Residents' 41, 52 and 54) quarterly assessments were not completed on time. These failures had the potential for Residents' 41, 52 and 54 to experience accident related to smoking like burn.Findings:During a review of resident 41's admission Record (AR-a document containing resident profile information), dated 3/20/26, the AR indicated resident 41 was admitted to the facility on [DATE] with diagnoses which included pulmonary embolism, depression (serious, long-lasting mood disorder), seizures (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness) and anxiety (body's natural reaction to stress, acting as a feeling of fear, dread, or uneasiness about future threats or unknown). During a review of Resident 41's Minimum Data Set (MDS- an assessment tool used to identify resident cognitive [pertaining to reasoning, memory and judgement] and physical functional level), assessment dated [DATE], indicated Resident 41's Brief Interview for Mental Status ([NAME]-screening tool used in nursing home to assess cognition) assessment score was 15 out of 15 (0-15 scale, 0-6 severe cognitive deficit, 7-12 moderate cognitive deficit, 13-15 no cognitive deficit) indicating Resident 41 had no cognitive deficit. During a concurrent observation and interview on 3/17/26 at 9:41 a.m. during initial tour in Resident 41's room, Resident 41 was observed sitting up in wheelchair at bedside watching TV. Resident 41 stated he is a smoker and goes outside after each meal to smoke. Resident 41 stated facility staff go outside with the smokers to ensure they are safe.During a review of Resident 52's AR dated 3/20/26, the admission Record, indicated Resident 52 was admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), Diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and seizures During a review of Resident 52's MDS assessment dated [DATE], indicated Resident 52's BIMS assessment score was 13 out of 15 indicating resident 52 had no cognitive deficit.During a concurrent observation and interview on 3/17/26 at 9:55 a.m. during the initial tour in the hallway outside of Resident 52's room, Resident 52 was observed sitting up in his wheelchair. Resident 52 stated he had been in the facility for almost two years and was just outside smoking. Resident 52 stated he was allowed to smoke three times a day after meals. During a review of Resident 54's admission Record, dated 3/20/26, the AR indicated Resident 54 was admitted to the facility on [DATE] with diagnoses which included anxiety, depression, and pain. During a review of Resident 54's MDS assessment dated [DATE], indicated Resident 54's BIMS assessment score was 14 out of 15 indicating resident 54 had no cognitive deficit.During a concurrent interview and record review on 3/19/26 at 10:55 a.m. with Registered Nurse (RN) 1, RN 1 reviewed clinical records of Residents' 41, 52 and 54. RN 1 stated Resident 41 was admitted to the facility on [DATE] and his smoking assessment was completed on 10/31/25 and 3/17/26. RN 1 stated Resident 52 was admitted to the facility on [DATE] and his smoking assessments were completed on 10/31/25 and 3/17/26. RN 1 stated Resident 54 was admitted to the facility on [DATE] and his smoking assessments were completed on 10/27/25 and 3/17/26. RN 1 stated she was not sure how often smoking assessments were completed because she had not completed one. RN 1 stated it was important to complete smoking assessment to ensure residents are safe to smoke.During a concurrent interview and record review on 3/19/26 at 2:56 pm. With Minimum Data Set Nurse (MDSN), MDSN stated smoking assessments are completed initially on admission and quarterly. The MDSN stated she was responsible in completing smoking assessments. The MDSN stated facility was not a smoking facility but in October 2025 facility started to allow residents to smoke and the social service person completed the initial smoking assessments. The MDSN stated smoking assessment was to be completed quarterly but Residents' 41, 52 and 54 was not completed until 3/17/26, stated It was supposed to be completed sooner. The MDSN stated (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555352	A. Building B. Wing	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grace Healthcare Center	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 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	smoking assessment was important to ensure residents are safe to smoke.During an interview on 3/20/26 at 2:25 p.m. with the Director of Nursing (DON), the DON stated her expectation was for the multidisciplinary team (MDT- experts from different fields work collaborate to provide comprehensive care) to ensure smoking assessments were completed quarterly. The DON stated there should have been another smoking assessment completed for Residents' 41, 52 and 54 after their initial assessments after the facility decided to allow residents to smoke. During an interview on 3/20/26 at 3:28 p.m. with the Administrator (ADM), the ADM stated she completed Residents' 41, 52 and 54's initial smoking assessment when she was the Social Service Director. The ADM stated, Smoking assessment should be completed quarterly to ensure residents are still safe to smoke. During a review of facility's policy and procedure (P&P) titled, Smoking Policy-Residents, dated 10/23, the P&P indicated, .Resident smoking status is evaluated upon admission.A resident's ability to smoke safely is re-evaluated quarterly, upon significant change [(physical or cognitive)] and as determined by staff. The facility may impose smoking restriction on a resident at any time if it is determined that the resident cannot smoke safely with the available levels of support and supervision.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555352	A. Building B. Wing	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grace Healthcare Center	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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure staff provided care in a manner that maintained resident dignity during mealtime assistance for one of four sampled residents (Resident 1)This failure to ensure staff assisted residents at eye level, rather than standing over residents during feeding, had the potential to cause Resident 1 to feel intimidated, uncomfortable and experience a loss of dignity during care.Findings:During an observation on 3/17/26 at 11:59 a.m. Certified Nursing Assistant (CNA) 6 was observed standing over Resident 1 while assisting with feeding at the bedside. Resident 1 was positioned in bed with the head of the bed elevated. CNA 6 remained standing directly over Resident 1 throughout the feeding assistance.During a review of Resident 1's admission Record (a summary of important information regarding a patient which include patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), the admission record indicated, Resident 1 was admitted to the facility on [DATE] with a diagnosis which included cerebral infarction (occurred when blood could not reach part of the brain. Without blood, that part of the brain did not get oxygen [a gas people breathed to stay alive and give the body energy] and became damaged. This could cause problems like weakness, trouble talking or moving), dementia (a condition that affected the brain and caused problems with memory, thinking and daily activities), depression (a condition that caused a person to feel very sad, lose interest in things and have trouble with daily life), and bipolar (a condition that caused a person to have extreme mood changes, including very high moods and very low moods).During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool used to identify resident cognitive, physical abilities and needs) assessment dated [DATE], the MDS assessment indicated Resident 1's Brief Interview for Mental Status (BIMS-screening tool used to assess resident cognition status) 0-15 scale (0-6 severe cognitive deficit, 7-12 moderate cognitive deficit, 13-15 no cognitive deficit) assessment score was incomplete indicating Resident 1 was severely cognitively impaired and BIMs score could not be completed.During an interview on 3/19/26 at 9:29 a.m. with CNA 6, CNA 6 stated when preparing to feed a resident, she would obtain the meal tray and position the resident for feeding with the head of the bed elevated. CNA 6 stated Resident 1 could be pushy at times and may attempt to fight, and therefore she preferred to remain standing while feeding him. CNA 6 further stated staff were typically expected to sit next to the resident during feeding to promote a homelike environment.During an interview on 3/20/26 at 9:25 a.m. with the Director of Staff Development (DSD), the DSD stated the CNA should sit next to the resident and offer food from the tray. The DSD stated the CNA should be at eye level and in close proximity to the resident during feeding. The DSD further stated it would be inappropriate for staff to stand over a resident during feeding, as this could be intimidating and make the resident uncomfortable, impacting the resident's dignity.During an interview on 3/20/26 at 11:56 a.m. with the Director of Nursing (DON), the DON stated it was not the facility's expectation for CNA's to stand over residents during feeding. The DON stated CNA's should be seated in a chair and positioned at eye level with the resident during feeding. The DON further stated this was a dignity issue and it was not appropriate for residents to have staff standing over them during mealtimes.During a review of the facility's policy and procedure (P&P) titled, Assistance with Meals, dated 2017, the P&P indicated, resident's who cannot feed themselves will be fed with attention to safety, comfort and dignity, for example: a. not standing over residents while assisting them with meals.During a review of the facility's policy and procedure (P&P) titled, Quality of Life-Dignity, dated 2009, the P&P indicated, residents shall be treated with dignity and respect at all times.treated with dignity and respect means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555352	A. Building B. Wing	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grace Healthcare Center	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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure physician (MD) notification of elevated blood glucose (the amount of sugar in the blood that the body used for energy) levels per facility procedure for one of four sampled residents (Resident 33). When Resident 33 had seven blood glucose readings from 3/1/26 through 3/18/26 that were greater than 350 milligrams per deciliter (mg/dL a unit of measurement. Blood glucose normal range is 80 to 130 before meals). This failure resulted in Resident 33's blood glucose levels to go unmonitored and delayed adjustment of the treatment regimen and had the potential to result in adverse outcomes including significantly elevated blood sugars, dehydration (when the body did not have enough water to stay healthy and work the way it should), infection and hospitalization. Findings:During an observation on 3/17/26 at 11:27 a.m., Resident 33 was observed in her room eating lunch while watching television. Registered Nurse (RN) 4 entered the room to perform a blood glucose check and administer lispro-a fast-acting type of insulin used to lower blood sugar levels, usually given around mealtimes) insulin 12 units as ordered. The blood glucose result was obtained and measured at 223mg/dL. Resident 33 appeared alert and oriented and did not exhibit signs of distress or concern. During the observation, Resident 33 stated it's been higher. During a review of Resident 33's admission Record (a summary of important information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), the admission record indicated, Resident 33 was admitted to the facility on [DATE] with a diagnosis which included type 2 diabetes. During a review of Resident 33's Minimum Data Set (MDS-resident assessment tool which indicates physical and cognitive abilities), the MDS indicated a Brief Interview for Mental Status (BIMS-an assessment of cognitive function) score of 13 (0-7 severe cognitive impairment, 8-12 moderate cognitive impairment, 13-15 no cognitive impairment) indicating Resident 33 had no cognitive impairment. During an interview on 3/18/26 at 2:15 p.m. with Certified Nursing Assistant (CNA) 7, CNA 7 described Resident 33 as an easy-going resident who was alert and preferred to do things independently. CNA 7 stated Resident 33 was diabetic, and staff were expected to notify the nurse when meal trays were delivered so insulin could be administered as ordered. During a concurrent interview and review of Resident 33's electronic health record on 3/19/26 at 10:37 a.m. with RNS, Resident 33 was described as alert and oriented and able to communicate her needs. Review of the medication orders indicated Resident 33 was prescribed brand name long acting (a long-acting type of insulin that worked slowly over the day to help keep blood glucose levels steady) in the evening and short acting insulin. The order for short acting insulin included instructions to hold the medication if the blood glucose level was less than 100 mg/dL. There were no additional blood glucose level parameters in Resident 33's medical record. RNS stated it was important to have MD notification parameters to determine when blood glucose levels were outside an acceptable range and whether medication adjustments were needed. RNS stated the facility followed a standard blood glucose range for diabetic residents and indicated nurses should know when to notify the MD. During the interview, RNS initiated entry of an order in Resident 33's chart to notify the MD if blood glucose levels were below 60 mg/dL or above 350 mg/dL. Review of Resident 33's blood glucose records for the month of March indicated blood glucose readings greater than 350 mg/dL on 3/5/26 (402 at breakfast and dinner), 3/8/26 (379 at dinner), 3/13/26 (366 at lunch), 3/14/26 (400 at dinner) and 3/16/26 (390 at breakfast and 393 at lunch). RNS stated the MD should have been notified of Resident 33's elevated glucose on 3/5/26, 3/8/26, 3/13/26, 3/14/26, and 3/16/26. There was no documentation that Resident 33's MD had been notified. During an interview on 3/20/26 at 11:56 a.m. with the Director of Nurses (DON), the DON stated nursing staff were expected to obtain blood glucose readings, follow ordered parameters and administer insulin according to a sliding scale. The (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555352	A. Building B. Wing	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grace Healthcare Center	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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	DON stated elevated blood glucose readings exceeding parameters required attention. The DON stated residents on insulin should have parameters in the medical record indicating when to notify the MD. The DON stated nurses should notify the MD when blood glucose readings were consistently elevated and multiple readings above 350mg/dL, a blood glucose greater than 350 mg/L would be considered a change in condition. The DON stated her expectation was for nursing staff to contact the MD to obtain appropriate blood glucose parameters for residents. The DON stated when Resident 33's blood glucose was elevated nurses should have completed a change in condition assessment. During a review of the facility's policy and procedure (P&P) titled, Change in a Resident's Condition or Status, dated 2001, the P&P indicated, the nurse will notify the resident's attending physician or physician on call when there has been a (an): e. need to alter the resident's medical treatment significantly. i. specific instruction to notify the physician of changes in the resident's condition.except in medical emergencies, notifications will be made within twenty-four hours of a change occurring in the resident's medical/mental condition or status.During a review of the facility's policy and procedure (P&P) titled, Diabetes-Clinical Protocol, dated 2001, the P&P indicated, the physician will follow up on any acute episodes associated with a significant sustained change in blood sugars.the physician will order desired parameters for monitoring and reporting information related to blood sugar management. a the staff will incorporate such parameters into the medication administration record and care plan.During a review of the facility's policy and procedure (P&P) titled, Charting and Documentation, dated 2001, the P&P indicated, documentation of procedures and treatments will include care-specific details, including f. notification of family, physician or other staff, if indicated.During a review of the facility's policy and procedure (P&P) titled, Obtaining a Fingerstick Glucose Level, dated 2001, the P&P indicated, reports promptly to the supervisor and the attending physician.reports other information in accordance with facility policy and professional standards of practice.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555352	A. Building B. Wing	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grace Healthcare Center	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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the Minimum Data Set Assessment (MDS- MDS-assessment of physical and psychological functions and needs) accurately reflected resident's health and functional status for two of four sampled residents (Residents' 9 and 52) when:1.Resident 9's surgery was inaccurately coded in the MDS assessment. This failure had the potential to result in Resident 9's surgical care needs to not be treated properly. 2.Resident 52's dental health was inaccurately coded in the MDS assessment. This failure had the potential to result in Resident 52's dental health problems to go untreated due to inaccurate assessments of missing and broken natural teeth.Findings:1.During a concurrent observation and interview on 3/17/26 at 9:48 a.m. during initial tour in Resident 9's room, Resident was lying in bed and watching a show on his electronic device. Certified Nurse Assistant (CNA) 11 was standing at bedside and trying to communicate with Resident 9 using gestures. CNA 11 stated Resident 9 did not speak and only communicated using signs, gestures and pointing at things. During a review of Resident 9's admission Record (AR- a document containing resident profile information), dated 3/19/26, the AR indicated Resident 9 was admitted to the facility on [DATE] with diagnoses which included paraplegia (loss of movement or sensation in the lower half of the body), chronic tubulo-interstitial nephritis (long-term kidney disease characterized by lasting inflammation and scarring in the spaces between the kidney) and infection and inflammatory reaction due to nephrostomy catheter (small, flexible tube inserted through the back into the kidney to drain urine directly into an external bag).During a review of Resident 9's Care Plan (personalized, written guide outlining a person's health needs, goals, and the specialized daily support required to manage their well-being) dated 3/2/26, the Care Plan indicated, Focus: Resident has infection to right quad (abdominal quadrants) laparoscopic (keyhole surgery-minimally invasive technique where doctors operate through 1-3 tiny incisions in the belly using a camera) site due to kidney removal (3/2/26).During an interview on 3/18/26 at 4:07 p.m. with CNA 3, CNA 3 stated she was familiar with Resident 9's care. CNA 3 stated Resident 9 had multiple wounds, three or four small openings on his abdominal area. CNA 3 stated the nurse changed the dressings every day. CNA 3 stated Resident 9 did not talk and communicated only by gestures and pointing at things. During a concurrent interview and record review on 3/20/26 at 8:51 a.m. with Minimum Data Set Nurse (MDSN), MDSN reviewed Resident 9's quarterly MDS assessment dated [DATE] section M (Surgical Conditions), MDSN stated Resident 9's surgical wound was not coded in the MDS assessment. MSDN stated she should have coded as yes because Resident 9 had a surgical wound and daily treatment was still being provided. 2.During a concurrent observation and interview on 3/17/26 at 9:55 a.m. during initial tour in the hallway outside of Resident 52's room, Resident 52 was sitting up in his wheelchair. Resident 52 stated he had been in the facility for almost two years. Resident 52 had broken and missing natural teeth to the top and bottom gums. Resident 52 stated he was seen by a dentist recently who was in the facility but did not remember the exact date. Resident 52 stated he did not have any mouth pain but would like to get his teeth fixed. During a review of Resident 52's AR dated 3/20/26, the admission Record, indicated Resident 52 was admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), Diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and seizures. During a concurrent interview and record review on 3/20/26 at 8:39 a.m. with Infection Preventionist (IP), the IP stated she covered as the MDS nurse but not sure of the exact dates. The IP reviewed Resident 52's annual MDS assessment dated [DATE] that she had completed. The IP stated MDS assessment section L (Oral/Dental Status) was not coded correctly because Resident 52 has broken natural teeth. The IP stated she should have placed a check mark on Section L0200D (obvious or likely cavity or broken natural teeth) but she did not. During an interview on 3/20/26 at 2:29 p.m. with the Director of Nursing (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555352	A. Building B. Wing	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grace Healthcare Center	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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(DON), the DON stated her expectation was for each person completing a section in the MDS assessment to accurately reflect resident assessed status.During an interview on 3/20/26 at 3:20 p.m. with the Administrator (ADM), the ADM stated, I trust the MDS nurse to make sure the assessments are accurate. The ADM stated each person completing a section in the MDS assessment was responsible in making sure their assessments reflected the condition of each resident.During a review of facility document titled, MDS Coordinator Job Description, undated, the Job description indicated, .Responsible for the initiation and completion of all MDSs on time. Responsible for assisting with all parts of the MDS. Responsible for insuring that the MDS reflect a true picture of the resident. During a review of facility policy and procedure (P&P) titled, Certifying Accuracy of the Resident Assessment, dated 11/19, the P&P indicated, .Any person who completes any portion of the MDS assessment, tracking form, or correction request form is required to sign the assessment certifying the accuracy of that portion of the assessment. The information captured on the assessment reflects the status of the resident. The resident assessment coordinator is responsible for ensuring that an MDS assessment has been completed for each resident.During a review of professional reference titled, Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual version 1.19.1 10/24, indicated. Coding Instructions. Check L0200D, obvious or likely cavity or broken natural teeth: if any cavity or broken tooth is seen. Definitions .Surgical Wounds any healing and non-healing, open or closed surgical incisions, skin grafts or drainage sites.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555352	A. Building B. Wing	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grace Healthcare Center	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 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to complete a level 1 Preadmission Screening and Resident Review (PASARR-federal requirement to help ensure that individuals who have a mental disorder or intellectual disabilities are not inappropriately placed in a nursing home) level 1 screening notifying the state mental health authority or state intellectual disability authority promptly after a significant change for one of three sampled residents (Resident 36). This failure had the potential for Resident 36 not to receive the appropriate services related to her diagnoses.Findings:During a record review of Resident 36's admission Record (AR-a document containing resident profile information), dated 3/19/26, the AR indicated Resident 36 was admitted to the facility on [DATE] with diagnoses which included palliative care (a type of medical care that helps people who have serious illness feel better; it focuses on relieving symptoms like pain, stress, and other problems, rather than trying to cure the illness), dementia (a progressive state of decline in mental abilities), and schizophrenia (a mental illness that is characterized by disturbance in thoughts).During a review of Resident 36's Order Summary Report (OSR- a breakdown of all orders placed within the specified time period), dated 3/19/26, the OSR indicated, .Resident admitted to [name of hospice agency] Hospice on 02/26/26 under Primary diagnosis of Alzheimer's Dementia (a disease characterized by a progressive decline in mental abilities) .During a concurrent observation and interview on 3/17/26 at 9:34 a.m. during the initial tour in Resident 36' room, Resident 36 was observed sitting at the edge of his bed watching TV and calling for assistance and was assisted by a certified nursing assistant. Resident appeared restless and not able to answer questions appropriately.During a concurrent interview and record review on 3/19/26 at 8:56 a.m. with Minimum Data Set Nurse (MDSN), the MDSN stated she started doing PASARR assessments January 2026. The MDSN stated for new admissions PASARR are completed at the acute hospital and sent to the facility. The MDSN stated she completes a new PASARR assessment for significant changes like admitted or discharged from hospice care. Resident 36 clinical record was reviewed and MDSN stated Resident 36 was admitted to hospice care on 2/26/26. MDSN stated she did not find a PASARR level 1 completed when Resident 36 was admitted under hospice care. MDSN stated, I should have completed a PASARR level 1 assessment when Resident 36 was admitted under hospice care. MDSN stated PASARR was important to see whether residents needed specialized care. During an interview on 3/20/26 at 2:46 p.m. with the Director of Nursing (DON), the DON stated MDSN was responsible for creating PASARR assessments for significant changes. The DON stated there should have been a new level 1 PASARR assessment completed when Resident 36 was admitted under hospice care. The DON stated PASARR was important to get payment or reimbursement for the care provided to residents. During a record review of the MDS Coordinator's job description undated, the job description indicated, .Responsible for the initiation and completion of all MDSs on time. Responsible for assisting with all parts of the MDS. Meeting with staff and residents to gather information that may have changed. During a record review of the Job Description Director of Nursing, undated, the job description indicated, .Assumes ultimate responsibility for planning, directing, implementing, and evaluating care for all facility residents.During a review of facility's policy and procedure (P&P) titled, Admissions-From Other Healthcare Facilities, revision date 3/17, the P&P indicated, .The following information will be provided to the facility prior to or upon the resident's admission: .PASARR (as appropriate) . During a review of professional reference from the California Department of Health Care Services (DHCS), (a government agency that provides healthcare services to low-income and disabled Californians) titled, Preadmission Screening and Resident Review (n.d.), the PASARR Policy Manual indicated, facilities must ensure that PASARR evaluations are updated when clinically indicated, including after significant changes in condition.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555352	A. Building B. Wing	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grace Healthcare Center	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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a comprehensive, person-centered care plan (a plan that provides direction for individualized care of the resident) was developed and implemented to meet the identified needs for two of four sampled residents (Resident 9 and Resident 36) when Resident 9 and Resident 36 did not have care plans for the use of antibiotics (medication used to treat infections caused by bacteria).These failures placed Resident 9 and Resident 36 at a potential risks for harm by not identifying and monitoring for side effects of medications. Findings: During a concurrent observation and interview on 3/17/26 at 9:48 a.m. during initial tour in Resident 9's room, Resident was lying in bed and watching a show on his electronic device. Certified Nurse Assistant (CNA) 11 was standing at bedside and trying to communicate with Resident 9 using gestures. CNA 11 stated Resident 9 did not speak and only communicated using signs, gestures and pointing at things. During a review of Resident 9's admission Record (AR- a document containing resident profile information), dated 3/19/26, the AR indicated Resident 9 was admitted to the facility on [DATE] with diagnoses which included paraplegia (loss of movement or sensation in the lower half of the body), chronic tubulo-interstitial nephritis (long-term kidney disease characterized by lasting inflammation and scarring in the spaces between the kidney) and infection and inflammatory reaction due to nephrostomy catheter (small, flexible tube inserted through the back into the kidney to drain urine directly into an external bag).During a record review of Resident 36's AR dated 3/19/26, the AR indicated Resident 36 was admitted to the facility on [DATE] with diagnoses which included palliative care (a type of medical care that helps people who have serious illness feel better; it focuses on relieving symptoms like pain, stress, and other problems, rather than trying to cure the illness), dementia (a progressive state of decline in mental abilities), and schizophrenia (a mental illness that is characterized by disturbance in thoughts).During a concurrent observation and interview on 3/17/26 at 9:34 a.m. during the initial tour in Resident 36' room, Resident 36 was observed sitting at the edge of his bed watching TV and calling for assistance and was assisted by a certified nursing assistant. Resident appeared restless and not able to answer questions appropriately.During an interview on 3/19/26 at 9:18 a.m. with Registered Nurse (RN) 1, RN 1 stated licensed nurses are responsible in initiating a care plan when receiving new medication order including antibiotics. RN 1 stated care plan was important to direct nursing staff to care for resident needs.During a concurrent interview and record review on 3/19/26 at 9:59 a.m. with Licensed Vocational Nurse/Assistant Director of Nursing (LVN/ADON), LVN/ADON reviewed Resident 9's clinical record and stated there was an order of antibiotic on 3/2/26 but there was no care plan. LVN/ADON stated there should have been a care plan initiated as soon as Resident 9 started the antibiotic. LVN/ADON stated care plan was important to direct staff how to care for residents. LVN/ADON stated it was the responsibility of licensed nurses to create a care plan as soon as they received new medication order.During a concurrent interview and record review on 3/19/26 at 3:15 p.m. with Minimum Data Set Nurse (MDSN), MDSN reviewed Resident 9's clinical record and stated Resident 9 had an order of antibiotic on 3/2/26. MDSN stated she did not find a care plan for the antibiotic and there should have been one. MDSN reviewed Resident 36's clinical record and stated Resident 36 was ordered antibiotic on 3/13/26. MDSN stated she did not find a care plan for the antibiotic order. The MDSN stated licensed nurse receiving the medication order was responsible in initiating a care plan. MDSN stated the Infection Preventionist (IP) was to make sure there was a care plan initiated and created a care plan if there was none. MDSN stated care plan was important to direct staff to care for residents.During an interview on 3/20/26 at 9:40 a.m. with the IP, the IP stated licensed nurses receiving antibiotic orders were responsible in creating a care plan. The IP stated she reviewed Resident 9 and Resident 36's antibiotic orders but did not remember if she reviewed the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555352	A. Building B. Wing	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grace Healthcare Center	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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	care plans. The IP stated, As the IP it was my responsibility to ensure they had care plans.During an interview on 3/20/26 at 2:12 p.m. with the Director of Nursing (DON), the DON stated her expectation was for licensed nurses to create a care plan as soon as a new order was received. The DON stated the multidisciplinary team (MDT-coordinated team of specialists collaborating to treat a patient's physical, mental, and social needs, rather than just their symptoms, ensuring holistic care) should have made sure all care plans were reviewed and created care plans if missing. The DON stated care plans directs staff on how to care for residents.During a review of facility policy and procedure (P&P) titles, Care Plans, Comprehensive Person-Centered, revised date 12/16, the P&P indicated, . The Interdisciplinary team (IDT-group of experts from different fields who work closely together to solve complex problems, such as comprehensive patient care), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The comprehensive, person-centered care plan will: Include measurable objectives and timeframes; Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555352	A. Building B. Wing	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grace Healthcare Center	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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the care plans (CP) were reviewed and revised for two of eight sampled residents (Resident 6 and Resident 11) when:1. Resident 6 had yankAuer suction catheter (YSC-a rigid, oral suction instrument used to clear blood, saliva, and secretions from a patient's mouth and throat, primarily to prevent aspiration) that he uses for his mouth and nose, and the CP was indicated for oral (relating to the mouth) suctioning use only.2. Resident 11's CP did have interventions reflective of their physician order dated 1/21/26.These failures had the potential for Resident 6 and Resident 11's needs to not be met.Findings:1. During an observation on 3/17/26 at 11:19 a.m. in Resident 6's room during the initial tour, Resident 6 was not in his room, the YSC was noted to be on Resident 6's dresserDuring a concurrent observation and interview on 3/17/26 at 12:09 p.m. with Resident 6 in his room, Resident 6 was sitting in a wheelchair. Resident 6 stated the YSC was to help suck the extra saliva in his mouth. Resident 6 stated when there is a buildup of saliva in my mouth, I choke on it. Resident 6 stated the last time he used the YSC to suction was the day before which indicated 3/16/26.During a review of Resident 6's admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 5/8/25, the AR indicated, Resident 6, was admitted to the facility on [DATE] from nursing home and had diagnoses that included . cerebral infarction (brain tissue death caused by a lack of blood supply), chronic obstructive pulmonary disease (COPD- is a progressive, long-term lung disease that makes it hard to breathe), dysphagia following cerebral infraction, Methicillin-resistant Staphylococcus aureus infections (MRSA-a type of staph bacteria resistant to many common antibiotics, causing serious, hard-to-treat infections) .During a review of Resident 6's Minimum Data Set (MDS- a resident assessment tool used to identify resident cognitive (mental) and physical functional level) assessment, dated 3/1/26, the MDS section C indicated Resident 6 had a Brief Interview for Mental Status (BIMS-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 15 out of 15 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07 indicates severe impairment, 99 indicates unable to complete the interview. The BIMS score indicated Resident 6 was cognitively intact.During a review of Resident 6's Order Summary Report (OSR- indicates the physician order), the OSR indicated .May use oral suctioning PRN for increased sections. order start date 6/19/25.During a review of Resident 6's CP, the CP indicated .Interventions. May use oral suctioning PRN for increased sections.During a concurrent interview and record review on 3/18/26 at 2:24 p.m. with RN 4, Resident 6's YSC order dated 6/19/25 was reviewed. The order indicated .May use oral suctioning PRN for increased sections. RN 4 stated she was unsure if the YSC was for the nose or mouth because the Respiratory Therapist said it was for Resident 6's nose.During an interview on 3/18/26 at 2:38 p.m. with CNA 8. CNA 8 stated Resident 6 used the YSC for both his nose and his mouth.During a concurrent interview and record review on 3/18/26 at 2:55 p.m. with the RT, Resident 6's YSC order was reviewed. The RT stated Resident 6 had a lot of secretion in his mouth and had runny nose. The RT stated Resident 6 used the YSC for his mouth and nose. The RT stated there should be 2 YSC for Resident 6, one for the mouth and one for the nose.During a concurrent interview and record review on 3/20/26 at 10:56 a.m. with the DON, Resident 6's CP was reviewed. The DON stated Resident 6 used the YSC for his nose and mouth and the CP did not reflect that. The DON stated the CP should have been revised to reflect the YSC could be used for both the nose and the mouth.2. During an observation on 3/17/26 at 9:20 a.m. with Resident 11 during the initial tour in Resident 11's room, Resident 11 was lying in bed with eyes opened, unable to communicate. Resident 11 had a gastrostomy tube (G-tube- a surgical opening made (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555352	A. Building B. Wing	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grace Healthcare Center	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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	through the abdominal wall into the stomach to insert a feeding tube for long-term nutritional support tube) with feeding pump by the bedside.During a review of Resident 11's AR, dated 3/18/26, the AR indicated, Resident 11, was admitted to the facility on [DATE] from acute care hospital and had diagnoses that included . hemiplegia (form of paralysis that causes severe or complete loss of muscle function, weakness, or stiffness on only one side of the body), quadriplegia (paralysis affecting all four limbs- both arms and both legs- and usually the torso, caused by damage to the spinal cord in the neck), gastrostomy status, dysphagia (difficulty or discomfort in swallowing), gastrostomy infection, gastrointestinal hemorrhage (bleeding that occurs anywhere along the digestive tract- from the esophagus down to the rectum) .During a review of Resident 11's MDS dated 12/29/25, the MDS section C1000 indicated, Resident 11's Staff Assessment for Mental Status- Cognitive skills for daily decision-making score was 3 (0. Independent- decision consistent/ reasonable, 1. modified independence- some difficulty in new situations only, 2. moderately impaired- decisions poor; cues/ supervision required, 3. severely impaired- never/ rarely made decisions). The score indicated Resident 11 was severely impairedDuring a review of Resident 11's OSR, the OSR indicated .Enteral Feed two times a day related to gastrostomy status .dysphagia, . G-tube: [named brand] feeding formula 1.5 kcal (kilocalorie- a unit of energy used to measure the amount of energy provided by food and drinks) at 40 mL (milliliter- unit of measure)/hour x 20 hours, providing 800 ml/1200kcal . order start date 1/21/26.During a review of Resident 11's CP, the CP indicated . Interventions. [named brand feeding formula] 1.5 VIA GTUBE PUMP @ at 70 mL (milliliter- unit of measure)/hour x 20 hours (provides 1400 ml total, 2100kcal, . dated 10/27/2023, revision on 10/11/2024.During a concurrent interview and record review on 3/19/26 at 1:27 p.m. with the Minimum Data Set Nurse (MDSN), Resident 11's CP dated 10/26/23 and OSR dated 1/21/26 were reviewed. The CP indicated . [brand name feeding formula] 1.5 via G tube pump @ 70ml/hour. The OSR indicated . the active order was 40ml/hour. The MDSN stated CP was completed by the MDSN, admission Nurses, and Floor Nurses. The MDSN stated she was responsible for updating the CP. The MDSN stated CP are revised when an intervention needs to be updated. The MDSN stated [brand name feeding formula] 1.5 via G tube pump @ 70ml/hour. should no longer be an intervention and the CP needed to be updated. The MDSN stated the intervention should have been updated when Resident 11's order was changed on 1/21/26. The MDSN stated the CP was the plan of care for the residents. The MDSN stated this could cause confusion because the order was updated on 1/21/26 and the intervention was not. The MDSN stated the LNs would question the order and there could be confusion over which order was correct.During a concurrent interview and record review on 3/20/26 at 10:56 a.m. with the DON, Resident 11's CP dated 10/26/23 and OSR dated 1/21/26 were reviewed. The DON stated the CP was reflecting dates 2023/ 2024, and .70ml/hour. The DON stated the active order stated .40ml/hour. The DON stated it was important that the CP was revised because the CP should be reflective of the care provided for Resident 11.During a review of the facility's policy and procedure (P&P) titled, Goals and Objectives, Care Plans, dated 4/2009, the P&P indicated, Policy Statement- Care plans shall incorporate goals and objectives that lead to the residents' highest obtainable level of independence. Policy interpretation and implementation- 1. Care plan goals and objectives are defined as the desired outcome for a specific resident problem. 2. When goals and objectives are not achieved, the residents clinical record will be documented as to why the results were not achieved and what new goals and objectives have been established. Care plans will be modified accordingly. 4. Goals and objectives as entered on the resident care plan so that all disciplines have access to such information and are able to report whether or not the desired outcomes are being achieved. 5. Goals and objectives are reviewed and or revised. d. at least quarterly .During a review of National Library of Medicine.org Professional Reference titled, Nursing Process, dated 4/10/23, retrieved from https://www.ncbi.nlm.nih.gov/books/NBK499937/ the reference indicated, . Planning: The planning stage is where goals and outcomes are formulated that directly impact patient care based on guidelines. These patient-specific goals and the attainment [the level of knowledge, skills, or (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555352	A. Building B. Wing	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grace Healthcare Center	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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	qualifications a learner has acquired at a specific point in time] of such assist in ensuring a positive outcome. Nursing care plans are essential in this phase of goal setting. Care plans provide a course of direction for personalized care tailored to an individual's unique needs. Overall condition and comorbid conditions play a role in the construction of a care plan. Care plans enhance communication, documentation, reimbursement, and continuity of care across the healthcare continuum. vital to positive patient outcomes. the nursing process to guide care is clinically significant going forward in this dynamic, complex world of patient care. Aging populations carry with them a multitude of health problems and inherent risks of missed opportunities to spot a life-altering condition.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555352	A. Building B. Wing	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grace Healthcare Center	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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation, interview, and record review, the facility failed to ensure1. Two of four Registered Nurses (RN 2 and RN 4) were competent in the enteral feeding (tube feeding- is a method of delivering liquid nutrients directly into the stomach or small intestine via a tube) process when providing care to Resident 40 during enteral feeding.2. The Licensed Nurse (LN)s Competency/ Skills checklist (CSC) (a measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics in performing that an individual need to perform work roles or occupational functions successfully) was performed upon hire for one of six staff members (RN 4).These failures had the potential for the facility to not be able to assess the skills necessary to provide nursing services such as enteral feeding and thus placed the Resident 40 at riskFindings:1. During an observation on 3/17/26 at 10:56 a.m. in Resident 40's room, Resident 40 was in bed sleeping and there was a feeding pump with feeding formula set up. The connector end of the feeding bag tubing for Resident 40 did not have a tube cover cap and was left open to air. The inside of the feeding bag tubing was observed to be clogged with dried formula build up and around the tip of the connector end of the feeding bag tubing had dried formula build up.During a concurrent observation and interview on 3/17/26 at 12:35 p.m. in Resident 40's room, Registered Nurse (RN) 4 was observed taking the exposed connector end of the feeding bag tubing that had dried formula buildup at the tip and was clogged to connect it to Resident 40's gastrostomy tube (G-tube or PEG tube- a surgical opening made through the abdominal wall into the stomach to insert a feeding tube for long-term nutritional support tube) feeding port. RN 4 was asked if the tip of the feeding tube should be opened and attached to Resident 40. RN 4 stated the tip of the feeding bag tubing should have been covered with a cap. RN 4 was observed cleaning around the end of the feeding bag tubing and inside the feeding bag tubing with the hand glove she had removed. When asked the process, RN 4 stated I use the inside of the gloves to clean the tip of the tube. When asked if that was the correct process, RN 4 stated it should not be like that, I would use a gauze with normal saline. When asked if using the gauze with normal saline would remove the dried formula, RN 4 stated after cleaning with the gauze and normal saline, the tube would still have dried formula.During a concurrent observation and interview on 3/19/26 at 11:43 a.m. with Registered Nurse (RN) 2 in Resident 40's room, Enhanced Barrier Precautions (EBP) RN 2 was observed operating the feeding tube on Resident 40. RN 2 did not wear a Personal Protective Equipment (PPE) gown. RN 2 stated there was no need for RNs to wear a PPE gown when handling a feeding tube. RN 2 stated feeding tubes were not included in the list of devices that required Enhanced Barrier Precautions (EBP) usage when residents are placed on EBP.During an interview on 3/18/26 at 3:37 p.m. with RN 4, RN 4 stated she had no training on feeding tube. RN 4 stated she had only one day of orientation when she was hired, and she started working with residents. RN 4 stated there was no skills or competency training, demonstration or evaluation on feeding tube training. RN 4 stated there was dried formula on the inside of the feeding bag tubing for Resident 40. RN 4 stated she should have inspected the feeding bag tubing before connecting it to Resident 40.During an interview on 3/20/26 at 8:50 a.m. with the Infection Preventionist (IP), The IP stated RN 4 was not competent, and the expectation was that RN 4 should have changed the whole tubing kit. The IP stated competency needed to be addressed. The IP stated she was unaware if there was a competency or skill check for staff's competency when providing care for residents using a feeding tube. The IP stated RNs should be skilled and checked for competency before the attempt to do it.2. During a concurrent interview and record review on 3/19/2026 at 1:57 p.m., with the Director of Staff Development (DSD), the DSD stated RN 4 had orientation training on 1/14/26 and RN 4's Competency/ Skills checklist (CSC) was done with the DON.During a concurrent interview and record review on 03/19/2026 at 4:45 p.m. with the DON, RN 3 and RN 4's CSC were reviewed, the CSC indicated RN 3 completed the CSC on 7/16/25 and there was no CSC for RN 4. The DON stated she did not complete RN 4's CSC. The DON stated RN (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555352	A. Building B. Wing	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grace Healthcare Center	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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4 started working in the facility in January 2026. The DON stated the CSC is completed after 3 months of staff employment. The DON stated the CSC should have been completed after orientation and there should have been a repeated evaluation after 3 months.During a concurrent interview and record review on 03/20/2026 at 10:56 a.m. with the DON, the feeding tube pictures were reviewed and the observation of RN 4 during the tube feeding session was discussed. The feeding tube pictures indicated the feeding tube was clogged. The DON stated RN 4 needed more skill testing. The DON stated RN 4 was not competent in enteral feeding. The DON stated she expected RN 4 to know what she was doing because she had previously worked in the facility. When asked if that was sufficient training for RN 4, the DON stated there was a need to ensure that RNs were shown the process and there was a repeat demonstration to ensure the RNs know what they were doing.During a concurrent interview and record review on 03/20/2026 at 11:56 a.m. with the Administrator (ADM), the observation of RN 4 during the tube feeding session was discussed. The ADM stated the expectation was that competency testing and training should be completed upon hire. The ADM stated, I see a hole there, a very big one. The ADM stated Resident 40 would not be getting sufficient feeding since the tubing was occluded. The ADM stated there should have been a cap on the tubing. The ADM stated the RN 4 needed training. The ADM stated RN 4 should have had a skills checkoff before she went on the cart by herself. The ADM stated the expectation from the DON, is that LNs should have passed their competencies and skill checks should have been completed. The ADM stated proper training, and frequent rounds should be done to ensure compliance. The ADM stated this was important because lives are involved, the LNs should know what they are doing because there are lives depending on them.During a review of the facility's Policy and Procedure (P&P) titled, Staffing, Sufficient and Competent Nursing, dated 04/2025, the P&P indicated, .Policy Statement- The Facility provides sufficient numbers of nursing staff with the appropriate skills and competency necessary to provide nursing and related care and services for all residents in accordance with resident care plans and the facility assessment. Policy Interpretation and implementation.Competent staff: 1. Competency is a measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics that an individual needs to perform work roles or occupational functions successfully. 2. All nursing staff must meet the specific competency requirements of their respective licensure and certification requirements defined by state law. 3. Licensed staff must demonstrate the skills and techniques necessary to care for resident needs including. i. nursing skills consistent with scope of practice.5. Competency requirements and training for nursing staff are established and monitored by nursing leadership.During a review of the facility's P&P titled, Hiring Policy & Procedure, undated, the P&P indicated, .Policy- The facility shall implement a standardized hiring process to ensure all employees are: Qualified, competent and legally eligible for employment; Properly screened . oriented and trained prior to resident care. Purpose- To ensure: Safe and competent staffing, protection of resident health and safety, compliance with state regulatory and survey standards, proper documentation for survey readiness.Responsibility- Administrator: Final hiring approval and compliance oversight, Human Resources (HR): Manage hiring process and documentation, Department Heads: Conduct interviews and competency validation, DON (Director of Nursing): Verify clinical staff qualifications. 5. Procedure.5.5 Pre employment screening (mandatory).5.8 Competency Validation: department head validates skills competency, clinical staff must demonstrate - safe patient care skills, equipment usage, documentation practices.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555352	A. Building B. Wing	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grace Healthcare Center	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 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on interview and record review, the facility did not ensure completion of a performance review/evaluation of nurse's aides were competed at least every 12 months for two of three Certified Nurse Assistant (CNA 8 and CNA 9) when the CNAs personnel files review did not have annual performance evaluations since their Date of Hire (DOH).This failure had the potential to negatively affect the competency of the CNAs and the quality of care provided to the facility residents. Findings:During a concurrent interview and record review on 3/19/2026 at 1:57 p.m., with the Director of Staff Development (DSD), CNA 8, CNA 9, and CNA 10's personnel files were reviewed. The personnel file for CNA 8 indicated CNA 8's DOH was 12/9/24, and there was no performance evaluation completed in CNA 8's file. The personnel file for CNA 9 indicated CNA 9's DOH was 6/6/23, and there was no performance evaluation completed in CNA 9's file since DOH. The DSD stated she was responsible for ensuring the performance review of the CNAs were completed. The DSD stated the sampled CNAs did not have performance evaluations completed annually. The DSD stated this was important because it helped ensure staff were able to provide quality care for residents.During an interview on 03/20/2026 at 10:56 a.m. with the Director Of Nurses (DON), the DON stated the performance review/evaluation determines if a staff is able to do the job the right way. The DON stated evaluations should be done 3 months after hire, after one year, and yearly for staff that are still employed longer than one year. The DON stated the expectation from the DSD was there should have been performance evaluation every year. The DON stated this was important because it would determine if the staff were performing poorly or improving. The DON stated if the staff were consistently performing poorly, the staff would need to be let go.During a review of the facility's Policy and Procedure (P&P) titled, Hiring Policy & Procedure, undated, the P&P indicated, .Policy- The facility shall implement a standardized hiring process to ensure all employees are: Qualified, competent and legally eligible for employment; Properly screened . oriented and trained prior to resident care. Purpose- To ensure: Safe and competent staffing, protection of resident health and safety, compliance with state regulatory and survey standards, proper documentation for survey readiness.Responsibility- Administrator: Final hiring approval and compliance oversight, Human Resources (HR): Manage hiring process and documentation, Department Heads: Conduct interviews and competency validation, DON (Director of Nursing): Verify clinical staff qualifications. 5. Procedure.5.9 Personnel File Requirement . Each employee file must include .Performance evaluations.During a review of the facility's P&P titled, Performance Evaluations, dated 09/2020, the P&P indicated, .Policy Statement- The job performance of each employee shall be reviewed and evaluated at least annually. Policy Interpretation and Implementation1. A performance evaluation will be completed on each employee at the conclusion of his/her 90-day probationary period, and at least annually thereafter.4. Performance evaluations will be completed by the employee' department directors and supervisors.5. The written performance evaluations will contain the director's and /or supervisor's remarks and suggestions, any actions that should be taken (e.g. further training, etc.), and goals.9. The completed performance evaluation will be. placed in the employee's personnel record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555352	A. Building B. Wing	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grace Healthcare Center	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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure appropriate monitoring and follow-up for a resident receiving valproic acid for one of four sampled residents (Resident 1) when Resident 1 had an active order for valproic acid (medication used to help control seizures and stabilize mood by affecting how the brain worked) since 12/4/26 for mood stabilization related to bipolar disorder (a condition that caused a person to have extreme mood changes, including very high moods and very low moods), and no valproic acid level had been obtained since initiation per facility procedure and and there was no documentation the physician (MD) or Responsible Party (RP) were notified.This failure resulted in the facility not ensuring appropriate medication monitoring and follow up for Resident 1 while receiving valproic acid, which had the potential to lead to undetected toxic or subtherapeutic drug levels, placing Resident 1 at risk for adverse effects, including liver dysfunction (when the liver did not work the way it should, making it harder for the body to clean the blood and process medicine), metabolic abnormalities (when the body did not properly balance things like sugar, salts or chemicals, which could affect how the body worked), thrombocytopenia (when a person had a low number of platelets [type of blood cell] in their blood, making it harder for their blood to clot and stop bleeding), or ineffective treatment.Findings:During an observation on 3/17/26 at 8:55 a.m. Resident 1 was observed in bed. Resident 1 appeared confused, intermittently mumbling words while speaking, with some words articulated clearly. Resident 1 was able to speak his name, and he did not appear sleepy, drowsy or sedated.During a review of Resident 1's admission Record (a summary of important information regarding a patient which include patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), the admission record indicated, Resident 1 was admitted to the facility on [DATE] with a diagnosis which included cerebral infarction (occurred when blood could not reach part of the brain), dementia (a condition that affected the brain and caused problems with memory, thinking and daily activities), depression (a condition that caused a person to feel very sad, lose interest in things and have trouble with daily life), and bipolar disorder.During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool used to identify resident cognitive, physical abilities and needs) assessment dated [DATE], the MDS assessment indicated Resident 1's Brief Interview for Mental Status (BIMS-screening tool used to assess resident cognition status) 0-15 scale (0-6 severe cognitive deficit, 7-12 moderate cognitive deficit, 13-15 no cognitive deficit) assessment score was incomplete indicating Resident 1 was severely cognitively impaired and BIMs score could not be completed.During an interview on 3/19/26 at 9:29 a.m. with Certified Nursing Assistant (CNA) 6, CNA 6 described Resident 1 as a difficult resident who refused care at times. CNA 6 stated Resident 1 was alert to self but otherwise confused.During a concurrent interview and record review on 3/19/26 at 10:06 a.m. with Registered Nurse Supervisor (RNS), the RNS described Resident 1 as alert, but very confused, with behaviors including combativeness, hitting, spitting and refusing care and laboratory draws. RNS stated Resident 1 was not his own RP and identified his daughter as the RP. RNS stated that when a resident refused care, staff would wait and reattempt care later, and if refusals persisted, staff were expected to notify the MD and RP and update the care plan, with such actions documented in a progress note. A review of Resident 1's electronic health record indicated progress notes dated 3/18/26 and 3/11/26 indicated Resident 1 refused lab draws on both occasions, documented as the third refusal for lab testing. The notes indicated Resident 1 was educated on the purpose of the lab tests and potential risks of refusal, acknowledged understanding, and declined to proceed. The record did not indicate whether the lab draw was attempted on those dates or if the refusal occurred prior to attempt. RNS stated if there was no documentation indicating the MD and RP were notified, then the notification did not occur. Review of Resident 1's care plan identified an intervention to notify the MD and RP with each refusal; however, the RNS stated this intervention was (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555352	A. Building B. Wing	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grace Healthcare Center	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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not followed. RNS further stated Resident 1's care plan for valproic acid did not include interventions for ongoing laboratory monitoring. Review of Resident 1's orders indicated Resident 1 had an active order for a valproic acid level. RNS stated monitoring valproic acid levels was important to assess for therapeutic range and potential toxicity. RNS stated there was no documented valproic acid level result in Resident 1's chart and stated Resident 1 had been receiving valproic acid since 12/4/25. RNS stated valproic acid levels were typically drawn every six months. Review of the March Monthly Regimen Review (MRR), completed 3/13/26, indicated the pharmacist recommended obtaining a valproic acid level and ammonia (a waste chemical in the body that was normally removed by the liver, but when built up, it could affect how the brain worked) level. RNS stated the laboratory was expected to complete the lab draw on 3/18/26; however, record review indicated Resident 1 refused the blood draw on that date. RNS further stated a valproic acid level should have been obtained when Resident 1 was initially started on valproic acid.During an interview on 3/20/26 at 8:14 a.m. with the Registered Pharmacist (RPh), the RPh stated standard monitoring parameters for a resident receiving valproic acid included obtaining valproic acid levels and ammonia levels, depending on the resident's condition and indication for use. RPh stated levels should be obtained every 6-12 months and that a baseline level should be obtained at the initiation of therapy. RPh stated the risk of not obtaining valproic acid levels included potential for levels to become too high, leading to toxicity, or being too low, resulting in lack of therapeutic effect. RPh further stated potential adverse effects associated with lack of monitoring included impacts to liver function (how well the liver worked to clean the blood, process medicines and help the body stay balanced), as well as abnormalities in the comprehensive metabolic panel (a group of blood tests that checked how the body was working, including things like the kidneys, liver and levels of sugar and salts)and platelet levels. RPh stated if a resident refused lab draws, a recommendation could be made to reduce the dose to minimize risk, or to have a discussion with the physician and RP regarding the importance of monitoring. RPh stated without lab values, treatment was shooting in the dark. RPh further stated if the resident was not his or her own RP, the facility should notify the RP and physician of refusal.During an interview on 3/20/26 at 11:56 a.m. with the Director of Nursing (DON), the DON stated residents receiving valproic acid required laboratory monitoring to determine potential toxicity. The DON stated a valproic acid level should be obtained within the first month of treatment and then every three months thereafter to ensure levels were not toxic. The DON stated that when a resident refused laboratory draws, staff were expected to notify the physician. The DON further stated if the resident lacked cognitive capacity to understand, staff were expected to explain the situation to the RP. The DON stated staff should attempt the lab draw, document the refusal and reattempt later. The DON stated her expectation was staff would notify the MD and RP with each refusal. The DON stated it was important to monitor levels and ensure laboratory testing was completed.During a review of Resident 1's Order Summary Report dated 3/19/26, the Order Summary Report indicated Resident 1 had an active order for valproic acid delayed-release sprinkle capsules, 125 milligram (mg-a unit of measurement) with instructions to .give [two] capsules by mouth two times a day. total dose [equal] 250mg start date 12/11/2025 [4 p.m.].During a review of Resident 1's Medication Administration Record (MAR) from December 2025 through 3/19/26 it was indicated Resident 1 received Valproic Acid sprinkle capsules twice daily at 8:00a.m. and 4:00p.m. from 12/11/26 through the review date. The order was for 125mg capsules administered twice daily, for a total daily dose of 500mg.During a review of Resident 1's CRMC Case MGMT dated 2/4/26, the CRMC Case MGMT indicated no valproic acid level was obtained during Resident 1's recent hospitalization from 1/29/26 through 2/4/26.During a review of the facility's policy and procedure (P&P) titled, Requesting, Refusing and/or Discontinuing Care or Treatment, dated 2017, the P&P indicated, Resident/representatives will be informed of the risks and benefits of the proposed treatment and/or care.the resident/representative will be informed of his or her rights to: a request, refuse and/or discontinue treatment.documentation pertaining to a resident's request, discontinuation or refusal of treatment (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555352	A. Building B. Wing	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grace Healthcare Center	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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	shall include at least the following: a. the date and time the care or treatment was attempted, g. the date and time the practitioner was notified as well as the practitioner's response.the healthcare practitioner must be notified of refusal of treatment, in a time frame determined by the resident's condition and potential serious consequences of the request.During a review of the facility's policy and procedure (P&P) titled, Lab and Diagnostic Test Results-Clinical Protocol, dated 2018, the P&P indicated, facility staff should document information about when, how and whom the information was provided and the response. This should be done in the Progress Notes section of the medical record.physicians or nurses who have concerns about test results have been handled or reported should communicate such concerns to the DON and/or Medical Director a. such concerns or disagreements should not prevent timely, clinically appropriate management of a current result or clinical situation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555352	A. Building B. Wing	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grace Healthcare Center	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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure drugs and biologicals (a class of drugs that are produced using a live system, such as a microorganism, plant cell, or animal cell) were locked and labeled in accordance with current accepted professional standards of practice and facility procedures for two of thirteen sampled residents (Resident 42 and Resident 36) when:1.Resident 42 had one metered dose inhaler (MDI-pressurized canister that delivers precise, pre-measured puff of medication directly into the lungs) with no label of name, direction, open date and used by date, three over the counter (OTC-nonprescription drugs bought off-the-shelf for self-treating minor ailments like pain, allergies, or colds) ointments (thick oil-based, and greasy medications applied directly to the skin) kept in the top drawer of his bedside table and two bottles of OTC eye drops (treat temporary symptoms like dryness, itching, and mild redness) on top of his bedside table.These failures had the potential for Resident 42's medications to be administered past the discard dates and for over the counter medicate to be self administered which could lead to more serious health condition.2. Resident 36's controlled medication (medications that are highly regulated by the government because of the significant risk of abuse and dependence they pose) record sheet did not indicate the Administration Instructions (specific directions, including dosage form, route [e.g., by mouth], and frequency [e.g., 1-tab daily] for use of the medications).This failure placed Resident 36 at risk of being administered the wrong dosage of the medication at the wrong time and route. Findings: 1.During a concurrent observation and interview on 3/19/26 at 4:39 p.m. in Resident 42's room, Resident 42 was sitting up in his wheelchair and observed a small bump with small cut on his forehead. Resident 42 stated he bumped his head on the bathroom door. Resident 42 stated he applied double antibiotic ointment he keeps on his bedside table. Resident 42 stated the nurse treated the bump and cut with ointment earlier, but he had to take a shower and did not want to bother the nurse, so he applied his own ointment. Resident 42 kept other medications in the drawer and top of his bedside table. Resident 42 stated he used the MDI twice a day in the morning and at bedtime. Resident 42 stated he used one puff instead of the two puffs prescribed by his primary doctor. Resident 42 stated he used the ointments as needed for his pain, redness in the back of his ears. Resident 42 stated he used the eye drops every morning one eye drop for his left eye and the other eye drop on his right eye. Resident 42 stated he did not remember letting the nursing staff know about the medications. Resident 42 stated, They must have seen it because I always keep them on top of my drawer and I have been here two weeks. During a review of Resident 42s' admission Record (AR -a document containing resident profile information), the AR indicated Resident 42 was admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and muscle weakness. During an interview on 3/20/26 at 9:30 a.m. with Registered Nurse Supervisor (RNS), the RNS stated Resident 42 should not have been allowed to keep medications at bedside. The RNS stated the facility practice was for all medications brought in from the hospital or home to be removed from resident's (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555352	A. Building B. Wing	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grace Healthcare Center	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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bedside and brought in the medication room and inventoried. The RNS stated the Medical Doctor (MD) had to be notified and give the order if agreeable, medications could then be ordered from the pharmacy. The RNS stated it was not safe to leave medications at bedside because other residents could go in and take medications causing serious health conditions. During an interview on 3/20/26 at 9:38 a.m. with Certified Nursing Assistant (CNA) 4, CNA 4 stated she was familiar with Resident 42. CNA 4 stated Resident 42 was alert and oriented and knows what is going on. CNA 4 stated she had seen the medications on top of Resident 42's bedside table and was sure licensed nurses had seen the medications. CNA 4 stated she was not sure why the nurses did not took medications away. During an interview on 3/20/26 at 9:50 a.m. with the Infection Preventionist (IP), the IP stated, Medications should never be left on top of bedside table even OTC medications. The IP stated the facility had never allowed residents to keep medications at bedside because medications had to be locked in order for other residents not to have access. During an interview on 3/20/26 at 11:15 a.m. with Registered Nurse (RN) 1, RN 1 stated she was aware of Resident 42's medications at bedside table because I have seen the medications, but Resident 42 did not want me to touch the medications. RN 1 stated she thought Resident 42 was allowed to keep medications because the medications were OTC. RN 1 stated she did not know Resident 42 kept a MDI medication at bedside. RN 1 stated MDI needed to have label with name, direction, open date and used by date to ensure it was not administered past its used by date and proper dose was being administered. RN 1 stated it was not safe to keep medications at bedside unlocked because other residents could go in the room, take medications and use the medication which they could be allergic to resulting in serious health condition. During an interview on 3/20/26 at 2:30 p.m. with the Director of Nursing (DON), the DON stated Resident 42 was alert and oriented and she was not aware Resident 42 kept medications at bedside. The DON stated she talked to Resident 42 and explained nursing staff had to have a list of his medications, notify the MD and keep track of dosages and frequency when he is taking medications to avoid overdosing or underdosing of medications. The DON stated Resident 42 wanted to keep medications at bedside table they have to put a lock in order for other residents not to have access to Resident 42's medications. The DON stated Resident 42's medications should have been labeled with resident name, direction, open date and used by date. During a review of facility's policy and procedure (P&P) titled, MEDICATION LABELS, undated, the P&P indicated, .Medications are labeled in accordance with facility requirements and stated and federal laws. Each prescription medication label includes: 1) Resident's name 2) Specific directions for use, including route of administration. Non prescription medications not labeled by the pharmacy are kept in manufacturer's original container and identified with the resident's name. During a review of facility policy and procedure (P&P) titled SELF-ADMINISTRATION OF MEDICATIONS, dated 4/08, the P&P indicated, .Bedside medication storage is permitted only when it does not present a risk to confused residents who wander into the room of, or room with, residents who self-administer. The following conditions are met for bedside storage to occur: 1) The manner of storage prevents access by other residents. Lockable drawers or cabinets are required if unlocked storage is deemed inappropriate. 2) The medications provided to the resident for bedside storage are kept in the containers dispensed by the provider pharmacy. All nurses and aides are required to report to the charge nurse on duty any medications found at the bedside not authorized for bedside storage (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555352	A. Building B. Wing	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grace Healthcare Center	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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and to give unauthorized medications to the charge nurse to return to the family or responsible party. 2. During a review of Resident 36's admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 3/19/26, the AR indicated Resident 36 was admitted to the facility from an acute care hospital on 2/26/26 with diagnoses which include . encounter for palliative care (a medical interaction specifically focused on improving the quality of life for someone with a serious, chronic, or life-limiting illness), unspecified dementia (decline in mental ability such as memory, thinking, or behavior that is severe enough to interfere with daily life) . During a review of Resident 36's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 3/5/26, the MDS section C indicated Resident 36 had a SSCH Brief Interview for Mental Status (BIMS-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 3. The BIMS score indicated Resident 36 had severe cognitive impairment. During a review of Resident 36's Order Summary report (OSR), the OSR indicated Resident 36 had physician orders for Morphine Sulfate (Concentrate)-(a Schedule II controlled medication used for severe pain requiring daily, around-the-clock, long-term treatment) Oral Solution 20mg/ml (Milligram/Milliliter- a metric unit of mass equal to one-thousandth of a gram/liter, used for medicine dosages)- Give 0.25ml by mouth every 2 hours as needed for mild pain (1-3/10)/ SOB-(Shortness of breath) related to Encounter for Palliative Care with a start date of 2/27/26. During a concurrent interview and record review on 3/19/26 at 3:37 p.m. in the nursing station, with Registered Nurse (RN) 1, the controlled drug record sheet (CDR) binder undated and Resident 36's medication box, dated 2/26/26 were reviewed. The CDR belonging to Resident 36 was noted to be incomplete. The CDR indicated Resident 36's name, and the name of the medication, without the administration instruction. The medication box indicated the medication administration instructions. RN 1 stated there was no dosage, direction, route, frequency/ time, and reason for why Resident 36 was taking the medication on the CDR. RN 1 stated these parameters should have been stated on the CDR. RN 1 stated this was important so that the Licensed Nurse (LN)s would know what the correct order for Resident 36 was and ensure there were no errors in medication administration. RN 1 stated this failure could potentially lead to Resident 36 receiving a wrong dose, and the medication given through the wrong route which could lead to toxicity. During a concurrent interview and record review on 03/20/2026 at 10:56 a.m. with the Director of Nursing (DON), the pictures of Resident 36's medication box, dated 2/26/26 and CDR, undated were reviewed. The DON stated the CDR did not indicate the method of administration which included dosage and other parameters. The DON stated the LNs needed to know the expiration date, and the other parameters because if the wrong method of administration was used, there would be complication for Resident 36. During a concurrent interview and record review on 03/20/2026 at 11:56 a.m. with the Administrator (ADM), the pictures of Resident 36's medication box, dated 2/26/26 and CDR, undated were reviewed. The ADM stated the CDR was missing method of administration. The ADM stated she expected the LNs to be attentive and ensured the right documentation was in place. During a review of the facility's Policy and Procedure (P&P) titled, ID3: Controlled Medications, dated 8/2014, the P&P indicated, .Policy- Medications included in the Drug Enforcement Administration (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555352	A. Building B. Wing	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grace Healthcare Center	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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(DEA) classification as controlled substances as subject to special handling, storage, disposal, and record keeping in the facility, in accordance with federal and state laws and regulations. Procedure.C. A controlled medication record accountability record is prepared by the pharmacy or facility for all scheduled II to V medications. The following information is completed: 1. name of resident 2. prescription number 3. name, strength, and dosage form of medication 4. date received 5. quantity received 6. name of person receiving medication supply 7. dispensing pharmacy information.I. The director of nursing in conjunction with consultant pharmacist or designee routinely monitors controlled medication storage, records, and expiration dates during medication storage inspection.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555352	A. Building B. Wing	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grace Healthcare Center	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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety when:1. One of two Dietary Aids (DA 1) working in the kitchen did not have a hair net on.2. One wet quarter pan was stacked on top of another quarter pan.3. Ground beef was thawing in the refrigerator with no pull/thaw date on it (the date marked on a food item when it is removed from the freezer to thaw), and no use by date. These failures had the potential to cause cross contamination (the process by which germs are unintentionally transferred from one substance or object to another, with harmful effect) and the growth of microorganisms (a microscopic organism, especially a bacterium, virus, or fungus) that harbor foodborne pathogens (a bacterium, virus, or other microorganism that can cause disease) of residents' food which could lead to food-borne illness (stomach illness acquired from ingesting contaminated food) for the 56 residents admitted to the facility who receive meals from the kitchen.1. During an interview on 3/17/26 at 8:36 a.m. with DA 2, DA 2 stated there were no hair nets in the kitchen available for use. DA 2 stated she had a hair net on that day because she kept her own personal supply of hairnets. DA 2 stated the kitchen staff do not wear hair nets if there are none available for use and stated there was one staff member in the kitchen with no hair net on.During a concurrent observation and interview on 3/17/26 at 8:41 a.m. with DA 1 in the kitchen, DA 1 was observed working in the kitchen with no hair net on. DA 1 stated she did not have a hair net on, because there were no hair nets available for use in the facility. DA 1 stated she did not wear a hair net when there were none available for use. DA 1 stated it was the facility's policy to wear hair nets always while in the kitchen. During an interview on 3/17/26 at 8:43 a.m. with DA 2, DA 2 stated it was important to wear hair nets in the kitchen because she would not want hair to get on the food because it would be unclean. DA 2 stated residents could choke on the hair in the food. During an interview on 3/18/26 at 8:22 a.m. with the Certified Dietary Manager (CDM), the CDM stated his expectation was that kitchen staff wash their hands and put on a hair net as soon as staff entered the kitchen. The CDM stated hair nets were important to prevent contaminants in the food that could cause food-borne illness for the residents.During a telephone interview on 3/19/26 at 11:05 a.m. with the Registered Dietitian Consultant (RDC), the RDC stated hair nets should be worn at all times including facial hair nets, while in the kitchen. RDC stated it was important to wear hair nets in the kitchen to prevent hair from going into the food and causing cross-contamination that could lead to resident illness.During an interview on 3/20/26 at 8:43 a.m. with the Administrator (ADM), the ADM stated she was made aware there were no hair nets available for use in the kitchen when she escorted the surveyor to the kitchen door and staff stated there were no hair nets available for the surveyor to put on. The ADM stated is was not acceptable for there to be no hair nets available for use in the kitchen and stated after she was made aware of no hairnets available for use in the kitchen, she conducted a verbal in-service with the CDM informing him he must always have a couple of boxes of hair nets on hand to have readily available and moving forward before he went home, he was to check the supplies and ensure supplies were available to staff. The ADM stated kitchen staff must always have hair restraints on in the kitchen because hair could fall into the food and that would be unsanitary and could cause cross-contamination that could lead to the possibility of residents getting sick. During a review of the facility document titled, In-Service: Proper Hair Restraint & Kitchen Hygiene, (undated), the document indicated, .one of the most critical steps in preventing physical contamination is the consistent and correct use of hairnets.Contamination: Hair can carry bacteria.Regulatory Compliance: Health codes require all food handlers to wear effective hair restraints. 2. During a concurrent observation and interview on 3/17/26 at 8:52 a.m. with DA 2 in the kitchen, a wet quarter pan was observed in a clean dish area/room stacked on top of other quarter pans. DA 2 stated the process for dishes was the dishes get washed, air dried, and once the dishes are dry, they are put away in the clean dish room or (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555352	A. Building B. Wing	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grace Healthcare Center	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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	storage area where they belong. DA 2 stated dishes should not be wet when stored because the water could harbor (to contain or allow the growth) bacteria. DA 2 touched the pan, stated the aluminum quarter pan was wet and stated dishes were not supposed to be wet when stored. DA 2 stated the quarter pan was wet and stacking a wet pan would not allow it to dry adequately.During an interview on 3/17/26 at 9:37 a.m. with the CDM, the CDM stated dishes were stored face down so that no water was pulling on the dishes because bacteria could grow in still water. The CDM stated there should be no water on the dishes once they are washed, dried and stored in their clean storage areas. The CDM stated water on dishes could cause bacterial growth that could lead to food-born illness that could affect residents health. The CDM referred to the stacked wet quarter pans as water nesting (the improper practice of stacking or storing pots, pans, or dishes while they are still damp) and stated the quarter pans should have been dry before they were stored in the clean area because stacked wet pans did not allow for proper air flow to allow drying.During a telephone interview on 3/19/26 at 11:07 a.m. with the RDC, the RDC stated all dishes needed to be air dried and not wet before being stored in their respective storage areas. The RDC stated it was important for there to be no water on the pans because water could harbor bacteria that could cause food-born illness and could lead to possible resident illness from wet water staying on the dishes/pans for prolonged periods of time. The RDC stated stacking pans while wet prevented appropriate air flow to dry the pans.During an interview on 3/20/26 at 8:46 a.m. with the ADM, the ADM stated her expectation was that dishes are not wet when stacked. The ADM stated the process for dishes was when dishes came out of the washer they were put on a rack to air dry. The ADM stated dishes/pans should not be stored wet because wet dishes/pans could cause bacteria to grow. The ADM stated stacking wet dishes prevented adequate airflow that prevented drying and could cause bacteria to grow causing cross-contamination that could lead to resident illness.During a review of the facility document titled, In-Service: Preventing Wet Stacking, (undated), the document indicated, .Wet stacking occurs when items.are stacked together while they are still damp.traps moisture between the surfaces, preventing air circulation and proper drying.Why is it a Problem.Bacterial Growth.Cross-Contamination.Before stacking, ensure the item is bone-dry to the touch. 3. During a concurrent observation and interview on 3/17/26 at 9:25 a.m. with the CDM in the kitchen, a plastic container with ground beef was observed thawing in the refrigerator with no pull/thaw date on it. The CDM stated there was no pull date on the ground beef, but remembered it was pulled from the freezer and put into the refrigerator to thaw on Friday 3/13/26. CDM stated there should have been a pull/thaw date on the ground beef so that all staff knew when the ground beef was pulled for thawing and when to throw the food away. The CDM stated it was important for food items to be labeled with a pull/thaw date and use by date to prevent bacterial growth on food that could cause food-borne illness.During an interview on 3/18/26 at 3:28 p.m. with DA 3, DA 3 stated pull/thaw dates and use by dates on food items were important because the food could get contaminated and it would not be safe to serve to the residents. DA 3 stated the food could contain mold that could get residents sick.During an interview on 3/18/26 at 3:33 p.m. with DC 1, DC 1 stated food items should always have pull / thaw dates on the stickers and a use by date. DC 1 stated it was important to not use expired meat because the meat could contain bacteria that could cause food-borne illness that could make residents sick.During a telephone interview on 3/19/26 at 11:11 a.m. with the RDC, the RDC stated her expectation was that food items have a use by date label on them. The RDC stated facility policy should be followed for food safety including dates and labeling of food items and stated she had not looked at the facility policy but her expectation was that facility policy be followed. During an interview on 3/20/26 at 8:50 a.m. with the ADM, the ADM stated her expectation was that all food should be labeled always. The ADM stated it was important to label food so that staff could keep track of when food was taken out of the freezer and when it was put in the refrigerator and when the staff were going to use the food. The ADM stated it was important to keep track of time frames for the food because if there was different staff working on different days, all staff needed to be aware of the use by date. The ADM stated use by (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555352	A. Building B. Wing	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grace Healthcare Center	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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dates should always be on the label and placed on the food item because use by dates helped ensure food was not contaminated and was safe to be served to the residents. The ADM stated if there was no use by date label on a food item and staff were unaware that the food was contaminated, it could have bacterial growth that could lead to food-borne illness in the residents.During a concurrent interview and record review on 3/18/26 at 3:47 p.m. with the ADM, the facility documents titled, In-Service: Proper Hair Restraint & Kitchen Hygiene, In-Service: Preventing Wet Stacking, In-Service: Food Safety Dates & Labeling, (undated) were reviewed. The ADM stated she was providing copies of the in-services given to kitchen staff on 3/18/26 for the following topics: Preventing Wet Stacking, Food Safety Dates and Labeling and Proper Hair Restraint and Kitchen Hygiene. The ADM stated the facility documents provided were also the facility's policies. The ADM stated they in-serviced to their policy.During a review of the facility document titled, In-Service: Food Safety Dates & Labeling, (undated), the document indicated, .Every item.prepared in-house must have a label containing: 1. Product Name.Date opened/Prepared 3. Discard Date (The Use By date).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555352	A. Building B. Wing	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grace Healthcare Center	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 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 observation, interview, and record review, the facility failed to maintain medical records which were complete and accurately documented in accordance with accepted professional standards and practices for one of four sampled residents (Resident 9) when Resident 9's weekly wound assessment and change of condition were not completed.These failures resulted in inaccurate medical records being kept for Resident 9 and had the potential to not meet and provided treatment needed which could have resulted to serious health problems.Findings:During a concurrent observation and interview on 3/17/26 at 9:48 a.m. during initial tour in Resident 9's room, Resident was lying in bed and watching a show on his electronic device. Certified Nurse Assistant (CNA) 11 was standing at bedside and trying to communicate with Resident 9 using gestures. CNA 11 stated Resident 9 did not speak and only communicated using signs, gestures and pointing at items and things. During a review of Resident 9's admission Record (AR- a document containing resident profile information), dated 3/19/26, the AR indicated Resident 9 was admitted to the facility on [DATE] with diagnoses which included paraplegia (loss of movement or sensation in the lower half of the body), chronic tubulo-interstitial nephritis (long-term kidney disease characterized by lasting inflammation and scarring in the spaces between the kidney) and infection and inflammatory reaction due to nephrostomy catheter (small, flexible tube inserted through the back into the kidney to drain urine directly into an external bag).During an interview on 3/18/26 at 4:07 p.m. with Certified Nurse Assistant (CNA) 3, CNA 3 stated she was familiar with Resident 9's care. CNA 3 stated Resident 9 needed assistance with turning and repositioning. CNA 3 stated Resident 9 has wounds on his back covered with dressings. CNA 3 stated licensed nurse changed dressing every day.During an interview on 3/19/26 at 9:18 a.m. with Registered Nurse (RN) 2, RN 2 stated she had been working in the facility seven months, and this was her first job as a nurse. RN 2 stated the facility practice when there was change in condition was to document right away and a change of condition was completed. RN 2 stated nurses were responsible in wound assessments and measurements. RN 2 stated wound measurements are completed weekly to monitor wounds. During a concurrent interview and record review on 3/19/26 at 10:05 a.m. with Licensed Vocational Nurse/Assistant Director of Nursing (LVN/ADON), LVN/ADON stated she assumed the position as ADON 1/7/26. LVN/ADON stated a wound doctor comes in the facility every week to see residents but not Resident 9. LVN/ADON stated it was her responsibility to complete Resident 9's weekly wound measurements and report any wound changes to Resident 9's doctor. LVN/ADON reviewed her late entry of Resident 9's weekly wound assessment effective date 3/11/26. LVN/ADON stated she remembered doing the wound measurements but did not have time to document. LVN/ADON stated she did a late entry effective 3/11/26 and did not realize Resident 9 was out of the facility and in the hospital and did not return until later in the afternoon. LVN/ADON stated her documentation of Resident 9's wound assessment was not accurate. LVN/ADON stated resident's medical records should be accurate to reflect their status.During a concurrent interview and record review on 3/19/26 at 10:44 a.m. with RN 1, RN 1 stated she was Resident 9's nurse and was familiar with Resident 9's care. RN 1 reviewed Resident 9's clinical record and stated Resident 9 was sent out to general acute care hospital (GACH) on the morning of 3/11/26 and returned in the facility in the afternoon. RN 1 stated the change in condition was completed on 3/16/26. RN 1 stated the change in condition documentation was late and it should have been completed the same day when Resident 9's change occurred. During an interview on 3/19/26 at 3:15 p.m. with Minimum Data Set Coordinator Nurse (MDSN), MDSN stated change of condition had to be completed the same day the situation occurred to monitor resident appropriately. MDSN stated medical record was supposed to go over documentation and audit. During an interview on 3/20/26 at 2:25 p.m. with the Director of Nursing (DON), the DON stated documentation should be (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555352	A. Building B. Wing	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grace Healthcare Center	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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	completed the same day. The DON stated, Change of condition should be completed the same day the incident happened, The DON stated her expectation when doing wound assessment was to document right away to address issues. The DON stated the LVN/ADON should have made sure the date and time were accurate, I cannot explain what happened.During a review of facility's policy and procedure (P&P) titled, Change in a Resident's Condition or Status, revised date 5/17. The P&P indicated, Our facility shall promptly notify the resident, his or her Attending Physician. of changes in the resident's medical/mental condition.The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status.During a review of facility's policy and procedure (P&P) titled, Pressure Ulcers/Skin Breakdown-Clinical Protocol, dated 2001, the P&P indicated, .The nursing staff and Attending Physician will assess and document an individual's significant risk factors for developing pressure ulcers. In addition, the nurse shall describe and document/report the following: . location, stage, length, width and depth. During resident visits, the physician will evaluate and document the progress of wound healing.