

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555426	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/15/2025
NAME OF PROVIDER OR SUPPLIER  Fresno Postacute Care		STREET ADDRESS, CITY, STATE, ZIP CODE  1233 A Street Fresno, CA 93706	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 33126</p> <p>Based on interview and record review, the facility failed to ensure residents were free from neglect when Certified Nursing Assistant (CNA) 9 intentionally did not provide incontinent care (provided for those who cannot control their bowels and/or bladder) for three of five residents (Resident 1, Resident 2, and Resident 3) on 12/21/24 between the hours of 11 p.m. and 7:30 a.m. on 12/22/24. CNA 9 expressly limited incontinent care to one change for Resident 1 and Resident 2 and did not provide care for the entire shift for Resident 3.</p> <p>These failures resulted in withholding of required services and neglecting the needs of Residents 1, 2, and 3. These failures resulted in the residents experiencing feelings of anger, frustration, loss of dignity and control, and disrespect by having to remain in their soiled briefs (a type of absorbent underwear worn by those who are incontinent) for three hours, and Resident 3 having to eat breakfast while in a soiled brief, which was against his stated preference that he be changed prior to dining.</p> <p>Findings:</p> <p>During a review of the facility document titled, Verification of Investigation Report (VOI), dated 12/26/24, the VOI indicated that during the night shift beginning at approximately 11:00 p.m., on 12/21/24, through approximately 7:30 a.m., on 12/22/24, Resident 1, Resident 2, and Resident 3 did not receive incontinent care during this shift. The VOI identified the staff person who did not perform the incontinent care as Certified Nursing Assistant (CNA) 9.</p> <p>The VOI indicated a Licensed Vocational Nurse (LVN 3) entered the room shared by Resident 1 and Resident 2, on 12/22/24, at approximately 8:30 a.m., to give them medication.</p> <p>The VOI indicated Resident 1 and Resident 2, informed [LVN 3] that they were upset about the care they received during [night] shift. Per both residents, their [night] shift CNA explained to them that she had 26 residents and would only be doing one brief change during the shift. Both residents explained that this made them feel unimportant and angry.</p> <p>The VOI indicated Resident 1 stated, Around midnight when [CNA 9] came in to change us, she informed us they were only 2 [CNAs on duty] and we would only get one brief change. Resident [1] stated, I felt neglected, and it made me feel angry.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The VOI indicated Resident 2 stated, I put my call light on close to twelve midnight to be changed. [CNA 9] came to my room and told me that she has 26 residents and would only be able to do 1 brief change for me this shift. [CNA 9] changed me at this time. I put on my call light again at 4:55 [a.m.] to be changed again. [CNA 9] came to my room at 5:30 [a.m.] through the bathroom door and said, I don ' t know who is on the light but I ' m probably not going to get to you because there was a death and I have to clean him up. [CNA 9] left room and my brief was changed by the day shift CNA at 8:00 a.m. Resident [2] stated, I felt neglected last night. Resident [2] said that she felt dirty and nasty from having to sit in a dirty brief. Resident [2] also expressed feeling helpless and neglected.</p> <p>The VOI indicated Resident 3 stated, On December 22nd, I was not changed from night shift to morning shift. I was not changed the entire shift. The CNA was [CNA 9].</p> <p>The VOI indicated Resident 1 and Resident 2 voiced that they felt neglected, gross, and angry regarding the incident on 12/22/24. Based on the investigation findings, the alleged neglect claim is substantiated. The VOI was signed by the Administrator on 12/26/24, at 3:30 p.m.</p> <p>During a review of Resident 1 ' s Admission Record (AR), dated 1/13/25, the AR indicated she was a [AGE] year-old female, and had been a resident of the facility for 11 months.</p> <p>During a review of Resident 1 ' s Minimum Data Set (MDS, a comprehensive, standardized assessment tool), dated 11/25/24, the MDS indicated at Question C0500 a score of 15 out of a possible 15, which indicated Resident 1 was cognitively intact (having sufficient judgment, planning, organization, self-control, and the persistence needed to manage the normal demands of the resident ' s environment). The MDS indicated at Question GG0130 - C, a score of 2, which indicated she required Substantial/maximal assistance - Helper does MORE THAN HALF the effort with Toileting hygiene: The ability to maintain perineal [area between anus and genitals, or ' private parts ' ] hygiene, adjust clothes before and after voiding [urination] or having a bowel movement.</p> <p>During a review of Resident 1 ' s Progress Notes, dated 12/22/24, at 8:56 a.m., the PN indicated, During med[ication] pass at 8:30 [a.m.] resident [1] complain to this charge nurse that she wanted to make a complaint. She stated the CNA made her feel unimportant and frustrated after CNA told her that she would only be able to do one brief change for her for the shift. Resident [1 complained] of feeling neglected by this CNA. Psychiatry to follow up with [Resident 1] related to alleged neglect.</p> <p>During a review of Resident 1 ' s document titled, Behavioral Health (BH), dated 12/25/24, the BH indicated, Follow-up psychiatric visit for evaluation of [signs and symptoms] of emotional distress following a complaint of neglect. [Resident 1] reported an incident that occurred the other night involving a caregiver and expressed frustration and anger due to the caregiver ' s disrespectful behavior and lack of concern for her and her roommate ' s needs. [Resident 1] mentioned that both she and her roommate needed to be changed after having a bowel movement, but the caregiver refused to do so, citing other responsibilities. [Resident 1] felt that the caregiver ' s actions were unprofessional and inappropriate. She reported feeling angry and frustrated during the incident, particularly due to the discomfort of being wet and needing to be changed. [Resident 1] expressed feeling of anger and frustration related to a recent incident of neglect.</p> <p>During a review of Resident 2 ' s Admission Record (AR), dated 1/13/25, the AR indicated she was a [AGE] year-old female and was admitted to the facility in 2020.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 2 ' s MDS, dated [DATE], the MDS indicated at Question C0500 a score of 15 out of a possible 15, which indicated Resident 2 was cognitively intact. The MDS indicated at Question GG0130 - C, a score of 2, which indicated she required Substantial/maximal assistance - Helper does MORE THAN HALF the effort with Toileting hygiene: The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement.</p> <p>During a review of Resident 2 ' s PN, dated 12/22/24, at 8:54 a.m., the PN indicated, During med[ication] pass at 8:30 [a.m.] resident [2] informed this charge nurse that she would like to make a complaint. Resident states she feels neglected. Per resident her CNA refused to change her brief at 5:30 [a.m.]. Resident states that she was changed by her CNA at midnight after pushing her call light. Resident again pushed her call light at 4:55 [a.m.] to be changed. CNA entered room at 5:30 [a.m.] and informed resident that she was busy . and would not be able to change her at this time. CNA then left without changing the resident. Resident was changed at 8:00 [a.m.] by dayshift CNA during their rounds. Psychiatry to follow up with [Resident 2] related to alleged neglect.</p> <p>During a review of Resident 2 ' s document titled, Behavioral Health (BH), dated 12/25/24, the BH indicated, Follow-up psychiatric visit for evaluation of [signs and symptoms] of emotional distress following a complaint of neglect. [Resident 2] reports an incident where she was left unattended for an extended period of time resulting in her sitting in soiled briefs for over 3 hours. She expressed feelings of embarrassment, loss of dignity, and increased anxiety due to this situation. incidents like the one described have caused her distress. She reported a loss of dignity and control, which contributed to her emotional distress.</p> <p>During an interview on 1/10/25, at 12:05 p.m., with Resident 1, Resident 1 stated that on 12/22/24, I got changed at 12:30 a.m., about the time I got my meds. [CNA 9] came in and answered our call light. She said I have 25 patients and would only be changing us once during the shift. At 5:00 a.m., my roommate [Resident 2] hit the call light because she needed changed, and I did too. [CNA 9] came in and told us she was dealing with a patient death, so she had to clean them up. She shut the door and left without changing either of us. We didn ' t get changed at all. We can ' t get changed during meals, do we didn ' t get changed until 8:30 a.m. This really upset me. It was like she didn ' t care about us as a person. It was depressing. She didn ' t give us a chance to say anything. I felt frustrated and angry. I only got changed once that night, at 12:30 a.m. This was a very depressing thing to happen to me. So disrespectful, like I was nothing to her. [CNA 9] was constantly complaining that she hated her job. I took this to mean she hated me, because I was her job.</p> <p>During an interview on 1/10/25, at 12:21 p.m., with Resident 2, Resident 2 stated that on 12/21/24, I called with my call light, at about 11:30 p.m. [CNA 9] came in . changed us, then said we will only get changed once tonight because we are shorthanded. At 4:55 a.m., I put my call light on. I know what time it was because I as looking at my [smartphone], [CNA 9] came in and told us she would not be changing us because she was too busy. Not getting changed made me feel disgusted. [CNA 1] changed us on day shift at about 8:30 a.m. I felt like my dignity was affected. Resident 2 stated she agreed with [Resident 1] that [CNA 9] was constantly complaining to her and Resident 1 about her job, and by doing so, it felt like she hated both of them.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 1/10/25, at 12:45 p.m., with CNA 1, CNA 1 stated he recalled caring for Resident 1 and Resident 2 during the morning of 12/22/24. CNA 1 stated, I recall changing them at 8:30 a.m. They both were angry, grumpy, frustrated over this event. [Resident 1] said she 'd not been changed and had to wait. They both said we 've been waiting so long, since about 4:30 a.m., to be changed, waiting for someone to come, nobody came. I saw [Resident 1] be tearful, I think it was due to her anger. [Resident 2] was angry, frustrated over the event.</p> <p>During an interview on 1/10/25, at 2:35 p.m., with LVN 2, LVN 2 stated he was CNA 9 ' s supervisor during the night shift beginning at about 11:00 p.m. on 12/21/24, to 7:30 a.m. on 12/22/24. LVN 2 stated he recalled CNA 9 was complaining all the time. LVN 2 stated during their 8-hour shift together, CNA 9 never informed him she had concerns about her workload, not being able to change residents as frequently as needed, or not being able to complete her assigned tasks. LVN 2 stated if CNA 9 had informed him of any issues with her workload, he would have given assistance or assigned more staff to help her. LVN 2 stated he was unaware of Resident 1 and Resident 2 ' s unmet needs until his next shift, the following day. LVN 2 stated he spoke with Resident 1 and Resident 2 about this, and stated, [Resident 2] was upset, [Resident 1] was really upset. LVN 2 stated he could tell Resident 2 was upset because when she gets mad, she moves her hand around, starts to point, with pressured speech. [Resident 1] cried, had tears in her eyes.</p> <p>During a concurrent interview and record review on 1/15/25, at 9:38 a.m., with the Director of Nursing (DON), the VOI was reviewed. DON stated she had spoken to Resident 1 and Resident 2 multiple times regarding the events during the night shift of 12/21/24 - 12/22/24. The DON stated the information indicated on the VOI is correct. The DON stated CNA 9 was terminated for neglect. The DON stated there was a third resident, [Resident 3] also who had complained of not being changed that night.</p> <p>During an interview on 1/15/25, at 10:15 a.m., with Resident 3, Resident 3 stated, Oh yeah, I remember that night. There was a CNA named [CNA 9]. I usually sleep all night, they normally change me at around 8:00 p. m., then again in the morning before breakfast, at about 5:00 a.m. That is my preference. I wear a brief. [CNA 9] didn ' t change me that morning. It ' s not really a big deal, but it would have been nice to be changed before breakfast. I wasn ' t changed until after. That morning, [a nurse] made me fill out a paper about what happened, so I did.</p> <p>During a review of a handwritten, undated document signed by Resident 3, the document indicated, On [DATE] I was not changed from night shift to morning shift[.] I was not changed the entire shift. The CNA was [CNA 9].</p> <p>During a review of Resident 3 ' s Admission Record (AR), dated 1/17/25, the AR indicated he was a [AGE] year-old male, and had been a resident of the facility for 11 months.</p> <p>During a review of Resident 3 ' s MDS, dated [DATE], the MDS indicated at Question C0500 a score of 15 out of a possible 15, which indicated Resident 3 was cognitively intact. The MDS indicated at Question GG0130 - C, a score of 1, which indicated he was Dependent - Helper does ALL of the effort. Resident does none of the effort to complete the activity with Toileting hygiene: The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement.</p> <p>During a review of the facility email to CNA 9, dated 1/10/25, at 10:48 a.m., the email indicated, This email is to advise you that your employment with [name of facility] is terminated effective January 9, 2025. The company is terminating employment for violation of policy.</p> <p>(continued on next page)</p>		

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F 0600  Level of Harm - Actual harm  Residents Affected - Few	<p>During a concurrent record review and interview on 1/15/25, at 2:35 p.m., with the Administrator, the VOI was reviewed. The Administrator stated she was the facility ' s Abuse Prevention Coordinator. The Administrator stated the information in the VOI was accurate. The Administrator stated, This was neglect. This should not have happened.</p> <p>During a review of the facility ' s Policy and Procedure (P&amp;P), titled, Abuse Prevention and Neglect Policy, dated 6/22, the P&amp;P indicated, It is the facility ' s policy to prohibit abuse, mistreatment, neglect, involuntary seclusion [confining, isolating or restricting a resident to their room or to a specific area in the facility], and misappropriation of property for all residents through the following: . Prevention of occurrences. Neglect is defined as the failure of the facility to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Neglect occurs when the facility is aware of, or should have been aware of, goods or services that a resident(s) requires but the facility fails to provide them to the resident(s), resulting in, or may result in, physical harm, pain, mental anguish, or emotional distress.</p> <p>During a review of the undated facility document titled, Here are your residents ' rights: (Rights), the Rights indicated, A dignified and comfortable living environment[.]</p>		