

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  08/16/2024
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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 40641</p> <p>Based on observation, interview and record review, the facility failed to ensure residents were treated with dignity and respect for three of nine sampled residents (Resident 20, Resident 24 and Resident 40) when:</p> <ol style="list-style-type: none"> <li>1. Registered Nurse (RN) 2 administered medication to Resident 20 in the hallway.</li> <li>2. RN 1 administered medication to Resident 24 and did not provide privacy.</li> <li>3. Licensed Vocational Nurse (LVN) 1 administered medications to Resident 40 and did not provide privacy.</li> </ol> <p>These failures resulted in Resident 20, Resident 24 and Resident 40 not being provided with respect and dignity while taking their medications.</p> <p>Findings:</p> <p>During a observation on 8/14/24 at 8:35 a.m. in Station one hallway during medication pass, Resident 20 was sitting up in his wheelchair. RN 2 prepared Resident 20's medications. RN 2 administered Resident 20's medications in the hallway with other residents, staff and visitors walking by.</p> <p>During a review of Resident 20's Admission Record, dated 8/16/24, the Admission Record indicated, Resident 20 was readmitted to the facility on [DATE] with diagnoses which included cerebral infarction (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it), lack of coordination and history of traumatic brain injury.</p> <p>During a review of Resident 20'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 20's Brief Interview for Mental Status (BIMS-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 5 had no cognitive deficit.</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent observation and interview on 14/24 at 2:50 p.m. with RN 2, RN 2 stated she administered Resident 20's medications in the hallway. RN 2 stated she should not have administered Resident 20's medications in the hallway. RN 2 stated, . I should have explained to Resident 20 the importance of providing privacy and to go back in his room . RN 2 stated it was important to provided privacy because it was one of their rights.</p> <p>During an interview on 8/15/24, at 9:35 a.m. with Licensed Vocational Nurse (LVN) 3, LVN 3 stated the practice was to provide privacy when administering medications to residents. LVN 3 stated residents are not to be given their medications in the hallway unless it was an emergency situation. LVN 3 stated other residents, staff and visitors passing by did not need to know what was going on, providing privacy is one of resident rights.</p> <p>2. During a concurrent observation and interview on 8/14/24 at 11:47 a.m. in Station one hallway, RN 1 prepared Resident 24's medication. RN 1 administered Resident 24's aspart (brand name- medication used to treat high blood sugar in the blood) injection to Resident 24's abdominal area. RN 1 did not provide privacy by closing the door or closing the privacy curtain to Resident 24 while she exposed Resident 24's abdominal area. RN 1 stated she should have provided privacy to Resident 24 but she did not. RN 1 stated residents have rights to have their privacy.</p> <p>During a review of Resident 24's Admission Record, dated 8/16/24, the Admission Record indicated, Resident 24 was readmitted to the facility on [DATE] with diagnoses which included diabetes (high blood sugar in the blood) and hemiplegia (complete paralysis) and hemiparesis (partial weakness).</p> <p>During a review of Resident 24's MDS assessment dated [DATE], indicated Resident 24's BIMS assessment score was 13 out of 15 indicating Resident 24 had no cognitive deficit.</p> <p>During an interview on 8/15/24 at 9: 37 a.m. with LVN 3, LVN 3 stated it was important to provide privacy to residents when administering medications. LVN 3 stated, . Residents should always be given privacy when taking their medications .</p> <p>3. During a concurrent observation and interview on 8/14/24 at 4:05 p.m. in Station 2 hallway, LVN 1 prepared Resident 40's medications. LVN 1 administered Resident 40's medication in Resident 40's room but did not provide privacy by closing the privacy curtain or the door.</p> <p>LVN 1 stated she did not closed the privacy curtain between bed A and bed B. LVN 1 stated she did not closed the door to the hallway and exposed Resident 40 for other residents, staff and visitors walking by. LVN 1 stated she administered medication to Resident 40 without privacy.</p> <p>During a review of Resident 40's Admission Record, dated 8/16/24, the Admission Record indicated, Resident 40 was readmitted to the facility on [DATE] with diagnoses which included heart failure, hyperlipidemia (high cholesterol) and hearing loss.</p> <p>During a review of Resident 40's MDS assessment dated [DATE], indicated Resident 40's BIMS assessment score was 13 out of 15 indicating Resident 40 had no cognitive deficit.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 8/16/24 at 2:13 p.m. with the Director of Nursing (DON), the DON stated her expectations from licensed nurses during medication administration was to give respect and privacy to residents by closing the privacy curtain and offer to take residents in their room to administer medications. The DON stated there were other residents, staff and visitors walking by in the hallway and could see residents taking their medications. The DON stated, . Residents have rights and one of them was to ensure privacy was provided at all times .</p> <p>During a review of facility's policy and procedure (P&amp;P) titled, Resident Rights, dated 1/18, the P&amp;P indicated, .be treated with respect, kindness, and dignity . be supported by the facility in exercising his or her rights .</p> <p>During a review of facility's P&amp;P titled, Specific procedures for all medications, undated, the P&amp;P indicated, . To administer medications in a safe and effective manner . Provide privacy for residents if appropriate .</p>

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<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48424</p> <p>Based observation, interview, and record review the facility failed to ensure four of fourteen residents (Residents 8, 30, 57 and 65) were provided their right to be treated with respect and dignity when:</p> <ol style="list-style-type: none"> <li>Resident 30's back was not covered after being transported out of the shower room.</li> </ol> <p>This failure resulted in Resident 30 having his back exposed while being transported out of the shower room, down the hall, and into his room.</p> <ol style="list-style-type: none"> <li>Certified Nursing Assistant (CNA) 11 stood over Resident 8 while spoon feeding him breakfast while lying in bed.</li> </ol> <p>This failure resulted in Resident 8 not being provided a respectful and dignified dining experience which could further enhance resident's quality of life.</p> <ol style="list-style-type: none"> <li>Resident 57 was lying flat in bed eating lunch but unable to see food placed on top of the overbed table positioned in front of her.</li> </ol> <p>This failure placed Resident 57 at risk for aspiration and choking which could lead to more serious health condition.</p> <ol style="list-style-type: none"> <li>Resident 65's urinary catheter (flexible tube inserted into bladder to drain urine) bag was not covered and was visible to residents and visitors to see.</li> </ol> <p>This failure had the potential to violate Resident 65's privacy and dignity.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>During a review of Resident 30's Admission Record (AR- a document that provides resident contact details, a brief medical history, level of functioning, preferences, and wishes), dated 8/15/24, the AR indicated Resident 30 was admitted with the following diagnoses: cerebrovascular disorder (term used to describe a group of conditions which affect blood flow to the brain) , dysphagia (difficulty swallowing), and anxiety disorder (condition in which a person has excessive worry and feelings of fear, dread, and uneasiness).</li> </ol> <p>During a review of Resident 30's Minimum Data Set (MDS- resident assessment tool which indicates physical and cognitive abilities), dated 5/26/24, the MDS indicated a Brief Interview for Mental Status (BIMS-an assessment of cognitive function) score of nine (0-7 severe cognitive impairment, 8-12 moderate cognitive impairment, 13-15 no cognitive impairment), indicating Resident 10 had moderate cognitive impairment.</p> <p>During an observation on 8/12/24 at 9:18 a.m. next to the shower room, Resident 30's back was not covered after being transported out of the shower room by certified nursing assistant (CNA) 4.</p> <p>(continued on next page)</p>

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<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 8/12/24 at 4:15 p.m. with CNA 4, CNA 4 stated CNAs were responsible for ensuring all areas of a resident's body were covered after coming out of the shower room. CNA 4 stated Resident 30 should not have had his back exposed, he should have been fully covered. CNA 4 stated it was important to cover a resident's whole body because it provided privacy.</p> <p>During an interview on 8/15/24 at 10:03 a.m. with CNA 2, CNA 2 stated staff were supposed to cover the body of any resident who comes out of the shower. CNA 2 stated the shower blanket should have covered the whole body because they provided privacy and dignity to the resident.</p> <p>During an interview on 8/15/24 at 1:59 p.m. with registered nurse (RN) 1, RN 1 stated CNAs were responsible for doing resident showers. RN 1 stated CNA 1 should have covered Resident 30 with a shower blanket. RN 1 stated if the shower blanket was too small, the CNA could have also used a second blanket or a gown to cover Resident 30's back. RN 1 stated Resident 30 should have been fully covered because he had a right to be provided privacy and dignity.</p> <p>During an interview on 8/16/24 at 9:12 a.m. with the director of staff development (DSD), the DSD stated CNAs needed to fully cover residents after coming out of the shower. The DSD stated if one blanket wasn't enough to fully cover the resident, then an additional blanket could have been used. The DSD stated it was important to fully cover residents after they exited the showers because residents have the right to be provided privacy.</p> <p>During an interview on 8/16/24 at 10:40 a.m. with the director of nursing (DON), the DON stated residents needed to be covered after staff took them out of the shower room. The DON stated ensuring proper coverage of the body after the shower was important because it provided dignity to residents.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Quality of Life-Dignity, dated 1/18, indicated, .Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality . 1. Residents shall be treated with dignity and respect at all times. 2. 'Treated with dignity' means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth .</p> <p>During a review of the facility's (P&amp;P) titled, Resident Rights, dated 1/18, indicated, .Employees shall treat residents with kindness, respect, and dignity . federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the residents rights to: a. a dignified existence b. be treated with respect, kindness, and dignity .</p> <p>40641</p> <p>2. During an observation on 8/14/24 at 8:42 a.m. in Resident 8's room, Resident 8 was lying in bed with head of the bed elevated and bed in highest position. Resident 8's bedside table on the side of the bed and CNA 11 was standing on the side of Resident 8's bed while spoon feeding him breakfast.</p> <p>During a review of Resident 8'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 8/16/24, the AR, indicated, Resident 8 was admitted to the facility with diagnoses which included quadriplegia (complete or severe loss of motor function in all four limbs) and dysphagia (difficulty swallowing).</p> <p>(continued on next page)</p>		

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<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 8/14/25 at 10:05 a.m. with CNA 11, he stated he assisted Resident 8 during breakfast. CNA 11 stated he was standing on the side of the bed while he was spoon-feeding Resident 8 because Resident 8's bed was high. CNA 11 stated, . I should have been sitting and lowered his [Resident 8] bed so we would have been face to face while I was spoon-feeding him [Resident 8] because it was a dignity issue .</p> <p>During an interview on 8/16/24 at 10 a.m. with the Director of Staff Development (DSD), she stated she was not sure whether staff should be sitting on a chair or standing next to resident's bed when assisting residents during meals. DSD stated she had seen staff pull a chair next to resident's bed and some staff preferred standing while spoon-feeding residents.</p> <p>During an interview on 8/16/24 at 10:45 a.m. with CNA 7, she stated the practice was to lower resident's bed, elevate the head of the bed and sit next to the resident. CNA 7 stated the bed should be positioned at eye level with resident when assisting residents with meals in bed. CNA 7 stated it was a dignity issue standing over residents while assisting during meals.</p> <p>During review of facility's policy and procedure (P&amp;P) titled, Quality of Life- Dignity, dated 1/18, the P&amp;P indicated, . Residents shall be treated with dignity and respect at all times . resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth .</p> <p>3. During a concurrent observation and interview on 8/12/24 at 1:10 p.m. in Resident 57's room, Resident 57 was lying flat in bed touching and picking on food from the food tray she could not see. Resident 57's food tray was placed on the overhead bed table higher than Resident 57's visual field. Resident 57 stated she did not need help.</p> <p>During a review of Resident 57's AR, dated 8/15/24 the AR indicated Resident 57 was admitted to the facility on [DATE] with diagnoses which included Transient Cerebral Ischemic Attack (TIA-stroke) and dementia (loss of mental skills that affects daily life).</p> <p>During an interview on 8/12/24 at 1:12 p.m. with CNA 6 in Resident 57's room, CNA 6 stated she tried to straighten Resident 57 to sit up during meals and tried to assist her but Resident 57 refused. CNA 6 stated Resident 57 was at risk for aspiration (inhaling food or liquid through the vocal cords into the airway) and choking because she was lying flat in bed and it was also a dignity issue.</p> <p>During interview on 8/15/24 at 9:20 a.m. with CNA 2, she stated she was familiar with Resident 57's care. CNA 2 stated she tried to help Resident 57 during meals and sometimes Resident 57 refused assistance. CNA 2 stated she made sure Resident 57's head of the bed was elevated. CNA 2 stated Resident 57 lying flat in bed when eating puts her at high risk for aspiration and choking.</p> <p>During an interview on 8/16/24 at 10:05 a.m. with the DSD, she stated when residents are eating in bed, residents are to be pulled all the way to the head of the bed and elevated to prevent the resident from sliding. The DSD stated residents lying flat in bed while eating puts them at risk for aspiration and choking.</p> <p>During an interview on 8/16/24 at 2:10 p.m. with the Director of Nursing (DON), she stated her expectation was for residents to be sitting up and positioned at 90 degree angle to prevent aspiration and choking. The DON stated the staff should have checked Resident 57 constantly when she refused assistance to make sure she was not lying flat in bed.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives an accurate assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40641</b></p> <p>Based on interview, and record review, the facility failed to ensure the Minimum Data Set assessment (MDS-assessment of physical and psychological functions and needs) accurately reflected resident's health and functional status of four of nine sampled residents (Residents' 14, 29, 34 and 38) when Resident 14, Resident 29, Resident 34 and Resident 38's smoking habits was inaccurately coded on the MDS assessment.</p> <p>This failure had the potential to result in Residents' 14, 29, 34 and 38's care needs not met.</p> <p>Findings:</p> <p>During a review of Resident 14'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 8/16/24, the AR indicated, Resident 14 was admitted to the facility on [DATE] with diagnoses which included pain, diabetes (high blood sugar in the blood) and abnormalities of gait and mobility.</p> <p>During a review of Resident 14's Smoking - Safety Screen dated 7/19/24, the Smoking-Safety Screen indicated, Resident 14 smoked 2-5 cigarettes per day.</p> <p>During a concurrent interview and record review on 8/16/24 at 8:50 a.m. with Minimum Data Set Nurse (MDSN), MDSN stated Resident 14 was a smoker. MDSN reviewed Resident 14's smoking assessment dated [DATE], which indicated Resident 14 was safe to smoke with supervision. MDSN reviewed Resident 14's annual MDS assessment dated [DATE], section J. Resident 14's tobacco use was not coded on the annual MDS assessment. MDSN stated Resident 14 should have been coded as a smoker.</p> <p>During a review of Resident 29's AR dated 8/16/24, the AR indicated, Resident 29 was admitted to the facility on [DATE] with diagnoses which included hyperlipidemia (high cholesterol-excess fats in the blood) and diabetes (high sugar level in the blood).</p> <p>During a review of Resident 29's Smoking - Safety Screen dated 5/15/24, the Smoking-Safety Screen indicated, Resident 29 smoked 2-5 cigarettes per day.</p> <p>During a concurrent interview and record review on 8/16/24 at 9 a.m. with Minimum Data Set Nurse (MDSN), MDSN stated Resident 29 was a smoker. MDSN reviewed Resident 9's smoking assessment dated [DATE], which indicated Resident 29 was safe to smoke with supervision. MDSN reviewed Resident 14's annual MDS assessment dated [DATE], section J. Resident 29's tobacco use was not coded on the annual MDS assessment. MDSN stated Resident 29 should have been coded as a smoker.</p> <p>During an interview on 8/12/24 at 11:50 a.m. in Resident 34's room, Resident 34 stated she smoked and they have a smoking schedule they follow. Resident 34 stated she goes out in the patio to smoke with other resident who smokes. Resident 34 stated there is always a staff outside to supervised.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 34's AR dated 8/16/24, the AR indicated, Resident 34 was admitted to the facility on [DATE] with diagnoses which included muscle weakness and asthma (a chronic (long-term) condition that affects the airways in the lungs).</p> <p>During a review of Resident 34's Smoking - Safety Screen dated 7/17/24, the Smoking-Safety Screen indicated, Resident 34 smoked 2-5 cigarettes per day.</p> <p>During a concurrent interview and record review on 8/16/24 at 8:42 a.m. with Minimum Data Set Nurse (MDSN), MDSN stated Resident 34 was a smoker. MDSN reviewed Resident 34's smoking assessment dated [DATE], which indicated Resident 34 was safe to smoke with supervision. MDSN reviewed Resident 34's annual MDS assessment dated [DATE], section J. Resident 34's tobacco use was not coded on the annual MDS assessment. MDSN stated Resident 34 should have been coded as a smoker.</p> <p>During an interview on 8/12/24 at 11:05 a.m. in Resident 38's room, Resident 38 stated he smokes and had been smoking since admitted to the facility. Resident 38 stated there was always a staff outside with the group during scheduled smoking.</p> <p>During a review of Resident 38's AR dated 8/16/24, the AR indicated, Resident 38 was admitted to the facility on [DATE] with diagnoses which included hyperlipidemia (high cholesterol-excess fats in the blood) and hemiplegia (paralysis of one side of the body) and hemiparesis (weakness or partial paralysis on one side of the body).</p> <p>During a review of Resident 38's Smoking - Safety Screen dated 7/15/24, the Smoking-Safety Screen indicated, Resident 38 smoked 2-5 cigarettes per day.</p> <p>During a concurrent interview and record review on 8/16/24 at 8:45 a.m. with Minimum Data Set Nurse (MDSN), MDSN stated Resident 38 was a smoker. MDSN reviewed Resident 38's smoking assessment dated [DATE], which indicated Resident 38 needs to be supervised to smoke. MDSN reviewed Resident 38's annual MDS assessment dated [DATE], section J. Resident 38's tobacco use was not coded on the annual MDS assessment. MDSN stated Resident 38 should have been coded as a smoker. The MDSN stated she followed RAI manual to complete her assessment.</p> <p>During an interview on 8/16/24 at 11:29 a.m. with the Activity Assistant (AA), the AA stated she takes residents out in the patio daily to smoke on the scheduled times. The AA stated she did not keep a log of who goes out to smoke. The AA stated all nine smokers on the list goes out everyday to smoke. The AA stated she supervised the whole time residents are out in the patio smoking.</p> <p>During an interview on 8/16/24 at 2:42 p.m. with the Director of Nursing (DON), the DON stated her expectation was accurate assessment on all MDS assessment. The DON stated inaccurate assessment is considered falsification of records.</p> <p>During an interview on 8/16/24 at 3:20 p.m with the Administrator (ADM), the ADM stated, . my expectation was to not make any mistakes, but in reality it is not possible . The ADM stated it was important for MDS assessment to be accurately captured.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of facility's policy and procedure (P&amp;P) titled, Certifying Accuracy of the Resident Assessment, dated 1/18, the P&amp;P indicated, . Any person who completes any portion of the MDS assessment, tracking form, or correction request for is required to sign the assessment certifying the accuracy of that portion of that assessment</p> <p>During a review of professional reference titled, Resident Assessment Instrument version #.0 Manual, dated 10/23, indicated, . Tobacco use includes tobacco used in any form . If the resident states he or she used tobacco in some form during the 7-day look back period code 1, yes . If the resident is unable to answer or indicates that he or she did not use tobacco of any kind during the look back period, review the medical record and interview staff for any indication of tobacco use by the resident during the look back period .</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48424</p> <p>Based on interview and record review the facility failed to develop and implement a comprehensive person-centered care plan that meets resident preferences for one of seven residents (Resident 66) when Resident 66's preference to be cared for by female staff was not care planned.</p> <p>This failure had the potential to cause male staff members to unknowingly enter Resident 66's room to provide care.</p> <p>Findings:</p> <p>During a review of Resident 66's Admission Record (AR- a document that provides resident contact details, a brief medical history, level of functioning, preferences, and wishes), dated 8/15/24, the AR indicated Resident 66 was admitted on [DATE] with the following diagnoses: heart failure (condition which makes it difficult for the heart to pump blood to the rest of the body), atrial fibrillation (heart condition characterized by an irregular and often times fast heart beat) and major depressive disorder (mental condition characterized by long bouts of sadness).</p> <p>During an interview on 8/15/23 at 9:55 a.m. with certified nursing assistant (CNA) 2, CNA 2 stated Resident 66 only wanted female staff taking care of her. CNA 2 stated Resident 66 did not like any male staff members entering her room or providing care to her. CNA 2 stated nurses gave verbal communication to male staff to not enter the room, but there was not any written documentation stating her preference. CNA 2 stated Resident 66 should have had her preferences documented in her care plan because nurses may forget to communicate to new male staff members here preferences. CNA 2 stated if a new male staff member entered Resident 66's room, it would have made her upset.</p> <p>During an interview on 8/15/24 at 10:33 a.m. with CNA 3, CNA 3 stated Resident 66 did not like male staff members taking care of her. CNA 3 stated nurses have been the ones communicating to staff about Resident 66's preference for female staff. CNA 3 stated Resident 66's preference was not documented anywhere. CNA 3 stated Resident66's preference for female staff should have been in her care plan to better communicate the information to all staff. CNA 3 stated it was important to follow Resident 66's preference to ensure she felt comfortable and safe.</p> <p>During an interview on 8/15/24 at 1:24 p.m. with CNA 11, CNA 11 stated care plans were important in order for all staff to know what a resident's specific preferences were. CNA 11 stated a resident's preference for female staff should have been included in the care, so all staff were made aware.</p> <p>During a concurrent interview and record review on 8/15/24 at 2:35 p.m. with registered nurse (RN) 1, Resident 66's care plan, undated, was reviewed. The care plan did not have Resident 66's preference to be cared for by female staff included. RN 2 stated Resident 66 did not have a care plan implemented for her preference and there were no interventions included anywhere to provide female only staff for her care. RN 2 stated it was important to appropriately care plan Resident 66's preferences because it helped ensure all staff were aware of who can and can't enter her room.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and record review on 8/15/24 at 2:35 p.m. with the minimum data set coordinator (MDSC), Resident 66's care plan, undated, was reviewed. The care plan did not have Resident 66's preference to be cared for by female staff included. The MDSC stated Resident 66's preferences should have been developed and implemented in a care plan. The MDSC stated it was important to develop a care plan for Resident 66's preference so she could have felt safe and comfortable.</p> <p>During an interview on 8/16/24 at 10:40 a.m. with the director of nursing (DON) the DON stated Resident 66 did not like male staff members giving her showers or doing brief changes. The DON stated Resident 66 should have had a care plan developed for her preferences so all staff members could have been made aware of her preference and what interventions to take.</p> <p>During a review of the facility's Licensed Vocational Nurse (LVN) job description, dated 10/19/15, the job description indicated, The LVN contributes to nursing assessment and care planning . Responsibilities/Accountabilities . care planning: 2.1 contributes to establishing individualized patient goals; 2.2 Assists in developing interventions to achieve goals; 2.3. Implements the plan of care .</p> <p>During a review of the facility's Registered Nurse job description, dated 10/23/15, the job description indicated, . Responsibilities/Accountabilities . 2) Writing and initiating plan of care . 3) Regularly re-evaluating patient . needs .4) Participating in revising the plan of care as necessary .2. Develops a care plan that establishes goals, based on nursing diagnosis .</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Care Plans, Comprehensive Person-Centered, dated 1/18, indicated . A comprehensive, person -centered care plan that includes measurable objectives . is developed and implemented for each resident. 7. The care planning process will: . c. incorporate the resident's personal and cultural preferences in developing the goals of care. 8. The comprehensive, person-centered care plan will: . f. include the resident's stated preference J. reflect the resident's expressed wishes regarding care and treatment goals .</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 40641</p> <p>Based on observation, interview and record review, the facility failed to meet professional standards of practice for four of eight sampled residents (Resident 8, 38, 2 and 57) when:</p> <ol style="list-style-type: none"> <li>1. Registered Nurse (RN) 2 did not follow medication administration direction when she gave medication to Resident 8 without giving food. This failure had the potential to put Resident 8 at risk for stomach upset.</li> <li>2. A small medication cup with one tablet was left on top of Resident 38's bedside table accessible to other residents. This failure had the potential for Resident 38 to not receive a prescribed medication and for other residents to have access to the medication.</li> <li>3. Resident 2 and Resident 57's physician order for bed rails was not followed. This failure had the potential to put Resident 2 and Resident 57 at risk for injury which could lead to more serious health condition.</li> </ol> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. During a concurrent observation and interview on 8/14/24 at 7:28 a.m. in Station 1 (one)outside of room [ROOM NUMBER]. RN 2 prepared Resident 8's medication which included Metformin (brand name-used to treat high blood sugar) Oral Tablet to be given with food. RN 2 administered medication to Resident 8 with water and did not give food as indicated in the medication direction. RN 2 stated she administered the medication to Resident 8 without food as indicated in the medication direction. RN 2 stated the medication could irritate Resident 8's stomach and cause upset stomach which could lead to serious health condition if done repeatedly.</li> </ol> <p>During a review of Resident 8's Admission Record, dated 8/16/24, the admission record indicated, Resident 8 was admitted to the facility on [DATE] with diagnoses which included quadriplegia (paralysis of all four limbs) and diabetes (high blood sugar in the blood).</p> <p>During a review of Resident 8's Order Summary Report [OSR], dated 8/16/24, the OSR indicated, . metFORMIN HCl [hydrochloride] Tablet 1000 MG[milligram-unit of measurement] . Give with food .</p> <p>During an interview on 8/16/24 at 10:15 a.m. with the Director of Staff Development (DSD), the DSD stated it was important to follow medication direction. DSD stated the medication should have been given with meals, snacks or any food. The DSD stated not giving medication with food to Resident 8 could cause nausea and stomach upset.</p> <p>During an interview on 8/16/24 at 1:47 p.m. with the Director of Nursing (DON), the DON stated Resident 8's metformin medication should have been given with meal to prevent stomach upset or nausea or RN 2 should have made sure Resident 8 was assisted to eat immediately after she administered the medication. The DON stated she could have given Resident 8 apple sauce to make sure Resident 8's stomach was not empty when medication was administered.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>According to Lexicomp, a nationally recognized drug reference, . All drugs may cause side effects. However, many people have no side effects or only have minor side effects. Call your doctor or get medical help if any of these side effects or any other side effects bother you or do not go away: Stomach pain or heartburn. Gas. Diarrhea, upset stomach, or throwing up. Feeling tired or weak. Headache . Use this drug as ordered by your doctor. Read all information given to you. Follow all instructions closely . Take with meals .</p> <p>2. During an observation on 8/12/24 at 9:20 a.m. in Resident 38's room, Resident 38 was lying in bed with eyes closed. There was a 30 ml (milliliter-unit of measurement) medicine cup with one round yellowish tablet on top of the bedside. The medication cup was available and accessible for other residents to take.</p> <p>During a review of Resident 38's Admission Record, dated 8/16/24, the Admission Record indicated, Resident 38 was admitted to the facility on [DATE], with diagnoses which included dysphagia (difficulty swallowing) and muscle weakness.</p> <p>During an interview on 8/12/24 at 9:25 a.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated he was the CNA for Resident 38. CNA 1 stated the medication cup with one tablet was for Resident 38 but he did not know why it was left on top of the bedside table. CNA 1 stated other residents goes in and out of other residents room and they could take the medicine and drink it themselves.</p> <p>During an interview on 8/12/24 at 9:40 a.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated he was the night nurse of Resident 38. LVN 2 stated the medication was a multivitamin for Resident 38. LVN 2 stated Resident 38 was awake when he left the medication cup on top of the bedside table. LVN 2 stated he should have went back to make sure Resident 38 took the medication. LVN 2 stated it was never a nursing practice to leave any type of medications at bedside table unattended. LVN 2 stated other residents could have gone in Resident 38's room and took the medication. LVN 2 stated if taken by other residents, it could potentially cause allergic reaction.</p> <p>During an interview on 8/16/24 at 2:05 p.m. with the Director of Nursing (DON), the DON stated it was never acceptable to leave medication on top of bedside table because other residents can go in the room, grab the medication cup with the medication and take it themselves which could potentially cause allergic reactions. The DON stated the practice was for licensed nurses to make sure resident swallowed medications before leaving resident's bedside and moved to another resident.</p> <p>During a review of facility's policy and procedure (P&amp;P) titled, Medication Administration-General Guideline, undated, the P&amp;P indicated, . Medications are administered only by licensed nursing . Medications are administered at the time they are prepared . The resident is always observed after administration to ensure that the dose was completely ingested .</p> <p>3. During initial tour and observation on 8/12/24 at 9:08 a.m. in Resident 2's room, Resident 2 was lying in bed eating breakfast from food laid on top of the overbed table across the bed. Resident 2's bed had one half bed rails on both sides of bed and bed rails did not have any padding.</p> <p>During a review of Resident 2's Admission Record, dated 8/16/24, the Admission Record indicated Resident 2 was readmitted to the facility on [DATE] with diagnoses which included convulsions (a medical condition that causes a person's muscles to contract and relax rapidly and repeatedly, resulting in uncontrolled shaking), anemia (blood does not have enough healthy red blood) and falls.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During a review of Resident 2's Order Summary Report, dated 8/16/24, the Order Summary Report indicated, . Half side rails with padding [protective cushion] X2 (times) for bed mobility and seizure . order date 1/17/21 .</p> <p>During a concurrent observation and interview on 8/12/24 at 9:05 a.m. with certified Nursing Assistant (CNA) 8, CNA 8 stated Resident 2 did not have padded bed rails. CNA 8 stated Resident 2 used to have padded bed rails but recently did not have the padding on her bed rails and was using pillows to pad Resident 2's bed rails. CNA 8 stated she was not sure when Resident 2's bed rails padding was no longer used.</p> <p>During a concurrent observation, interview and record review on 8/2/24 with Licensed Vocational Nurse (LVN) 1, LVN 1 reviewed Resident 2's bed rails order and stated Resident 2's bed rails order was 1/2 (one half) rails on both side of bed with padding. LVN 1 Observed Resident 2's bed rails at bed side and stated Resident 2's bed rails did not have padding. LVN 1 stated Resident 2 needed her bed rails padded because of safety issues. LVN 1 stated Resident 2 could potentially injure herself like hitting her head against the bed rails or put her arms and legs through the bed rails when having seizure episodes.</p> <p>During an interview on 8/16/24 at 2:20 p.m. with the Director of Nursing (DON), the DON stated her expectation was for the bed rails order was followed. DON stated the staff should have made sure Resident 2's bed rails were padded because Resident 2 was diagnosed with seizure. DON stated Resident 2 could potentially sustain injuries hitting her head on the bed rails when having seizure episodes.</p> <p>During initial tour and observation on 8/12/24 at 9:50 a.m. in Resident 57's room, Resident 57 was observed lying in bed with eyes closed and did not answer any questions asked. Resident 57's bed was observed with whole bed rails on both sides of the bed and one bed rail had padding applied.</p> <p>During a review of Resident 57's Admission Record, dated 8/15/24, the Admission Record indicated, Resident 57 was admitted to the facility on [DATE] with diagnoses which included Transient Ischemic Attack (TIA- stroke), hypertension (high blood pressure) and history of falling.</p> <p>During a review of Resident 57's Order Summary Report, dated 8/15/24, the Order Summary Report indicated, . Half side rails X2 (times) when in bed for bed mobility per RP (responsible party) request .</p> <p>During an interview on 8/14/24 at 10:05 a.m. with Certified Nursing Assistant (CNA) 11, CNA 11 stated he was familiar with Resident 65's care. CNA 11 stated he was aware Resident 65's bed had full bed rails on with padding on one side. CNA 11 stated he did not know Resident 65 supposed to have 1/2 (one half) bed rails on each side of bed only. CNA 11 stated he did not remember any of the licensed nurses mentioned Resident 65 to have 1/2 rails only.</p> <p>During a concurrent observation, interview and record review on 8/15/24 at 9:45 a.m. with LVN 3, LVN 3 reviewed Resident 65's order for bed rails. LVN 3 stated Resident 65 has an order for 1/2 rails and no padding. LVN 3 observed Resident 65's bed at bedside and stated, . Resident's bed with full bed rails, her order is only for 1/2 rails . LVN 3 stated the Physician order was not being followed. LVN 3 stated it was a safety issue and did not want to answer any more questions because she was not familiar with Resident 65.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During a concurrent interview and record review on 8/16/24 at 2:30p.m. with DON, the DON stated Resident 65 was under hospice care (specialized care that provides physical comfort and emotional, social, and spiritual support for people nearing the end of life). DON stated hospice company provided Resident 65 her bed including the bedrails. DON reviewed Resident 65's bed rails order and stated the physician order for bed rails was not followed.</p> <p>During a review of facility's policy and procedure (P&amp;P) titled, Proper use of Side Rails, dated 1/18, the &amp;P indicated, . The purpose of these guidelines are to ensure the safe use of side rails as restraints unless necessary to treat a resident's medical condition .</p> <p>Review of professional reference <a href="https://www.fda.gov/medical-devices/hospital-beds/guide-bed-safety-bed-rai-ls-hospitals-nursing-homes-and-home-health-care-facts">https://www.fda.gov/medical-devices/hospital-beds/guide-bed-safety-bed-rai-ls-hospitals-nursing-homes-and-home-health-care-facts</a> . Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient ' s health care team will help to determine how best to keep the patient safe .</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 40641</p> <p>Based on observation, interview and record review, the facility failed to provide pharmaceutical services which ensured the administration of medication to meet residents needs for one of nine sampled residents (Resident 65) when Resident 65's Ergocalciferol (medication used to prevent and treat Vitamin D deficiency [nutrient the body needs for building and maintaining healthy bones]) was not available for administration for one day on 8/14/24.</p> <p>This failure had the potential for Resident 65 to not received the nutrient her body needs which could lead to serious health condition.</p> <p>Findings:</p> <p>During a concurrent medication administration observation and interview on 8/14/24 at 8:42 a.m. at Station one, Registered Nurse (RN) 2 was preparing Resident 65's medications. RN 2 did not administer Resident 65's Ergocalciferol medication. RN 2 stated she did not administer the medication because she had to clarify with pharmacy the medication available on hand. RN 2 stated the medication bubble pack had different medication name compared to the order on the eMAR (electronic Medication Administration Record) RN 2 stated she should have called pharmacy and verified medication.</p> <p>During a review of Resident 65's Admission Record, dated 8/15/24, the admission record indicated Resident 65 was admitted to the facility on [DATE] with diagnoses which included Vitamin D deficiency and muscle wasting and atrophy (partial or complete wasting away of a part of the body).</p> <p>During a review of Resident 65's eMAR dated 8/1/24-8/31/24, the eMAR indicated, Resident 65 did not received ergocalciferol brand name medication on 8/14/24.</p> <p>During a concurrent interview and record review on 8/14/24 at 2:30 p.m. RN 2, reviewed Resident 65's clinical record. RN 2 stated she put a hold on the eMAR for 8/14/24 for ergocalciferol (brand name) medication because the medication name in the bubble pack the pharmacy sent was different from the order in the eMAR. RN 2 stated she did not call pharmacy to clarify the name of medication but she called the physician. RN 2 stated Resident 65 did not receive her ergocalciferol medication and she really needed it because she has a diagnosis of Vitamin D deficiency (lack of).</p> <p>During an interview on 8/16/24 at 1:50 p.m. with the Director of Nursing (DON), the DON stated licensed nurses are responsible for ordering medications from the pharmacy. DON stated not administering a routine medication to a resident is not acceptable, licensed nurses should be making sure they are checking resident's medications ahead and checking medications delivered from the pharmacy to make sure it was the right medication.</p> <p>During a review of facility's policy and procedure (P&amp;P), titled, Medication Administration-General Guidelines, undated, the P&amp;P indicated, . Medications are administered in accordance with written orders of the attending physician . Medications are administered within (60 minutes) of scheduled time, except before or after meals orders . routine medications are administered according to the established medication administration schedule .</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of facility's P&amp;P, titled, Provider Pharmacy Requirements, undated, the P&amp;P indicated, . Providing routine and timely pharmacy service seven days per week and emergency pharmacy services 24 hours per day, seven days per week . Providing medication information and consultation to the facility's nursing staff .</p>		

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NAME OF PROVIDER OR SUPPLIER  Fresno Postacute Care		STREET ADDRESS, CITY, STATE, ZIP CODE  1233 A Street Fresno, CA 93706	
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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40641</b></p> <p>Based on observation, interview and record review, the facility failed to ensure the facility medication error rate did not exceed five percent (10.34 percent) when:</p> <ol style="list-style-type: none"> <li>Registered Nurse (RN) 2 administered metformin medication to Resident 8 without food when the medication direction indicated to administer with food.</li> </ol> <p>This failure had the potential for Resident 8 to develop upset stomach or gastrointestinal (GI) problems which could lead to more serious health condition.</p> <ol style="list-style-type: none"> <li>RN 2 did not completely dilute Resident 65's Juven therapeutic powder (brand name [used for wound healing]) before administering to Resident 65 leaving residue of the powder in the bottom of the cup.</li> </ol> <p>This failure resulted in Resident 65 not receiving the complete dose which had the potential for slower wound healing and could lead to more serious health condition.</p> <ol style="list-style-type: none"> <li>Registered Nurse (RN) 2 did not administer Resident 65's ergocalciferol (brand name [medication used for Vitamin D deficiency]) medication during medication pass.</li> </ol> <p>This failure had the potential for Resident 65 to have lower level of Vitamin D and lead to serious health condition.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>During an observation on 8/14/24 at 7:25 a.m. in Resident 8's room, Resident 8 was lying flat in bed, eyes open and watching television. There was a food tray with lids still on and placed on top of the overbed table placed on the side.</li> </ol> <p>During a concurrent observation and interview on 8/14/24 at 7:28 a.m. in Station 1, cart 1.</p> <p>RN 2 prepared Resident 8's medication and administered three medications scheduled for Resident 8 including metformin (brand name) with a cup of water. RN 2 stated she administered metformin to Resident 8 without food. RN 2 stated she should have given Resident 8 apple sauce or crackers.</p> <p>During a review of Resident 8's Admission Record, dated 8/16/24, the admission record indicated, Resident 8 was readmitted to the facility on [DATE] with diagnoses which included diabetes (high blood sugar level in the blood) and muscle spasm.</p> <p>During a review of Resident 8's Order Summary Report, dated 8/16/24, the order summary report indicated, . metFORMIN HCl [hydrochloride] Tablet 1000MG [milligram-unit of measurement] Give 1 [one] tablet by mouth one time a day . Give with food .</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 8/14/24 at 2:40 p.m. with RN 2, she reviewed Resident 8's clinical record and stated metformin was to be given with food. RN 2 stated she did not give Resident 8 any food because the breakfast tray was already on top of the overbed table. RN 2 stated she did not know Resident 8 waited 15-20 minutes before a Certified Nursing Assistant (CNA) went in Resident 8's room to spoon feed him (Resident 8). RN 2 stated giving the medication on empty stomach could lead to GI upset which could result to more serious health condition.</p> <p>During an interview on 8/15/24 at 9:30 a.m. with Licensed Vocational Nurse (LVN) 3, she stated medication orders needed to be followed as ordered. LVN 3 stated medication orders with instructions to give with food had to be given with food when administering to resident. LN 3 stated not giving food with medication during medication administration could lead to upset stomach.</p> <p>During an interview on 8/16/24 at 1:47 p.m. with the Director of Nursing (DON), the DON stated her expectation was to follow direction when administering medication. DON stated RN 2 should have administered medication to Resident 8 with apple sauce or a sandwich. DON stated it could cause nausea or upset stomach when medication was administered on empty stomach and instruction was to give with food.</p> <p>According to Lexicomp, a nationally recognized drug reference, . Use this drug as ordered by your doctor. Read all information given to you. Follow all instructions closely.</p> <p>All products: Take with meals. Keep taking this drug as you have been told by your doctor or other health care provider .</p> <p>2. During a concurrent observation and interview on 8/14/24 at 8:05 a.m. in Station 1, cart 1.</p> <p>RN 2 prepared Resident 65's Juven therapeutic Nutrition powder to Resident 65. RN 2 mixed the powder with colored liquid in two separate clear plastic cups and transferred the mixture to a coffee cup and hand the cup to Resident 65. Observed two clear plastic cups with white orange residues (remains) on the bottom of the clear cups. RN 2 stated she should have made sure she mixed the powder well before she administered Juven to Resident 65. RN 2 stated Resident 65 did not received the whole dose as ordered.</p> <p>During a review of Resident 65's Admission Record, dated 8/15/24, the admission record indicated, Resident 65 was admitted to the facility on [DATE] with diagnoses which included</p> <p>Vitamin D deficiency (can lead to a loss of bone density [bone mineral in bone tissue] which can contribute to osteoporosis [weak and brittle bone] and fractures [broken bones]) muscle wasting and atrophy (partial or complete wasting away of a part of the body).</p> <p>During an interview on 8/15/24 at 9:45 a.m. with LVN 3, LVN 3 stated licensed nurses when administering medications with instruction to mixed with liquids had to make sure there were no residues left at the bottom of the container to make sure resident received the whole medication dose. LVN 3 stated Resident 65 did not received the whole medication dose when there were residues left at the bottom of the clear cup used to mixed the powder.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 8/16/24 at 1:50 p.m. with the DON, the DON stated RN 2 should have made sure she mixed the powder and the liquid completely before she administered to Resident 65. DON stated Resident 65 did not received the whole dose of the medication when there were residues left on the bottom of the clear cups.</p> <p>According to Lexicomp, a nationally recognized drug reference, . Medical foods are distinguished by the requirement that they are intended to meet distinctive nutritional requirements of a disease or condition, used under medical supervision, and intended for the specific dietary management of a disease or condition. Medical foods are not those simply recommended by a physician as part of an overall diet to manage the symptoms or reduce the risk of a disease or condition. Instead, medical foods are specially formulated and processed (as opposed to a naturally occurring foodstuff used in a natural state) for a patient who is seriously ill or who requires use of the product as a major component of a disease or condition's specific dietary management .</p> <p>3. During a concurrent observation and interview on 8/15/24 at 8:42 a.m. in Station 1, RN 2 prepared Resident 65's medications and administered four of five medications scheduled for Resident 65. RN 2 stated she did not administer ergocalciferol (brand name-medication supplement) because she was not sure the medication bubble pack was the same as the order in eMAR (Electronic Medicine Administration Record) dated 8/1/24-8/31/24.</p> <p>During an interview on 8/15/24 at 2:20 p.m. with RN 2, she stated she did not administer Resident 65's ergocalciferol because the medication name was different in the bubble pack and the order. RN 2 stated she called the physician but did not call pharmacy to verify medication.</p> <p>RN 2 stated she did not administer the routine medication to Resident 65.</p> <p>During an interview on 8/16/24 at 1:55 p.m. with the DON, the DON stated her expectation was for routine medications to be available to administer to residents. The DON stated not administering routine medication was not acceptable because Resident 65 missed the dose.</p> <p>DON stated licensed nurses are responsible in ordering medications and making sure routine medications are available for administration.</p> <p>During an interview on 8/16/24 at 3:25 p.m. with the Administrator (ADM), the ADM stated, . make no mistakes but in reality it is not possible .</p> <p>According to Lexicomp, a nationally recognized drug reference, . Vitamin D supplementation has been shown to increase muscle function and strength, as well as improve balance. Patients at risk for falls should have vitamin D serum concentrations measured and be evaluated for supplementation .</p> <p>During a review of facility's policy and procedure (P&amp;P) titled, Adverse consequences and Medication Errors. dated 1/18, the P&amp;P indicated, . The staff and practitioner shall strive to minimize adverse consequences by: a. following relevant clinical guidelines and manufacturer's specification for use, dose, administration, duration . A medication error is defined as the preparation or administration of drugs or biologicals which is not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principles of the professional (s) providing services .</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 40641</p> <p>Based on observation, interview and record review the facility failed to ensure medications used were stored in accordance with accepted professional standards of practice for 12 of 19 sampled residents ((Residents 4, 8, 31, 34, 48, 53, 58, 65, 66, 68, 74, and 235) when:</p> <ol style="list-style-type: none"> <li>1. Medication cart in Station 1 was left unlocked and unattended by Registered Nurse (RN) 2.</li> </ol> <p>This failure resulted in the availability of medications to unauthorized residents, staff and visitors.</p> <ol style="list-style-type: none"> <li>2. Medication cart one in station two had, two boxes of pain medication that were observed without an expiration date.</li> <li>3. Medication cart two was observed unlocked and unattended in the hallway outside of resident's room.</li> <li>4. Medication bubble packs for 12 of 19 sampled residents' (Residents 4, 8, 31, 34, 48, 53, 58, 65, 66, 68, 74, and 235) were not separated from other residents' medications in medication cart three in station one.</li> <li>5. One box of glucometer (portable machine that's used to measure how much glucose (a type of sugar) is in the blood) control solution (used to help you check your test strips and blood glucose meter are functioning correctly) was observed in a bottom drawer covered by clear plastic bags, with expiration date of 06/04/2022 in medication cart three in station one.</li> </ol> <p>These failures had the potential for medications to be administered incorrectly causing an underdosing or overdosing of medications, or to be administered to the wrong residents causing harm to the resident.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. During a concurrent observation on 8/15/24 at 9:21 a.m. and 9:45 a.m. in Station 1 cart 1 with Registered Nurse (RN)2, medication cart was left at the nursing station 1 unlocked and unattended while RN 2 walked in the nursing station washes her hands and used the restroom.</li> </ol> <p>RN 2 left medication cart unlocked and unattended in the hallway outside of room [ROOM NUMBER] when she entered room [ROOM NUMBER] and administered Resident 4's medications.</p> <p>During an interview on 8/15/24 at 3 p.m. with RN 2, she stated she did not realized she left her medication cart unlocked and unattended twice during her medication pass. RN 2 stated, .</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Unlocked medication cart could be compromised . RN 2 stated unlocked medication cart could have been accessed by other residents, staff and visitors walking by and took medications inside the medication cart that may lead to overdose and or allergic reactions.</p> <p>During an interview on 8/16/24 at 2:01 p.m. with the Director of Nursing (DON), the DON stated licensed nurses needed to make sure medication carts are locked everytime they turned their back on their medication carts. DON stated licensed nurses can not leave their medication carts unlocked when unattended and had no sight of medication cart. DON stated residents may get in the medication cart, take medications to drink which could potentially lead to adverse reaction and results to more serious health condition. DON stated, Staff can steal medications .</p> <p>During an interview on 8/6/24 at 3:25 p.m. with the Administrator (ADM) the ADM stated .Licensed Nurses are supposed to be doing things properly everyday when they are at work . I expect them to be doing things correctly everyday .</p> <p>During a review of facility's policy and procedure (P&amp;P) titled, SPECIFIC PROCEDURES FOR ALL MEDICATIONS, undated, the P&amp;P indicated, . Medication cart is locked at all times unless in use and under direct observation .</p> <p>During a review of facility's P&amp;P titled, MEDICATION ADMINISTRATION-GENERAL GUIDELINES, undated, the P&amp;P indicated, . During administration of medications, the medication cart is kept closed and locked when out of sight . The cart must be clearly visible to the personnel administering medications . must be inaccessible to residents or others passing by .</p> <p>41608</p> <p>Findings:</p> <p>2. During a concurrent observation and interview on 8/15/24 at 9:45 a.m. with Licensed Vocational Nurse (LVN) 4 in station 2 at medication cart one, two medication bottles of Perampanel (medication used to prevent seizures [rapid, rhythmic, uncontrollable shaking, with muscles contracting and relaxing repeatedly]), with no visible expiration dates. LVN 4 stated she was unable to find a visible expiration date on the label from the pharmacy and the expiration date was not marked on the bottles. LVN 4 stated every medication is to have a visible expiration date, prior to dispensing medication to residents the expiration date is to be reviewed and if the medication is expired it is to be discarded. LVN 4 stated, expired medication could have lost efficacy (desired result) and not give the desired effect or give unwanted side effects to the resident.</p> <p>During an interview and observation on 8/16/24 at 3:20 p.m. with Director of Nurses (DON), the DON stated the pharmacy should have written the expiration date on the label placed on the medication bottles. The DON stated, the Licensed Nurse (LN) accepting the medication, should have checked the medication for the expiration dates and got clarification prior to administering medication to Residents.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facilities policy and procedure (P&amp;P) titled, Medication Storage in The Facility dated 1/2018, the P&amp;P indicated, . E. The nurse will check the expiration date of each medication before administering it. F. No expired medication will be administered to a resident. G. All expired medication will be removed from the active supply and destroyed in the facility, regardless of amount remaining . I. Nursing staff should consult with dispensing pharmacist for any questions related to medication expiration dates .</p> <p>During a review of the facilities P&amp;P titled, Specific Medication Administration Procedures (undated), indicated, To administer medications in a safe and effective manner . E. Check expiration date on package/container .</p> <p>During a review of the facilities P&amp;P titled, HR Manual: Job Description . Licensed Vocational Nurse dated 10/19/2015, the P&amp;P indicated, .Responsibilities/Accountabilities . 2. Care Planning: . 2.4. Evaluates effectiveness of interventions to achieve patient goals and minimize re-hospitalization s . 3. Provision of Direct Patient Care: 3.1. Administers medications and performs treatments per physician orders .</p> <p>3. During an observation on 8/16/24 at 8:17 a.m. at the entrance to the facility, an unlocked, unattended medication cart was observed in the hall against the wall outside of resident room [ROOM NUMBER].</p> <p>During a concurrent observation and interview on 8/16/24 at 8:19 a.m. with LVN 6 at the unattended medication cart, LVN 6 stated the medication cart belonged to LVN 5 and it should not have been left unlocked and unattended. LVN 6 stated a resident or visitor could have gotten into the medication cart and been harmed.</p> <p>During an interview on 8/16/24 at 9:01 a.m. with the DON, the DON stated, the medication cart should not have been unlocked and, LVN 5 should have locked the medication cart prior to entering the resident room to prevent residents from getting into the medication cart and being harmed.</p> <p>During an interview on 8/16/24 at 1:38 p.m. with LVN 5 in station 1, LVN 5 stated she left the medication cart unlocked in the hall while she went into resident room. LVN 5 stated she should not have left the medication cart unlocked, a resident could get into the medication cart and injured themselves by taking another resident's medication.</p> <p>During a review of the facilities P&amp;P titled, HR Manual: Job Description . Licensed Vocational Nurse dated 10/19/2015, the P&amp;P indicated, .Responsibilities/Accountabilities . 2. Care Planning: . 2.4. Evaluates effectiveness of interventions to achieve patient goals and minimize re-hospitalization s . 3. Provision of Direct Patient Care: 3.1. Administers medications and performs treatments per physician orders . 4.4. Ensures that assigned tasks are performed in accordance with policies and procedures .</p> <p>During a review of the facilities P&amp;P titled, Specific Medication Administration Procedures (undated), indicated, To administer medications in a safe and effective manner . A. Medication cart is locked at all times unless in use and under direct observation of the medication nurse .</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. During a concurrent observation and interview on 8/16/24 at 1:40 p.m. with LVN 5, in station one at medication cart three, LVN 5 opened the second drawer on the left side of the medication cart, the drawer had plastic dividers with room numbers written on them for each resident. The medication bubble packs for 12 of 19 sampled residents' (residents 4, 8, 31, 34, 48, 53, 58, 65, 66, 68, 74, and 235), medication bubble packs were not stored separately. LVN 5 stated, . only the resident in the room number identified on the card belonged behind the card. Having the medications separate is a safety measure. If the medicines are mixed it up it would be easy to give a resident another residents medication. A resident could suffer unwanted effects when taking another residents medication .</p> <p>During an interview on 8/16/24 at 3:22 p.m. with the DON, the DON stated, her expectation is for the medication carts to be clean and organized at all times.</p> <p>During an interview on 8/16/24 at 3:25 p.m. with the Administrator (ADM), the ADM stated, his expectation is for the nurses to review the carts at the start of the shift to reduce the chance of medication errors. The ADM stated, . if the nurse does not have an organized medication cart, they can get distracted and mistakenly give the wrong medication .</p> <p>During a review of Resident 4's Admission Record [AR], dated 8/16/24, the AR indicated, Resident 4 was admitted on [DATE] with diagnosis of Major Depressive Disorder (a serious mental health condition that causes a persistently low or depressed mood and a loss of interest in activities that once brought joy), Anxiety (felling of fear, dread, or uneasiness) and Psychosis (loss of contact from reality).</p> <p>During a review of Residents 4's Minimum Data Set (MDS- a resident assessment tool used to identify resident cognitive and physical function) Section C assessment dated [DATE], indicated Resident 8's Brief Interview of Mental status assessment (BIMS - assessment of cognitive status for memory and judgement) scored 15 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, 00-07 indicates severe impairment and 99 indicates they are unable to complete the interview). The BIMS assessment indicated Resident 4 had no cognitive impairment.</p> <p>During a review of Resident 8's AR dated 8/16/24, the AR indicated, Resident 8 was admitted on [DATE] with diagnosis of Quadriplegia (paralysis below the neck that affects all of a person's limbs), Type 2 Diabetes Mellitus (DM - a chronic condition that causes the body to have too much sugar [glucose] in the blood), and Anemia (a condition that develops when your blood produces a lower-than normal amount of healthy red blood cells).</p> <p>During a review of Resident 8's MDS Section C dated 7/18/24, the MDS Section C indicated, Resident 8 had a BIMS score of 15, no cognitive impairment.</p> <p>During a review of Resident 31's AR dated 8/16/24, the AR indicated, Resident 31 was admitted on [DATE] with diagnosis of Cerebral Infarction I artery in the brain ruptures or becomes blocked, cutting off blood supply to the brain and causing brain tissue to die), Major Depressive Disorder, DM, and Anxiety.</p> <p>During a review of Resident 31's MDS Section C dated 5/6/24, the MDS Section C indicated, Resident 8 had a BIMS score of 15, no cognitive impairment.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 34's AR dated 8/19/24, the AR indicated Resident 34 was admitted on [DATE] with diagnosis of Asthma (a chronic lung disease that causes inflammation and muscle tightening around the airways, making it difficult to breathe), Muscle Weakness, and Calculus of the Ureter (mineral deposits in the urinary tract).</p> <p>During a review of Resident 34's MDS Section C dated 7-20-24, the MDS Section C indicated, Resident 34 had a BIMS Score of 14, no cognitive impairment.</p> <p>During a review of Resident 48's AR dated 8/19/24, the AR indicated, Resident 48 was admitted on [DATE] with diagnosis of Chronic Obstructive Pulmonary Disease (COPD - a lung disease that damages the airways and other parts of the lungs, making it difficult to breathe), Depression, Bipolar Disorder (mental illness that causes extreme mood swings, or episodes, that can range from mania to depression), and Parkinson's Disease (chronic, degenerative brain disorder that affects the nervous system and the parts of the body controlled by the nerves), and Heart Failure.</p> <p>During a review of Resident 48's MDS Section C dated 5/27/24, the MDS Section C indicated, Resident 48 had a BIMS score of 15, no cognitive impairment.</p> <p>During a review of Resident 53's AR dated 8/19/24, the AR indicated, Resident 53 was admitted on [DATE] with diagnosis of COPD, Heart Failure, Anxiety, Schizophrenia (delusions (false beliefs), hallucinations (seeing or hearing things that don't exist), unusual physical behavior, and disorganized thinking and speech), and muscle weakness.</p> <p>During a review of Resident 53's MDS Section C dated 5/22/24, the MDS Section C indicated, Resident 53 had a BIMS score of 6, severe cognitive impairment.</p> <p>During a review of Resident 58's AR dated 8/19/24, the AR indicted, Resident 58 was admitted on [DATE] with diagnosis of Anxiety, History of Falling, Acute Kidney Failure, and Iron Deficiency.</p> <p>During a review of Resident 58's MDS Section C dated 5/10/24, the MDS Section C indicated, Resident 58 had a BIMS score of 3, severe cognitive impairment.</p> <p>During a review of Resident 65's AR dated 8/19/24, the AR indicated, Resident was admitted on [DATE] with diagnosis of Vitamin D Deficiency, Insomnia (difficulty sleeping), Hypertension (high blood pressure), Dysphasia (trouble swallowing), and difficulty walking.</p> <p>During a review of Resident 65's MDS Section C dated 5/13/24, the MDS Section C indicated, Resident 65 had a BIMS score of 15, no cognitive impairment.</p> <p>During a review of Resident 66's AR dated 8/19/24, the AR indicated Resident 66 was admitted on [DATE] with diagnosis of Heart Failure, DM, Dysphagia, Depression, Kidney Failure, and Bradycardia (slow heart rate).</p> <p>During a review of Resident 66's MDS Section C dated 6/17/24, the MDS Section C indicated, Resident 66 had a BIMS Score of 12, moderate cognitive impairment.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 68's AR dated 8/19/24, the AR indicated Resident 68 was admitted on [DATE] with diagnosis of Chronic Atrial Fibrillation (A Fib - irregular heartbeat, or arrhythmia, that occurs when the upper chambers of the heartbeat rapidly and irregularly), DM, Anxiety, Vitamin D, Pain, Falls, and Muscle Weakness.</p> <p>During a review of Resident 68's MDS Section C dated 5/25/24, the MDS Section C indicated, Resident 68 had a BIMS score of 15, no cognitive impairment.</p> <p>During a review of Resident 74's AR dated 8/19/24, the AR indicated Resident 74 was admitted on [DATE] with diagnosis of Endocarditis (a rare and potentially fatal infection of the heart's inner lining), Muscle Weakness, Depression, and DM.</p> <p>During a review of Resident 74's MDS Section C dated 6/18/24, the MDS Section C indicated, Resident 74 had a BIMS score of 15, no cognitive impairment.</p> <p>During a review of Resident 235's AR dated 8/19/24, the AR indicated Resident 235 was admitted on [DATE] with diagnosis of Dementia (illness that affect the brain and a person's ability to perform everyday tasks), A Fib, Muscle Weakness, and Hypothyroidism (condition where the thyroid gland does not produce enough thyroid hormones).</p> <p>During a review of Resident 235's MDS Section C dated 5/31/24 indicated, Resident 235 had a BIMS score of 2, severe cognitive impairment.</p> <p>During a review of Cal. Code Regs. Tit. 22, S 73365 - Pharmaceutical Service-Labeling and Storage of Drugs dated 6/7/1991, the Cal. Code Regs. Tit. 22, S 73365 - Pharmaceutical Service-Labeling and Storage of Drugs indicated, . (g) Drugs shall be stored in an orderly manner in cabinets, drawers or carts .</p> <p>5. During a concurrent observation and interview on 8/16/24 at 2:04 p.m. with LVN 5 in station one, a box of glucometer control solution was observed in a bottom drawer covered by clear plastic bags, with expiration date of 06/04/2022. LVN 5 stated, .the solution had been expired for over two years and should not have been in the drawer. The solution could give a wrong reading on the glucometer resulting in the resident receiving the wrong amount of medication .</p> <p>During an interview on 8/16/24 at 3:30 p.m. with DON, the DON stated, there should be no expired medications or solutions in the medication cart, expired medications should be removed from the cart and destroyed.</p> <p>During a review of the facility's P&amp;P titled, HR Manual: Job Description . Licensed Vocational Nurse dated 10/19/2015, the P&amp;P indicated, .Responsibilities/Accountabilities . 2. Care Planning: . 2.4. Evaluates effectiveness of interventions to achieve patient goals and minimize re-hospitalization s . 3. Provision of Direct Patient Care: 3.1. Administers medications and performs treatments per physician orders . 4.4. Ensures that assigned tasks are performed in accordance with policies and procedures .</p> <p>During a review of the facility's P&amp;P titled, Medication Storage in the Facility dated 1/2022, the P&amp;P indicated, . All expired medications will be removed from the active supply and destroyed in the facility .</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Fresno Postacute Care		STREET ADDRESS, CITY, STATE, ZIP CODE  1233 A Street Fresno, CA 93706	

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F 0761  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some	~~~~~ ~~~~~ ~~~~~ 108/16/24 09:39 AM

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<p>F 0802</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service.</p> <p>28773</p> <p>Based on observation, interview and record review, the facility failed to ensure three food service staff (DA 1, DA 2 and [NAME] 1) were competent to carry out the functions of food and nutrition services safely and effectively when they served incorrect portion sizes of food items and did not have a competency or skills check done.</p> <p>This failure had the potential to result in residents' diet orders and facility menus not being followed.</p> <p>Findings:</p> <p>During the lunch meal service and meal preparation on August 12, 2024, the following was observed:</p> <p>*Starting at 12:31 p.m., the steam table had scoops for the following: #12 scoop for the regular texture roast beef, #16 scoop for the mechanical soft roast beef, #12 scoop for the pureed roast beef, and four-ounce (oz - unit of measurement) scoop (1/2 cup) for the regular texture sweet potato fries; and</p> <p>*Starting At 12:32 p.m. Dietary Aide (DA) 1 was not calling out CCHO [Consistent Carbohydrate (CCHO) diet (a diet that provides a consistent amount of carbohydrates at each meal and from day to day to help keep blood sugar levels stable); or renal (diet with lower amounts of sodium, protein, potassium, and phosphorus provided for residents with limited kidney function) from the meal tickets when telling the cook what to put on the plate; and</p> <p>*During a concurrent interview and observation on 8/12/24 at 10:53 a.m. with DA 2 in the kitchen, DA 2 was using a #12 scoop when scooping chocolate pudding into approximately 20 bowls on a tray. There were approximately 10 bowls that were not full. DA 2 stated some bowls had less pudding than the other bowls since she did not fill up the scoop as much. DA 2 then put the lids on the bowls and started a new tray of bowls. Cross Reference F803.</p> <p>During a review of the facility's Summer Menus for the lunch meal for August 12, 2024, showed the regular diet with regular portions to receive: 3 ounces french dip - roast beef, 1 soft sandwich roll, 2 ounces Au Jus juice/sauce, 1/2 cup sweet potato fries, #8 scoop (1/2 cup) corn coleslaw; #12 cappuccino mousse (cap mousse). The large portion showed: 3 ounces roast beef, 1 soft sandwich roll, 3/4 cup sweet potato fries, #8 scoop corn coleslaw, #12 scoop cap mousse. Mechanical Soft diet showed: Ground roast beef #10 scoop, 1/2 cup sweet potato fries, #8 scoop corn coleslaw, #12 scoop cap mousse. Puree diet showed: #8 scoop roast beef moisten with broth, #12 scoop puree roll, #8 scoop puree sweet potato fries, #12 scoop corn coleslaw, #12 scoop cap mousse. CCHO, regular texture diet showed: 3 ounces roast beef with 1 roll, 1/4 cup sweet potato fries, #8 scoop corn coleslaw, #12 scoop cap mousse. Renal diet showed: 3 ounces roast beef, 1 roll, 2 ounces Au Jus, pineapple ring (no fries), #8 scoop corn coleslaw, Sugar cookies - 2 small.</p> <p>(continued on next page)</p>		

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<p>F 0802</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facility's employee files (EF), the EF indicated DA 1 was hired on 6/23/22, DA 2 was hired on 10/26/23, and [NAME] 1 was hired on 2/20/23. DA 1, DA 2, and [NAME] 1 did not have a competency or skills check completed.</p> <p>During an interview on 8/14/24 at 11:13 a.m. with the Certified Dietary Manager (CDM), the CDM stated there were no competency or skills check done for DA 1, DA 2 and [NAME] 1.</p> <p>During a review of the facility's RCR, dated 7/29/2024, the RCR indicated, Concern/Request Identified by the Resident Council: Food Quality &amp; preferences . Department Head Response . look at food and tray cards [meal tickets] for proper preferences and diets . educated staff, not reading cards [meal tickets] properly.</p> <p>During a review of the facility's dietary in-services, the CDM was unable to provide documentation of in-services regarding portion sizes, following menus and therapeutic diets.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Demonstrating Food Safety and Job Competency for Food and Nutrition Services Employees, dated 2023, the P&amp;P indicated, Food and Nutrition Services employees will be tested on the competency of their skill to meet the needs of the facility. Each employee must successfully complete the following within each year (12 months) for the job they were hired to perform: Verification of Demonstrated Job Competencies (Cooks or Diet Aids) - Attachment A and B, Equipment Competency for the appropriate equipment used in the job - Attachment C, 2 written tests.</p> <p>50409</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>28773</p> <p>Based on observation, interview, and record review, the facility failed to ensure the planned menus were followed for the lunch meal on August 12, 2024 when:</p> <ol style="list-style-type: none"> <li>1. Incorrect portion sizes were used on the therapeutic diets: <ol style="list-style-type: none"> <li>a. 1/2 cup (4 ounces) of sweet potato fries were served instead of 1/4 cup (2 ounces) to 20 residents (Resident 42, 5, 16, 6, 26, 9, 23, 60, 12, 74, 34, 4, 37, 24, 77, 25, 22, 29, 78, and 13) who were on a Consistent Carbohydrate (CCHO) diet (a diet that provides a consistent amount of carbohydrates at each meal and from day to day to help keep blood sugar levels stable); and</li> <li>b. #16 scoop (2 ounces) of roast beef was served instead of #10 scoop (3.2 ounces) to eight residents (Resident 21, 57, 61, 54, 3, 55, 66, and 28) who were on a mechanical soft diet (a diet of soft-textured foods that are easy to chew and swallow); and</li> <li>c. #12 scoop (2.67 ounces) of pureed roast beef was served instead of #8 scoop (4 ounces) to seven residents (Resident 27, 1, 69, 2, 15, 49, and 44) on a puree diet (designed for residents who have difficulty chewing and/or swallowing and the texture of the food should be of a smooth, moist consistency and able to hold its shape); and</li> <li>d. Double portions of all food items were given to three residents (Resident 227, 20, and 44) on a large portion diet; and</li> <li>e. 4 ounces of sweet potato fries were given to two residents (Resident 13 and 45) on a renal diet (diet with lower amounts of sodium, protein, potassium, and phosphorus provided for residents with limited kidney function) and did not receive the food stated on the menu.</li> </ol> </li> <li>2. Pureed coleslaw was not measured when placed into bowls; and</li> <li>3. Cappuccino mousse was not served, and chocolate pudding was not filled up consistently in the scoop when portioned as the dessert; and</li> <li>4. Corn coleslaw was not served.</li> </ol> <p>These failures had the potential to result in residents on therapeutic diets to not meet their physician's prescribed diet order and their nutrition needs to not be met which can result in over or under nutrition.</p> <p>Findings:</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>1. During a review of the facility's Summer Menus for the lunch meal for August 12, 2024, showed the regular diet with regular portions to receive: 3 ounces (oz.) french dip - roast beef, 1 soft sandwich roll, 2 ounces Au Jus juice/sauce, 1/2 cup sweet potato fries, #8 scoop (1/2 cup) corn coleslaw; #12 cappuccino mousse (cap mousse). The large portion showed: 3 ounces roast beef, 1 soft sandwich roll, 3/4 cup sweet potato fries, #8 scoop corn coleslaw, #12 scoop cap mousse. Mechanical Soft diet showed: Ground roast beef #10 scoop, 1/2 cup sweet potato fries, #8 scoop corn coleslaw, #12 scoop cap mousse. Puree diet showed: #8 scoop roast beef moisten with broth, #12 scoop puree roll, #8 scoop puree sweet potato fries, #12 scoop corn coleslaw, #12 scoop cap mousse. CCHO, regular texture diet showed: 3 ounces roast beef with 1 roll, 1/4 cup sweet potato fries, #8 scoop corn coleslaw, #12 scoop cap mousse. Renal diet showed: 3 ounces roast beef, 1 roll, 2 ounces Au Jus, pineapple ring (no fries), #8 scoop corn coleslaw, Sugar cookies - 2 small.</p> <p>During an observation of the lunch meal service on 8/12/24 starting at 12:31 p.m. in the kitchen, the steam table had scoops for the following: #12 scoop for the regular texture roast beef, #16 scoop for the mechanical soft roast beef, #12 scoop for the pureed roast beef, and four-ounce (oz - unit of measurement) scoop (1/2 cup) for the regular texture sweet potato fries. Cross Reference F802.</p> <p>a. During a review of the facility's Summer Menus (SM), dated 8/12/24, the SM indicated residents on regular texture, CCHO, regular portions diet, to receive 1/4 cup of sweet potato fries. The SM indicated 1/2 cup of sweet potato fries is large portions for residents on regular texture, CCHO diet.</p> <p>During an observation on 8/12/24 at 12:32 p.m. in the kitchen, Dietary Aide (DA) 1 was not calling out CCHO from the meal tickets when telling the cook what to put on the plate.</p> <p>During an observation of the lunch meal service on 8/12/24, starting at 12:32 p.m. in the kitchen, [NAME] 1 used a four oz. scoop to serve regular texture sweet potato fries to 20 residents (Resident 42, 5, 16, 6, 26, 9, 23, 60, 12, 74, 34, 4, 37, 24, 77, 25, 22, 29, 78, 13) on regular texture, CCHO, regular portions diet.</p> <p>During a review of the facility's Diet Type Report (DTR), dated 8/12/24, the DTR indicated the following residents are on regular texture, CCHO, regular portions diet: Resident 42, 5, 16, 6, 26, 9, 23, 60, 12, 74, 34, 4, 37, 24, 77, 25, 22, 29, 78, 13).</p> <p>b. During a review of the facility's SM, dated 8/12/24, the SM indicated residents on mechanical soft regular portions diet get #10 scoop (3.2 ounces) of ground roast beef. The SM indicated #16 scoop (2 ounces) of ground roast beef is small portions for residents on mechanical soft diet.</p> <p>During an observation of the lunch meal service on 8/12/24 starting at 12:31 p.m. in the kitchen, [NAME] 1 used #16 scoop (small portions) to serve ground roast beef to eight residents (Resident 21, 57, 61, 54, 3, 55, 66, 28) on mechanical soft regular portions diet.</p> <p>During a review of the facility's DTR, dated 8/12/24, the DTR indicated the following residents are on mechanical soft regular portions diet: Resident 21, 57, 61, 54, 3, 55, 66, 28).</p> <p>c. During a review of the facility's SM, dated 8/12/24, the SM indicated residents on pureed regular portions diet get #8 scoop (4 ounces) of pureed roast beef. The SM indicated #12 scoop of pureed roast beef is small portions for residents on pureed diet.</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an observation of the lunch meal service on 8/12/24 starting at 12:31 p.m. in the kitchen, [NAME] 1 used #12 scoop (small portions) to serve pureed roast beef to seven residents (Resident 27, 1, 69, 2, 15, 49, 44) on pureed regular portions diet.</p> <p>During a review of the facility's DTR, dated 8/12/24, the DTR indicated the following residents are on pureed, regular portions diet: Resident 27, 1, 69, 2, 15, 49, 44). d. During a review of the facility's SM, dated 8/12/24, the SM indicated residents on regular texture, large portions diet get three oz of roast beef and 3/4 cup of sweet potato fries.</p> <p>During an observation of the lunch meal service on 8/12/24 starting at 12:31 p.m., in the kitchen, [NAME] 1 served two #12 (5.34 oz) scoops of roast beef and two 4 oz scoop (one cup) of sweet potato fries to Resident 227 and Resident 20.</p> <p>During a review of the facility's DTR, dated 8/12/24, the DTR indicated Resident 227 and Resident 20 are on regular texture, large portions diet.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Portion Sizes, dated 2023, the P&amp;P indicated, The small and large portion servings will be served as printed on the cook's spreadsheets for every meal Double portions are used for residents with high caloric needs who are eating well and for whom large portions are inadequate.:</p> <p>e. During an observation on 8/12/24 at 12:40 p.m. in the kitchen, DA 1 was not calling out Renal from the meal tickets when telling the cook what to put on the plate.</p> <p>During an observation of the lunch meal service on 8/12/24 at starting at 12:31 p.m. in the kitchen, [NAME] 1 served roast beef and sweet potato fries to Resident 13 and Resident 45.</p> <p>During a review of the facility's DTR, dated 8/12/24, the DTR indicated Resident 13 and Resident 45 are on renal diet.</p> <p>During a review of the facility's SM, dated 8/12/24, the SM indicated. Renal diets. French Dip: Roast Beef Roll with Au Jus, Pineapple Ring ** No Fries.</p> <p>During an interview on 8/12/24 at 1:20 p.m. with [NAME] 1, [NAME] 1 stated residents on renal diet should get pineapple rings and not sweet potato fries. [NAME] 1 stated DA 2 should call out if residents are on renal diet. [NAME] 1 confirmed while reading the menu that the portion sizes were incorrect for CCHO, mechanical soft, large portions and puree diets.</p> <p>During an interview on 8/14/24 at 2:43 p.m. with Registered Dietitian (RD), RD stated she expects the kitchen staff to follow the portion sizes on the menu spreadsheet and follow what menu shows for all the different therapeutic diets. RD stated large portions is not double portions.</p> <p>2. During an observation and concurrent interview on 8/12/24 at 12:21 p.m., with [NAME] 1, blended coleslaw in a blender. [NAME] 1 stated she had 12 servings portioned in the blender.</p> <p>During an observation on 8/12/24 at 12:22 p.m. with DA 3, DA 3 poured a pitcher of pureed coleslaw into seven disposable bowls unmeasured.</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During a review of the facility's SM, dated 8/12/24, the SM indicated residents on pureed diet get #12 scoop of pureed coleslaw.</p> <p>During a review of the facility's DTR, dated 8/12/24, the DTR indicated the following residents are on pureed diet: Resident 27, 1, 69, 2, 15, 49, 44.</p> <p>During an interview on 8/14/24 at 2:43 p.m. with RD, RD stated she expects the kitchen staff to follow the portion sizes on the menu spreadsheet and not to guess what the portion sizes are.</p> <p>3. During an observation on 8/12/24 at 10:52 a.m. in the kitchen, DA 2 was preparing chocolate pudding for the residents' dessert for lunch.</p> <p>During a concurrent interview and observation on 8/12/24 at 10:53 a.m. with DA 2 in the kitchen, DA 2 was using a #12 scoop when scooping chocolate pudding into approximately 20 bowls on a tray. There were approximately 10 bowls that were not full. DA 2 stated some bowls had less pudding than the other bowls since she did not fill up the scoop as much. DA 2 then put the lids on the bowls and started a new tray of bowls.</p> <p>During an interview on 8/13/24 at 10:03 a.m. with DA 2, DA 2 stated, I don't think we had the ingredients for that [cappuccino mousse].</p> <p>During an interview on 8/14/24 at 2:43 p.m. with RD, RD stated she expects the kitchen staff to follow the portion sizes on the menu spreadsheet and to fill up the scoops when portioning food items.</p> <p>4. During an observation on 8/12/24 at 10:33 a.m. in the kitchen, [NAME] 1 was preparing coleslaw for the residents' side for lunch. The coleslaw did not have corn.</p> <p>During a review of the facility's SM, dated 8/12/24, the SM indicated, French Dip-Roast Beef on a Soft Sandwich Roll, Au Jus, Sweet Potato Fries, Ketchup, Corn Coleslaw, Cappuccino Mousse, Milk for lunch.</p> <p>During an interview on 8/13/24 at 10:01 a.m. with [NAME] 1, [NAME] 1 stated she did not put corn in the corn coleslaw. [NAME] 1 stated some ingredients were not in house for the recipes.</p> <p>During a review of the facility's Resident Council Minutes (RCM), RCM, dated 5/29/24, the RCM indicated, Old business: Portion size, food preference.</p> <p>During a review of the facility's RCM, dated 6/24/24, the RCM indicated, Old business: Portion size, food preferences. Dietary: Food continuously coming out late.</p> <p>During a review of the facility's P&amp;P titled, Menu Planning dated 2023, showed menus are planned to meet nutritional needs of residents in accordance with established national guidelines, physician's orders, and to the extent medically possible, in accordance with the most recent recommended dietary allowances of the Food and Nutrition Board of the National Research Council National Academy of Sciences. Menus provide a variety of foods in adequate amounts each meal.</p> <p>50409</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>28773</p> <p>Based on observation, interview, and record review, the facility failed to ensure food was palatable and flavorful when the lunch served for residents had firm and undercooked peas, dry and bland chicken, and bland rice.</p> <p>This failure had the potential to result in residents to have decreased meal intake due to difficulty chewing and eating their food which can lead to resident's not meeting their nutrition needs.</p> <p>Findings:</p> <p>During an interview on 8/12/24 at 8:38 a.m. with Resident 29, Resident 29 stated food from the kitchen is dreadful.</p> <p>During an interview on 8/12/24 at 8:40 a.m. with Resident 12, Resident 12 stated the broccoli was too watery and felt like it was cooked for days. Resident 12 stated the rice and mashed potatoes did not taste good. Resident stated lunch and dinner from the kitchen were not appetizing at all.</p> <p>During an interview on 8/12/24 at 8:50 a.m. with Resident 177, Resident 177 stated the food tasted horrible and the cook did not know how to cook anything. Resident stated the food was either overcooked or undercooked.</p> <p>During an interview on 8/12/24 at 10:59 a.m. with Resident 31, Resident 31 stated food from the kitchen does not taste good. Resident 31 stated the kitchen does not serve what is on the menu. Resident 31 stated the chicken was dry and cold, and the soup from the kitchen was cold, nasty and watered down.</p> <p>During an interview on 8/13/24 at 10:14 a.m. with Resident 49, Resident 49 stated food is not that good.</p> <p>During an interview on 8/13/24 at 10:56 a.m. with Resident 26, Resident 26 stated she does not like the food from the kitchen and it is bland.</p> <p>During a review of the facility's Summer Menus (SM), dated 8/13/24, the SM indicated, Curry Lemon Chicken, Garlic Rice, Peas w/ [with] onions, Parsley Garnish, Wheat Roll for lunch.</p> <p>During a concurrent observation and interview on 8/13/24 at 12:15 p.m. with the Certified Dietary Manager (CDM) in Station 2 hallway, the regular and puree test tray were sampled. The regular diet had a plate of curry lemon chicken, garlic rice, and peas with onions. The peas were firm, undercooked and starchy. The curry lemon chicken was dry and had mild curry taste, and the garlic rice tasted like plain brown rice. The CDM confirmed the peas were firm and that that he could taste the curry better on the pureed chicken than the regular chicken.</p> <p>During an interview on 8/13/24 at 1:40 p.m. with Resident 12, Resident 12 stated the peas tasted like it came straight from the can and it was hard. Resident 12 stated, I did not like most of the food in the plate.</p> <p>(continued on next page)</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facility's Resident Council Response (RCR), dated June 2024, the RCR indicated, Concern/Request Identified by the Resident Council: Food quality is not good . Department Head Response . To ensure that Residents get proper quality food and water.</p> <p>During a review of the facility's RCR, dated 7/29/2024, the RCR indicated, Concern/Request Identified by the Resident Council: Food Quality &amp; preferences . Department Head Response . look at food and tray cards for proper preferences and diets . educated staff, not reading cards [meal tickets] properly.</p> <p>50409</p>

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  08/16/2024
NAME OF PROVIDER OR SUPPLIER  Fresno Postacute Care		STREET ADDRESS, CITY, STATE, ZIP CODE  1233 A Street Fresno, CA 93706	
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<p>F 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.</p> <p>28773</p> <p>Based on observation, interview, and record review, the facility failed to ensure pureed meat was able to hold its shape or form for seven of 64 sampled residents (Resident 27, 1, 69, 2, 15, 49, and 44). This failure had the potential to result in residents choking or decreased meal intake.</p> <p>Findings:</p> <p>During a concurrent observation and interview on 8/13/24 at 12:15 p.m. with the Certified Dietary Manager (CDM) in Station 2 hallway, the pureed diet test tray was sampled. The pureed curry chicken was spread all over the plate and did not hold its shape or form. The CDM acknowledged that the pureed chicken did not hold its shape or form.</p> <p>During a review of the facility's Diet Type Report (DTR), dated 8/12/24, the DTR indicated the following residents are on pureed diet:</p> <ul style="list-style-type: none"> <li>a. Resident 27 is on CCHO, puree, nectar thick liquids diet.</li> <li>b. Resident 1 is on regular puree, honey thick liquids diet.</li> <li>c. Resident 69 is on fortified puree diet.</li> <li>d. Resident 2 is on regular puree, honey thick liquids diet.</li> <li>e. Resident 15 is on no added salt, puree, honey thick liquids diet.</li> <li>f. Resident 49 is on regular puree, regular liquids diet.</li> <li>g. Resident 44 is on regular puree, regular liquids, large portions diet.</li> </ul> <p>During a review of the facility's diet manual (DM) titled, Regular Pureed diet, dated 2023, the DM indicated, The pureed diet is a regular diet that has been designed for residents who have difficulty chewing and/or swallowing. The texture of the food should be of a smooth and moist consistency and able to hold its shape.</p> <p>50409</p>		

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p>28773</p> <p>Based on observation, interview, and record review, the facility failed to ensure:</p> <ol style="list-style-type: none"> <li>Food preferences were not accommodated for three of 64 sampled residents (Resident 12, Resident 23, and Resident 18) and;</li> <li>Options of similar nutritive value was served to residents who chose not to eat food that was on the menu for three of 64 sampled residents (Resident 31, Resident 51, Resident 34).</li> <li>One of seven sampled resident's (Resident 29) dislike of ham was not documented, and preference of potatoes was not documented or provided by kitchen staff on 8/19/24.</li> </ol> <p>These failures had the potential to result in residents to have decreased meal satisfaction and not meet their nutrition needs which can lead to unplanned weight changes.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>During an observation of the lunch meal service on 8/12/24 at 12:57 p.m. in the kitchen, Resident 23's meal tray had chocolate pudding.</li> </ol> <p>During a concurrent interview and record review on 8/14/24 at 12:57 p.m. with Dietary Aide (DA) 2, Resident 23's meal ticket (MT) indicated, Dislikes: Eggs, Fish, Meat, OTHER (No Chicken/Tofu), Coffee, Chocolate. DA 2 confirmed Resident 23 dislikes chocolate. DA 2 stated Resident 23 needed a different dessert.</p> <ol style="list-style-type: none"> <li>During an observation of the lunch meal service on 8/12/24 at 1:08 p.m. in the kitchen, Resident 18's meal tray had chocolate pudding.</li> </ol> <p>During a concurrent interview and record review on 8/14/24 at 1:08 p.m. with DA 4, Resident 18's MT indicated, Dislikes: Dessert (PUDDING). DA 4 confirmed Resident 18 dislikes pudding and the chocolate pudding was on her meal tray and should not have been.</p> <ol style="list-style-type: none"> <li>During an observation of the lunch meal service on 8/12/24 at 1:16 p.m. in the kitchen, Resident 12's meal tray had chocolate pudding.</li> </ol> <p>During a concurrent interview and record review on 8/12/24 at 1:16 p.m. with DA 4, Resident 12's MT indicated, Notes: Dislikes pudding. DA 4 confirmed Resident 12 dislikes pudding and the chocolate pudding was on her meal tray and should not have been.</p> <p>During an interview on 8/13/24 at 12:26 p.m. with the Certified Dietary Manager (CDM), the CDM stated he expects residents with dislikes to have alternatives.</p> <p>During a review of the facility's Resident Council Minutes (RCM), dated 5/29/24, the RCM indicated, Old business: Portion size, food preference.</p> <p>(continued on next page)</p>

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facility's RCM, dated 6/24/24, the RCM indicated, Old business: Portion size, food preferences. Dietary: Food continuously coming out late.</p> <p>During an interview on 8/14/24 at 2:44 p.m. with the Registered Dietitian (RD), the RD stated she expects the kitchen staff to follow the residents' food preferences.</p> <p>2. During a review of the facility's Summer Menus (SM), dated 8/13/24, the SM indicated, Curry Lemon Chicken, Garlic Rice, Peas w/ [with] Onions, Parsley Garnish, Wheat Roll, Margarine, Ice Cream, Milk for lunch.</p> <p>a. During an observation on 8/13/24 at 11:38 a.m. in the kitchen, Resident 31's meal tray had rice, chicken, wheat roll, and orange drink.</p> <p>During a review of Resident 31's MT, MT indicated, Dislikes: Vegetables (PEAS and CORN).</p> <p>b. During an observation on 8/13/24 at 11:43 a.m. in the kitchen, Resident 51's meal tray had chicken, rice, wheat roll, iced tea, and milk.</p> <p>During a review of Resident 51's MT, MT indicated, Dislikes: Vegetables (canned spinach, peas).</p> <p>c. During an observation on 8/13/24 at 11:44 a.m. in the kitchen, Resident 34's meal tray had chicken, rice, wheat roll, milk, and lemonade.</p> <p>During a review of Resident 34's MT, MT indicated, Dislikes: Vegetables (Peas).</p> <p>During an interview on 8/13/24 at 12:26 p.m. with the CDM, the CDM stated he expects residents who dislike peas would have alternative vegetables.</p> <p>During an interview on 8/14/24 at 2:44 p.m. with the RD, the RD stated she expects the kitchen staff to provide a different vegetable for those who do not like a vegetable on the menu.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Food Preferences, dated 2023, the P&amp;P indicated, Resident's food preferences will be adhered to within reason. Substitutes for all foods disliked will be given from the appropriate food group.</p> <p>48424</p> <p>3. During a review of Resident 29's Admission Record (AR- a document that provides resident contact details, a brief medical history, level of functioning, preferences, and wishes), dated 8/15/24, the AR indicated Resident 29 was admitted with the following diagnoses: diabetes mellitus (A disease which result in too much sugar in the blood), chronic kidney disease (when the kidneys have been damaged over time resulting in decreased function), vitamin D deficiency (vitamin deficiency that causes issues with your bones and muscles), and muscle weakness.</p> <p>(continued on next page)</p>		

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 29's Minimum Data Set (MDS- resident assessment tool which indicates physical and cognitive abilities), dated 5/16/24, the MDS indicated a Brief Interview for Mental Status (BIMS-an assessment of cognitive function) score of 15 (0-7 severe cognitive impairment, 8-12 moderate cognitive impairment, 13-15 no cognitive impairment), indicating Resident 29 had no cognitive impairment.</p> <p>During a concurrent observation and interview on 8/12/24 at 9:11 a.m. with Resident 29 in Resident 29's room, Resident 29's breakfast contained a slice of ham and no potatoes. Resident 29 stated he did not like ham and preferred to have potatoes in his meal. Resident 29 stated kitchen staff were aware of his food preference, and they did not provide it to him. Resident 29 stated he had communicated with kitchen staff about his preferences before. Resident 29 stated he would not eat his breakfast due to his preferences not being given to him.</p> <p>During an interview on 8/14/24 at 2:43 p.m. with the registered dietitian (RD), the RD stated residents were expected to receive their requested food preferences. The RD stated if food preferences were not provided, residents would not receive the therapeutic benefit of their meals.</p> <p>During an interview on 8/15/24 at 1:59 p.m. with registered nurse (RN) 1, RN 1 stated nursing staff and kitchen staff were responsible for ensuring food provided to the resident matched their wants and needs. RN 1 stated Resident 29 talked to kitchen staff about his preference himself, so it was the kitchen staff's responsibility to update his meal ticket. RN 1 stated it was important to update and document a resident's preference on their meal ticket in order to ensure residents received the food they actually wanted to eat.</p> <p>During a concurrent interview and record review on 8/15/24 at 3:21 p.m. with the certified dietary manager (CDM), Resident 29's meal ticket, undated, was reviewed. The meal ticket did not show any dislikes, or resident preferences listed. The CDM stated Resident 29's food preferences were not listed on his meal ticket. The CDM stated Resident 29 was upset as a result of not being provided his preferred food items. The CDM stated Resident 29 had communicated his preferences to him and his meal ticket had never been updated. The CDM stated Resident 29's preferences should have been documented upon his admission on 11/3/2021. The CDM stated it was his responsibility to update resident meal tickets with any preferences or dislikes. The CDM stated it was important to document meal preferences and dislikes because the facility was Resident 29's home and if he did not receive his preferred food he would not eat.</p> <p>During an interview on 8/16/24 at 10:40 a.m. with the director of nursing (DON) the DON stated, Resident 29 should have had his meal preferences documented. The DON stated it was important to document and provide Resident 29's preferences because he may skip out on his meals if his preferences weren't given to him.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Food Preference, dated 2023, indicated, . Resident's food preferences will be adhered to within reason . Food preferences will be obtained as soon as possible through the initial resident screen . Food preferences can be obtained from the resident . Updating of food preferences will be done as the resident's needs change and/ or during quarterly review.</p> <p>During a review of the facility's P&amp;P titled, Menu Planning, dated 2023, indicated, Menus are planned to consider: a. input received from residents .</p> <p>(continued on next page)</p>		

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>50409</p>

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<p>F 0810</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide special eating equipment and utensils for residents who need them and appropriate assistance.</p> <p>28773</p> <p>Based on observation, interview, and record review, the facility failed to ensure adaptive equipment was provided for one sampled resident (Resident 3) when Resident 3 was not provided a sippy cup on his meal tray.</p> <p>This failure had the potential to limit Resident 3's ability to drink independently and safely. The facility census was 75.</p> <p>Findings:</p> <p>During an observation on 8/13/24 at 12:04 p.m. in the kitchen, Resident 3's meal tray has two regular cups with no handle.</p> <p>During a review of Resident 3's meal ticket (MT), MT indicated, Adaptive Equip [equipment]: Sippy Cup.</p> <p>During an interview on 8/14/24 at 10:05 a.m. with Dietary Aide (DA) 2, DA 2 stated the kitchen does not have enough sippy cups to go on residents' meal trays.</p> <p>During an interview on 8/14/24 at 10:06 a.m. with DA 1, DA 1 stated the kitchen does not have enough sippy cups and regular cups so he would also use disposable cups.</p> <p>During a review of Resident 3's Order Summary Report (OSR), dated 8/14/24, the OSR indicated, Light up utensils and sippy cup to decrease spillage during meals.</p> <p>During an observation on 8/14/24 at 10:17 a.m. in Resident 3's room, there was a pitcher with straw and a coffee cup on the bedside table. There was no sippy cup at Resident 3's bedside.</p> <p>During an interview on 8/14/24 at 10:18 a.m. with Registered Nurse (RN) 1, RN 1 stated Resident 3 uses a sippy cup or a cup with a handle for all his drinks for safety. RN stated, We don't give him that [cups with no handles]. RN stated Resident 3 uses cups with a handle because he is on seizure precautions.</p> <p>During an interview on 8/14/24 at 11:13 a.m. with the Certified Dietary Manager (CDM), the CDM stated he expects the kitchen to provide sippy cups for adaptive equipment.</p> <p>During an interview on 8/14/24 at 1:58 p.m. with Certified Nursing Assistant (CNA) 5, CNA 5 stated he is the CNA for Resident 3, and he assisted Resident 3 with his meals. CNA 5 stated he had never seen Resident 3 use a sippy cup before. CNA 5 stated Resident 3 had a disposable cup with no handle on his meal tray. CNA 5 stated he is not aware of Resident 3 having an order for a sippy cup.</p> <p>(continued on next page)</p>		

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<p>F 0810</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's policy and procedure (P&amp;P) titled, Self-feeding Devices, dated 2023, the P&amp;P indicated, Devices commonly used . such as divider plates and feeding cups, will be kept in stock. A physician's order is recommended. The Food &amp; Nutrition Services Department will store self-feeding devices. Residents needing devices will receive them with each meal or snack, on their meal trays.</p> <p>50409</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48424</b></p> <p>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 three of seven residents (Resident 51, Resident 2 and Resident 22) when:</p> <ol style="list-style-type: none"> <li>1. Resident 51's name was spelled incorrectly on his Physician Order for Life Sustaining Treatment (POLST- a medical document which outlines a patient's preferences for end-of-life care).</li> </ol> <p>This failure resulted in inaccurate medical records being kept for Resident 51 and had the potential to cause confusion to staff who read his POLST form.</p> <ol style="list-style-type: none"> <li>2. Resident 2's copy of Physician Orders for Life-Sustaining Treatment (POLST) form was not signed and readily available as part of Resident 2's current medical records.</li> <li>3. Resident 22's copy of Physician Orders for Life-Sustaining Treatment (POLST) form was inaccurately dated when signed and readily available as part of Resident 22's current medical records.</li> </ol> <p>These failures had the potential risk for Residents' 2 and 22's decision regarding their healthcare and treatment options not being honored.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. During a review of Resident 51's Admission Record (AR- a document that provides resident contact details, a brief medical history, level of functioning, preferences, and wishes), dated 8/15/24, the AR indicated Resident 51 was admitted with the following diagnoses: heart failure (a condition that occurs when the heart can't pump enough blood to meet the body's needs), atrial fibrillation (condition which causes an irregular and often times a faster heartbeat), and muscle weakness.</li> </ol> <p>During an interview on 8/15/24 with certified nursing assistant (CNA) 11, CNA 11 stated POLST forms were present for every resident. CNA 11 stated POLST forms were important because they detailed what to do during situations like cardiac arrest (medical emergency characterized by when the heart stops beating). CNA 11 stated POLST forms needed to be accurate because they were a doctor's order and in the residents official medical record.</p> <p>During a concurrent interview and record review on 8/15/24 at 2:17 a.m. with registered nurse (RN) 1, Resident 51's POLST, dated 2/2/24 was reviewed. The POLST indicated Resident 51 had his last name spelled incorrectly. RN 1 stated the nurse who received the resident during their first admission was responsible for completing the POLST. RN 1 stated the nurse who filled out Resident 51's POLST form should have spelled his name correctly, the nurse should have looked at his identification or hospital forms to ensure the name was the same. RN 1 stated it was important to ensure the POLST had the correct spelling for Resident 51's last name because it was a medical record and it tells staff what treatment the specific resident needed for end of life care.</p> <p>(continued on next page)</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and record review on 8/15/24 at 9:36 a.m. with the medical records coordinator (MRC), Resident 51's POLST, dated 2/2/24 was reviewed. The POLST indicated Resident 51 had his last name spelled incorrectly. The MRC stated Resident 51's POLST form was documented incorrectly and was not accurate. The MRC stated Resident 51's last name should have been spelled correctly to ensure he had an accurate medical record. The MRC stated it was important to have accurate medical records, so staff know they treated the correct resident.</p> <p>During an interview on 8/16/24 at 10:40 a.m. with the director of nursing (DON), the DON stated the nurse who filled out Resident 51's POLST should have ensured the spelling of the name was accurate. The DON stated the MRC should have also reviewed the POLST for accuracy. The DON stated it was important to have an accurate POLST so staff could have been sure they took care of the correct resident.</p> <p>During a review of the facility's Medical Records Coordinator job description, dated 10/19/15, the job description indicated, . The Medical Records Coordinator maintains customer records containing all items required by State and Federal Regulation, and Reliant policies . 1. Maintain accurate order of open charts .</p> <p>During a review of the facility policy and procedure (P&amp;P) titled, Charting and Documentation, dated 1/18, indicated, 3. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate .</p> <p>40641</p> <p>Findings:</p> <p>2. During a review of Resident 2's Admission Record, (AR-document containing resident profiles) dated 8/15/24, the AR indicated, Resident 2 was readmitted to the facility on [DATE] with diagnoses which included convulsions (a medical condition that causes a person's muscles to contract and relax rapidly and repeatedly, resulting in uncontrolled shaking) and hyperlipidemia (high lipid levels in the blood).</p> <p>3. During a review of Resident 22's AR dated 8/15/24, the AR indicated, Resident 22 was readmitted to the facility on [DATE] with diagnoses which included Chronic Obstructive Pulmonary Disease (COPD- common lung disease causing restricted airflow and breathing problems) anemia (not enough healthy red blood cells) and chronic pain.</p> <p>During a concurrent interview and record review on 8/15/24 at 8:19 a.m. with Medical Record (MR) person, the MR person stated she was responsible in making sure resident records are accurate and complete. Resident 2's POLST form was reviewed, MR person stated no signature on Section D for patient or legally recognized decision maker. MR person stated the POLST form is not a complete document because there is no signature of resident or decision maker. MR person stated admission nurse and licensed nurses are responsible in making sure there was signature. MR person stated she was responsible in making sure the POLST form was complete.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and record review on 8/15/24 at 8:24 a.m. with MR person, Resident 22's POLST form was reviewed, MR person stated the POLST form of Resident 22 was not accurate. MR person stated the date when the POLST form was completed was 1/4/24 and the date physician signed was 1/4/23. MR person stated the POLST form was completed and came from general acute care hospital (GACH). MR person stated, . I did not checked the documents closely prior to scanning into the computer. MR person stated they could have completed a new one that was complete and accurate.</p> <p>During an interview on 8/16/24 at 2:35 p.m. with the Director of Nursing (DON), the DON stated the IDT (interdisciplinary team- group of health professionals from different disciplines who work together to treat a patient's condition or diagnosis) reviews resident records when admitted or readmitted back in the facility. The DON stated Resident 2 and 22's POLST forms were inaccurate and incomplete.</p> <p>During an interview on 8/16/24 at 3:35 p.m. with the Administrator (ADM), the ADM stated POLST forms needed to be accurate and complete before they are scanned in the computer system. The ADM stated, . Medical Records person should be checking records more closely to ensure accurateness of records before it is put in the system .</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled Physician Order for Life Sustaining Treatment, dated 3/21 indicated, . A completed, fully executed POLST is a physician order, and is immediately actionable . The POLST will be reviewed by the facility interdisciplinary team during the quarterly care planning conference .</p> <p><a href="https://www.[NAME]-[NAME].org/programs/support-services/services/healthcare-ethics/polst.html">https://www.[NAME]-[NAME].org/programs/support-services/services/healthcare-ethics/polst.html</a>, .The POLST form is completed by a patient ' s physician (or by someone who has undergone special training about POLST and who works with the patient ' s physician) in conjunction with thorough conversation with the patient regarding the patient ' s current and future health conditions and treatment preferences. Both the physician and patient must sign the POLST. If the patient lacks capacity to make medical decisions, the patient ' s legally recognized decision-maker can participate in both completing and signing the POLST form .</p>		

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  08/16/2024
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>48424</p> <p>Based on Observation, interview, and record review the facility failed to provide a sanitary environment to help prevent the development and transmission of communicable diseases and infections for two of seven residents (Resident 61 and Resident 238) when Certified Nursing Assistant (CNA) 1 did not perform hand hygiene (process of washing or disinfecting hands to prevent the spread of germs) after leaving the shared room of Resident 61 and Resident 238, while carrying a bag of soiled (dirty or contaminated) linen. CNA 1 then moved the linen cart without performing hand hygiene.</p> <p>This failure had the potential to contaminate the surface of the linen cart and cause cross contamination (when germs move from one area to another) of other surfaces.</p> <p>Findings:</p> <p>During an observation on 8/12/24 at 10:47 a.m. outside of Resident 61 and Resident 238's room, CNA 1 exited Resident 61 and Resident 238's room carrying a bag of soiled linen. CNA 1 disposed of the soiled linen bag and did not perform hand hygiene after; CNA 1 then pushed the linen cart forward without performing hand hygiene.</p> <p>During an interview on 8/12/24 at 3:50 p.m. with CNA 1, CNA 1 stated he came out of Resident 61 and Resident 238's room to dispose of the soiled linen and pushed the linen cart forward without performing hand hygiene after. CNA 1 stated he should have performed hand hygiene before moving the linen cart. CNA 1 stated hand hygiene was important to prevent the spread of germs across surfaces.</p> <p>During an interview on 8/14/24 at 2:35 p.m. with CNA 5, CNA 5 stated all staff were supposed to perform hand hygiene anytime they entered or exited a resident room. CNA 5 stated staff were not supposed to touch any surfaces until after they did hand hygiene. CNA 5 stated if a staff member needed to dispose of something they should have disposed of the item and then performed hand hygiene afterwards, before touching any surface. CNA 5 stated it was important to perform hand hygiene because it prevented cross contamination of other surfaces.</p> <p>During an interview on 8/15/23 at 3:45 p.m. with the infection preventionist (IP), the IP stated CNA 1 should have conducted hand hygiene before moving the linen cart after he disposed of the soiled linen from Resident 61 and Resident 238's room. The IP stated all staff members were supposed to do hand hygiene before they touched any surface because it helped keep the equipment and facility clean.</p> <p>During an interview on 8/16/24 at 9:17 a.m. with the director of staff development (DSD), the DSD stated CNA 1 should have conducted hand hygiene before moving the linen cart after he disposed of the soiled linen from Resident 61 and Resident 238's room. The DSD stated performing hand hygiene was important because it helped prevent the spread of infections.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 8/16/24 at 10:40 a.m. with the director of nursing (DON), the DON stated CNAs were supposed to perform hand hygiene anytime they came out of rooms or came in contact with dirty linens. The DON stated if dirty materials were being disposed of staff should have done hand hygiene after their disposal. The DON stated if staff did not perform hand hygiene, they could have carried infections with them on their hands and they could potentially spread it to others.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Handwashing, undated, the P&amp;P indicated, . All staff members will wash their hands before and after direct resident care and after contact with potentially contaminated substances to prevent, to the extent possible, the spread of nosocomial (sickness a person receives when the stay in a facility) infections .</p>

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<p>F 0912</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms.</p> <p>41608</p> <p>Based on observation and interview, the facility failed to provide the minimum of at least 80 square feet per resident in 17 resident bedrooms (Rooms 4, 5, 6, 7, 8, 9, 10, 11, 12, 14, 15, 16, 17, 18, 19, 20 and 21) when there were two residents in rooms which did not meet the square footage requirement.</p> <p>This failure had the potential to place residents at risk for not having sufficient space to accommodate residents' needs, privacy, and comfort.</p> <p>Findings:</p> <p>During a concurrent observation and interview on 8/16/24 at 11:05 a.m. with the Maintenance Supervisor (MS), facility tour was conducted. MS stated the rooms failed to provide the minimum square footage as required by regulation. Room variations were in accordance with the particular needs of the residents. The residents had a reasonable amount of privacy. Closets and storage space were adequate. Bedside stands were available. There was sufficient room for nursing care and for residents to ambulate. Wheelchairs and toilet facilities were accessible. The waiver will not adversely affect the health and safety of residents.</p> <p>Room Number Square Feet Number of Residents</p> <p>4 142.2 2</p> <p>5 142.1 2</p> <p>6 143.2 2</p> <p>7 140.97 2</p> <p>8 142.1 2</p> <p>9 142.1 2</p> <p>10 142.1 2</p> <p>11 142.1 2</p> <p>12 142.1 2</p> <p>14 142.1 2</p> <p>15 142.2 2</p> <p>16 142.1 2</p> <p>(continued on next page)</p>

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F 0912  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	17 141.7 2  18 142.1 2  19 142.2 2  20 142.2 2  21 142.1 2  Recommend waiver continue in effect.  -----  Health Facilities Evaluator Nurse Date  Request waiver continue in effect.  -----  Facility Administrator Date

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41608</b></p> <p>Based on observation, interview, and record review, the facility failed to provide a sanitary, comfortable environment for four of 31 sampled residents (Resident 11, Resident 22, Resident 47 and Resident 60), when the smell of urine was noted in room [ROOM NUMBER] and hallway.</p> <p>This failure had the potential for Resident 11, 22, 47 and 60, to experience an uncomfortable environment.</p> <p>Findings:</p> <p>During an observation on 8/12/24 at 8:15 a.m. in the hall outside of rooms [ROOM NUMBERS], a strong urine odor was noted.</p> <p>During an observation in 8/12/24 at 8:20 a.m. with Resident 11 in room [ROOM NUMBER], there was a strong urine odor in the room. Resident 11 was sitting up in his bed, eating his breakfast. The privacy curtain was pulled between Resident 11's bed and Resident 60's bed.</p> <p>During an observation on 8/12/24 at 11:55 a.m. in the hall outside of room [ROOM NUMBER] and, a strong urine odor was noted.</p> <p>During an observation and interview on 8/12/24 at 1:15 p.m. with Resident 11</p> <p>in his room, Resident 11 stated, .I have a headache from the strong smell of urine in this room .</p> <p>During an observation on 8/13/24 at 9:00 a.m. in the hall outside of rooms [ROOM NUMBERS], a strong odor of urine was noted.</p> <p>During an observation on 8/13/24 at 3:41 p.m. in the hall between resident rooms [ROOM NUMBERS], a strong odor of urine was noted.</p> <p>During an observation on 8/14/24 at 10:55 a.m. in the hall between room [ROOM NUMBER] and 16, a strong odor of urine was noted.</p> <p>During a concurrent observation and interview on 8/16/24 at 10:15 a.m. with the Infection Preventionist (IP), in room [ROOM NUMBER], the IP stated, .the smell of urine is very strong as if it was in the walls and floor . the smell is not acceptable for the residents in this room .</p> <p>During a concurrent observation and interview on 8/16/24 at 10:14 a.m. in room [ROOM NUMBER] with the Activities Coordinator (AC), the AC stated, . the room smells like urine . I would not want to stay in the room . this is not a homelike environment .</p> <p>During an interview on 8/16/24 at 10:30 p.m. in room [ROOM NUMBER] with the Maintenance Supervisor (MS), the MS stated, . the room has been deep cleaned twice and the odor of urine is still present . I would not want to live in this room .</p> <p>(continued on next page)</p>

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 8/16/24 at 3:15 p.m. with the Administrator (ADM), the ADM stated, room [ROOM NUMBER] was cleaned twice and the odor was still present. The ADM stated he thought the odor was trapped in the laminate flooring. The ADM stated, the residents should not have to be in a room that smells like urine.</p> <p>During a review of Resident 11's Admission Record [AR], dated 8/16/24, the AR indicated, Resident 11 was admitted on [DATE] with diagnosis of Muscle Weakness, History of Falling, Chronic Pain, and Cancer of the Left Kidney.</p> <p>During a review of Residents 11's Minimum Data Set (MDS- a resident assessment tool used to identify resident cognitive and physical function) Section C assessment dated [DATE], indicated Resident 8's Brief Interview of Mental status assessment (BIMS - assessment of cognitive status for memory and judgement) scored 15 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, 00-07 indicates severe impairment and 99 indicates they are unable to complete the interview). The BIMS assessment indicated Resident 15 had no cognitive impairment.</p> <p>During a review of Resident 22's AR dated 8/15/24, the AR indicated Resident 22 admitted on [DATE] with diagnosis of Heart Failure, Dysphagia (difficulty swallowing, Chronic Pain, Anxiety (feeling of fear, dread, uneasiness as a result to stress), and Depression (a persistent feeling of sadness, loss of interest in activities).</p> <p>During a review of Resident 22's MDS Section C indicated, Resident 22 had a BIMS score of 14, no cognitive impairment.</p> <p>During a review of Resident 47's AR dated 8/15/24, the AR indicated Resident 47 admitted on [DATE] with diagnosis of Muscle Weakness, Difficulty Walking, Alcohol Abuse and Anxiety.</p> <p>During a review of Resident 47's MDS Section C indicated, Resident 47 had a BIMS score of 7, moderate cognitive impairment.</p> <p>During a review of Resident 60's AR dated 8/15/24, the AR indicated Resident 60 admitted on 1 with diagnosis of Cognitive Communication Deficit, History of Falling, and Muscle Weakness. m</p> <p>During a review of Resident 60's MDS Section C indicated, Resident 60 had a BIMS score of 11, moderate cognitive impairment.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Quality of Life - Homelike Environment dated 1/2018, the P&amp;P indicated, .a. clean, sanitary, and orderly environment . f. pleasant neutral scents .</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>28773</p> <p>Based on observation, interview, and record review, the facility failed to maintain an effective pest control program when cockroaches were found in the facility kitchen and hallway.</p> <p>This failure had the potential to result in residents, staff, and visitors to contract diseases caused by pests. The facility census was 75.</p> <p>Findings:</p> <p>During a concurrent observation and interview on 8/12/24 at 10:31 a.m. with Dietary Aide (DA) 2 in the kitchen, there was a cockroach crawling on the wall at the dish machine area. DA 2 confirmed she saw the cockroach. DA 2 stated the kitchen had issues with cockroaches in the past.</p> <p>During an observation on 8/12/24 at 10:32 a.m. in the kitchen, there was a cockroach crawling on the floor by the handwashing station.</p> <p>During an observation on 8/12/24 at 10:34 a.m. in the kitchen, there was a cockroach crawling on the floor under the food preparation table, near the three-compartment sink.</p> <p>During an interview on 8/12/24 at 10:40 a.m. with the Certified Dietary Manager (CDM), the CDM stated the kitchen staff told him there has been issues with cockroaches in the kitchen.</p> <p>During a concurrent observation and interview on 8/13/24 at 10:24 a.m. with Resident 30 in Station 2 hallway by the shower room, there was a cockroach crawling on the floor. Resident 30 stated he saw the cockroach and he has been seeing cockroaches often in the facility.</p> <p>During a concurrent observation and interview on 8/13/24 at 10:25 a.m. with the Maintenance Supervisor (MS) in Station 2 hallway, the cockroach crawled into a crack on the shower room floor. The MS stated he saw where the cockroach went on the shower room floor and stated he would need to seal that up.</p> <p>During an observation on 8/13/24 at 12:13 p.m. in Station 2 shower room, there was a cockroach crawling on the floor.</p> <p>During an interview on 8/13/24 at 12:37 p.m. with the Pest Control Technician (PCT), the PCT stated he is the pest control technician that services the facility. The PCT stated he had been to the facility twice in July and June. PCT stated he had made recommendations to seal cracks in the corners of the kitchen at the dish machine area, but he is not sure if it had been done.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Pest Control, dated January 2018, the P&amp;P indicated, This facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents.</p> <p>50409</p>		