

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555900	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025
NAME OF PROVIDER OR SUPPLIER Veterans Home of California - Fresno		STREET ADDRESS, CITY, STATE, ZIP CODE 2811 W Cesar Chavez Blvd 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 - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51978</p> <p>Based on observation, interview, and record review, the facility failed to enhance one of 26 sampled residents (Resident 68) quality of life, when Resident 68 qualification assessment for power wheelchair request was not provided.</p> <p>This failure resulted in a violation of Resident 68's Rights and had the potential to negatively impact the resident's quality of life.</p> <p>Findings:</p> <p>During a review of the Resident 68's Demographics (Face Sheet), the Face Sheet indicated Resident 68 was admitted to the facility on [DATE] with diagnoses which included Parkinson (disorders that affect movement, balance, and coordination).</p> <p>During an interview on 2/25/2025 at 8:55 a.m. with Resident 68, Resident 68 stated he frequently participated in completing the puzzles in the common area, near his room; however, he has had difficulty with movement around puzzle table due to limitations in manual wheelchair. Resident 68 stated he had been requesting an assessment for a power wheelchair, and had not received an assessment.</p> <p>During an interview on 2/26/2025 at 2:22 p.m. with Restorative Nursing Assistant (RNA), RNA stated Resident 68 requested an assessment for power wheelchair approximately one month ago during a session with her. RNA stated she spoke to a staff member in the Physical Therapy department about Resident 68's request, but did not remember who she spoke to.</p> <p>During a concurrent interview and record review on 2/26/2025 at 3:17 p.m. with Occupational Therapist (OT), OT stated Occupational Therapy department performed resident qualification assessments for power wheelchairs. OT stated Occupational Therapy department received referral form with resident's request for assessment from nursing department, and OT arranged for assessment to be performed with the resident. OT confirmed there was no referral form for assessment for power wheelchair for Resident 68. There was no evidence of an assessment conducted by the OT staff found in Resident 68's clinical record.</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 - Few</p>	<p>During a concurrent observation and interview on 2/27/2025 at 9:31 a.m. with Resident 68, Resident 68 was observed pushing himself in manual wheelchair with some difficulty and at a very slow pace. Resident 68 stated a power wheelchair would have made it easier, quicker to move around and less of a hassle to attend and participate in activities.</p> <p>During an interview on 2/27/2025 at 12:28 p.m. with Director of Nursing Services (DON), DON stated the RNA should have communicated Resident 68's request to the licensed nurse for a follow up.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>50852</p> <p>Based on observation, interview and record review, the facility failed to meet professional standards of quality for three of 26 sampled residents (Residents 77, 51 and 47) when:</p> <ol style="list-style-type: none"> 1. Resident 77, Diltiazem, Lisinopril and Metoprolol (Treatment for Heart/Blood pressure) medications were administered to the resident without checking the blood pressure/ heart rate as per physician's orders. 2. Resident 51, Alfuzosin (prostate medication) was administered without food as per physician's orders. 3. Resident 47, Novolog insulin (Treatment for blood sugar) was administered via ASPART insulin flexpen without priming the medication as per the manufacturer's instructions . <p>These deficient practices had the potential to adversely affect the residents' medical health condition.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During a review of the clinical record for Resident 77, the physician order dated 10/30/2024, indicated Diltiazem (heart/ blood pressure medication) capsule 360 mg (milligram - unit of measure) ER (extended release), take one (1) tablet by mouth daily, hold for SBP (systolic blood pressure) less than 90. <p>During a concurrent medication pass observation and interview on 2/26/2025 at 7:11 a.m. with Licensed Vocational Nurse (LVN) 2 , LVN 2 administered Diltiazem 360 mg ER to Resident 77 orally without checking Resident 77's blood pressure. There was no evidence to indicate that LVN 2 took the resident's blood pressure prior to the medication administration during the medication pass observation.</p> <p>During an interview on 2/26/2025 at 2:10 p.m. with Director of Nursing Services (DON), DON stated the licensed nurse should have taken the resident's blood pressure, right before the medication administration.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Medication Treatment Administration dated 1/17/2025, P&P indicated, . Tests and taking of vital signs, upon which administration of medications or treatments are conditioned, will be performed as required .</p> <p>During a review of the clinical record for Resident 77, the physician order dated 10/30/2024 indicated, Lisinopril (blood pressure medication) tab 10 mg (milligram), take one (1) tablet by mouth daily. Hold if SBP [Systolic Blood pressure] less than 110; or HR [Heart rate] less than 60.</p> <p>During a concurrent medication pass observation and interview on 2/26/2025 at 7:11 a.m. with LVN 2, LVN 2 administered Lisinopril 10 mg orally to Resident 77 without checking Resident 77's blood pressure and heart rate. There was no evidence to indicate that LVN 2 took the resident's blood pressure and heart rate prior to the medication administration during the medication pass observation.</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 - Some</p>	<p>During an interview on 2/26/2025 at 2:10 p.m. with the DON, DON stated the licensed nurse should take the heart rate and blood pressure right before the medication administration.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Medication Treatment Administration dated 1/17/2025, P&P indicated, . Tests and taking of vital signs, upon which administration of medications or treatments are conditioned, will be performed as required .</p> <p>During a review of the clinical record for Resident 77, the physician order dated 12/1/2024 indicated, Metoprolol suc [succinate] [heart/ blood pressure medication] tablet 25 mg (milligram) ER, take one (1) tablet by mouth daily, HOLD if heart [rate] less than 50.</p> <p>During a concurrent medication pass observation and interview on 2/26/2025 at 7:11 a.m. with LVN 2 , LVN 2 administered Metoprolol 25 mg ER to Resident 77 without checking Resident 77's heart rate. There was no evidence to indicate that LVN 2 took the resident's blood pressure or heart rate prior to the medication administration during the medication pass observation.</p> <p>During an interview on 2/26/2025 at 2:10 p.m. with the DON, DON stated the licensed nurse should take the heart rate and blood pressure right before the medication administration.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Medication Treatment Administration dated 1/17/2025, P&P indicated, . Tests and taking of vital signs, upon which administration of medications or treatments are conditioned, will be performed as required .</p> <p>2. During a review of the clinical record for Resident 51, the physician order dated on 6/20/2024 indicated, Alfuzosin tablet 10 mg (milligram) ER, take one (1) tablet by mouth daily with food for BPH [Benign prostate hypertrophy].</p> <p>During a medication pass observation on 2/26/2025 at 7:50 a.m. with Registered Nurse (RN) 1, RN 1 administered Alfuzosin 10 mg ER orally to Resident 51 without food.</p> <p>During a review of the facility's policy and procedures (P&P) titled, Medication Treatment Administration dated 1/17/2025, P&P indicated, Medications that are ordered in relation to meals are administered as follows: . B. WITH MEALS - Administer during meal and up to 30 minutes after meal time.</p> <p>3. During a medication pass observation on 2/26/2025 at 11:37 a.m. with LVN 3, LVN 3 administered 9 units of Novolog insulin subcutaneously (injection into fat layer under skin) via an ASPART insulin flexpen (device used to inject insulin medication) to Resident 47's abdomen without visualizing a drop from priming the device.</p> <p>During an interview on 2/26/2025 at 4:10 p.m. with DON, DON stated that the insulin flexpen needs to be primed with two units before administration.</p> <p>During a review of the manufacturer's instructions titled Patient Information Insulin Aspart under Giving the Airshot before each injection, it indicated Before each injection small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure proper dosing . A drop of insulin should appear at the needle tip. If not, change the needle and repeat the procedure no more than 6 times. If you do not see a drop of insulin after 6 times, do not use the Insulin Aspart Flexpen .</p>

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<p>F 0675</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor each resident's preferences, choices, values and beliefs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51978</p> <p>Based on observation, interview and record review, the facility failed to provide necessary services for one of 26 sampled residents (Resident 68) to maintain highest practicable physical and psychosocial well-being, when Resident 68 request for qualification assessment for power wheelchair was not fulfilled.</p> <p>This failure had the potential to result in a decline of Resident's 68 physical and psychosocial well-being.</p> <p>Findings:</p> <p>During a review of the Resident 68's Demographics (Face Sheet), the Face Sheet indicated Resident 68 was admitted to the facility on [DATE] with diagnoses which included Parkinson (disorders that affect movement, balance, and coordination).</p> <p>During a review of Resident 68's Physician's Monthly Orders, dated February 2025, the physician's orders indicated, Resident 68 had the capacity to make own healthcare decisions.</p> <p>During a review of Resident 68's Minimum Data Set (MDS-an assessment care-planning tool), dated 2/11/2025, the MDS indicated, Resident 68 had the ability to understand others and make himself understood by others.</p> <p>During an interview on 2/25/2025 at 8:55 a.m. with Resident 68, Resident 68 stated he frequently participated in completing the puzzles in the common area near his room; however, he has had difficulty with movement around puzzle table due to limitations in manual wheelchair. Resident 68 stated he had been requesting an assessment for a power wheelchair and had not received an assessment.</p> <p>During an interview on 2/26/2025 at 2:22 p.m. with Restorative Nursing Assistant (RNA), RNA stated Resident 68 requested an assessment for power wheelchair approximately one month ago during a session with her. RNA stated she spoke to a staff member in the Physical Therapy department about Resident 68's request, but did not remember who she spoke to.</p> <p>During a concurrent interview and record review on 2/26/2025 at 3:17 p.m. with Occupational Therapist (OT), OT stated Occupational Therapy department performed resident qualification assessments for power wheelchairs. OT stated Occupational Therapy department received referral form with resident's request for assessment from nursing department, and OT arranged for assessment to be performed with the resident. OT confirmed there was no referral form for assessment for power wheelchair for Resident 68. There was no evidence of an assessment conducted by the OT staff found in Resident 68's clinical record.</p> <p>During a concurrent observation and interview on 2/27/2025 at 9:31 a.m. with Resident 68, Resident 68 was observed pushing himself in manual wheelchair with some difficulty and at a very slow pace. Resident 68 stated a power wheelchair would have made it easier, quicker to move around, and less of a hassle to attend and participate in activities.</p> <p>(continued on next page)</p>		

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<p>F 0675</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/27/2025 at 12:28 p.m. with Director of Nursing Services (DON), DON stated the RNA should have communicated Resident 68's request to the licensed nurse for a follow up.</p>

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>50852</p> <p>Ensure medication error rates are not 5 percent or greater.</p> <p>Based on observation, interview, and record review, the facility failed to ensure the facility medication error rate did not exceed five percent (5%) or greater during the medication pass observation for three of 26 sampled residents (Residents 77, 51 and 47) when:</p> <ol style="list-style-type: none"> 1. Resident 77, Diltiazem, Lisinopril and Metoprolol (Treatment for Heart/Blood pressure) medications were administered to the resident without checking the blood pressure/ heart rate. 2. Resident 51, Alfuzosin (Prostate medication) was administered without food. 3. Resident 47, Novolog insulin (Treatment for blood sugar) was administered via ASPART insulin flexpen without priming the medication. <p>The facility had a cumulative medication error rate of 15.15% consisting of five errors out of 33 opportunities. These deficient practices had the potential to adversely affect the residents' medical health condition.</p> <p>Findings:</p> <p>1. During a review of the clinical record for Resident 77, the physician order dated 10/30/2024, indicated Diltiazem (heart/ blood pressure medication) capsule 360 mg (milligram - unit of measure) ER (extended release), take one (1) tablet by mouth daily, hold for SBP (systolic blood pressure) less than 90.</p> <p>During a concurrent medication pass observation and interview on 2/26/2025 at 7:11 a.m. with Licensed Vocational Nurse (LVN) 2 , LVN 2 administered Diltiazem 360 mg ER to Resident 77 orally without checking Resident 77's blood pressure. There was no evidence to indicate that LVN 2 took the resident's blood pressure prior to the medication administration during the medication pass observation.</p> <p>During an interview on 2/26/2025 at 2:10 p.m. with Director of Nursing Services (DON), DON stated the licensed nurse should have taken the resident's blood pressure, right before the medication administration.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Medication Treatment Administration dated 1/17/2025, P&P indicated, . Tests and taking of vital signs, upon which administration of medications or treatments are conditioned, will be performed as required .</p> <p>During a review of the clinical record for Resident 77, the physician order dated 10/30/2024 indicated, Lisinopril (blood pressure medication) tab 10 mg (milligram), take one (1) tablet by mouth daily. Hold if SBP [Systolic Blood pressure] less than 110; or HR [Heart rate] less than 60.</p> <p>During a concurrent medication pass observation and interview on 2/26/2025 at 7:11 a.m. with LVN 2, LVN 2 administered Lisinopril 10 mg orally to Resident 77 without checking Resident 77's blood pressure and heart rate. There was no evidence to indicate that LVN 2 took the resident's blood pressure and heart rate prior to the medication administration during the medication pass observation.</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 - Some</p>	<p>During an interview on 2/26/2025 at 2:10 p.m. with the DON, DON stated the licensed nurse should take the heart rate and blood pressure right before the medication administration.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Medication Treatment Administration dated 1/17/2025, P&P indicated, . Tests and taking of vital signs, upon which administration of medications or treatments are conditioned, will be performed as required .</p> <p>During a review of the clinical record for Resident 77, the physician order dated 12/1/2024 indicated, Metoprolol suc [succinate] [heart/ blood pressure medication] tablet 25 mg (milligram) ER, take one (1) tablet by mouth daily, HOLD if heart [rate] less than 50.</p> <p>During a concurrent medication pass observation and interview on 2/26/2025 at 7:11 a.m. with LVN 2 , LVN 2 administered Metoprolol 25 mg ER to Resident 77 without checking Resident 77's heart rate. There was no evidence to indicate that LVN 2 took the resident's blood pressure or heart rate prior to the medication administration during the medication pass observation.</p> <p>During an interview on 2/26/2025 at 2:10 p.m. with the DON, DON stated the licensed nurse should take the heart rate and blood pressure right before the medication administration.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Medication Treatment Administration dated 1/17/2025, P&P indicated, . Tests and taking of vital signs, upon which administration of medications or treatments are conditioned, will be performed as required .</p> <p>2. During a review of the clinical record for Resident 51, the physician order dated on 6/20/2024 indicated, Alfuzosin tablet 10 mg (milligram) ER, take one (1) tablet by mouth daily with food for BPH [Benign prostate hypertrophy].</p> <p>During a medication pass observation on 2/26/2025 at 7:50 a.m. with Registered Nurse (RN) 1, RN 1 administered Alfuzosin 10 mg ER orally to Resident 51 without food.</p> <p>During a review of the facility's policy and procedures (P&P) titled, Medication Treatment Administration dated 1/17/2025, P&P indicated, Medications that are ordered in relation to meals are administered as follows: . B. WITH MEALS - Administer during meal and up to 30 minutes after meal time.</p> <p>3. During a medication pass observation on 2/26/2025 at 11:37 a.m. with LVN 3, LVN 3 administered 9 units of Novolog insulin subcutaneously (injection into fat layer under skin) via an ASPART insulin flexpen (device used to inject insulin medication) to Resident 47's abdomen without visualizing a drop from priming the device.</p> <p>During an interview on 2/26/2025 at 4:10 p.m. with DON, DON stated that the insulin flexpen needs to be primed with two units before administration.</p> <p>During a review of the manufacturer's instructions titled Patient Information Insulin Aspart under Giving the Airshot before each injection, it indicated Before each injection small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure proper dosing . A drop of insulin should appear at the needle tip. If not, change the needle and repeat the procedure no more than 6 times. If you do not see a drop of insulin after 6 times, do not use the Insulin Aspart Flexpen .</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>51225</p> <p>Based on observations, interview, and record review, the facility failed to store and serve food in accordance with professional standards for food service safety when the fryer had a build-up of grease on the wheels and on the compartment underneath. The tile floor in front of the cooking line was missing grout between the tiles and it had a black build-up of food and grease. The floor under the center island of the cooking line had a build-up of black grime and old food.</p> <p>This failure resulted in the potential for food to be contaminated and cause food borne illness in 98 of 98 medically compromised residents who received food from the kitchen.</p> <p>Findings:</p> <p>During a concurrent observation and interview on 2/24/2025 at 9:40 a.m., with the Dietary Director (DD), in the main kitchen, the fryer had a build-up of yellow grease on the wheels and in the compartment underneath. The DD stated the fryer should be cleaned more often to prevent grease build-up. In the same area there was a compartment that housed the gas lines and inside this area there was black grease build-up. The DD stated it should be kept clean. On the floor in front of the cooking line (fryer, stove top, griddle), the tiles were missing the white grout and between the tiles was a build-up of grime and grease. The floor under the center island of the cooking area had a build-up of black grime and old food. The DD stated it was difficult for them to keep the floor under this island clean.</p> <p>During an interview on 2/24/2025 at 2:15 p.m. with DD, DD stated maintenance strips and cleans (deep cleaning of flooring) main kitchen floor once a quarter. DD stated deep cleaning should have been done more often.</p> <p>During an interview on 2/24/2025 at 2:30 p.m. with Director Plant Operations II (DPO), DPO stated a contract request had been filed on 12/11/24 for a complete rehaul of the tile flooring in the main kitchen. DPO stated it was a six-month process requiring approval, in the meantime he could have the grout redone in this area where there is build-up of grease in between the tiles but he was not aware it was an issue. The dietary team did not inform him.</p> <p>During an interview on 2/26/2025 at 10:30 a.m., with DD, DD stated her expectation was the fryer should be cleaned daily to prevent build-up. DD stated she should have had the cabinet next to the stove that housed the gas lines on the cleaning schedule.</p> <p>During a review of Cooks Cleaning List AM's, dated 2/16/2025 through 2/23/2025, the Cooks Cleaning List AM's indicated Prep area - wipe down all prep tables and prep sink. Clean stove. Clean floor drains, clean ovens, inside and outside, Sweep and mop floor.</p> <p>During a review of facilities policy and procedure (P&P) titled, Food & Nutrition Services - Sanitation (All Homes), dated 8/7/2024, the P&P indicated, Kitchen and serving area will be kept clean, free from litter and rubbish . floors . will be kept clean and maintained in good repair (i.e. free from breaks, corrosion, holes, cracks, chips, dirt, and/or grime).</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p>	<p>During a review of Food Code, U.S. Food and Drug Administration 4-601.11 (C), dated 2022, the Food Code, U.S. Food and Drug Administration 4-601.11 (C) indicated Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris . to remove soil from nonfood contact surfaces so that pathogenic microorganisms (disease causing bugs or fungus) will not be allowed to accumulate, and insects and rodents will not be attracted.</p> <p>During a review of Food Code, U.S. Food and Drug Administration 4-602.13, dated 2022, the Food Code, U. S. Food and Drug Administration 4-602.13 indicated, Nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues . Hard-to-clean areas could result in the attraction and harborage of insects and rodents and allow the growth of foodborne pathogenic microorganisms.</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>51978</p> <p>Based on interview and record review, the facility failed to maintain accurate and systematically organized medical records for two of 26 sampled residents (Resident 68 and Resident 550) when:</p> <ol style="list-style-type: none"> 1. Resident 68's Restorative Nurses Aid-Weekly Notes documentation had incorrect dates. 2. Resident 550's medical chart contained Physician Progress Notes belonging to another resident. <p>These failures had the potential to result in inaccurate clinical records.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During a concurrent interview and record review on 2/26/2025 at 2:22 p.m. with Restorative Nursing Assistant (RNA), Resident 68's Restorative Nurses Aide-Weekly Notes (RNA-Weekly Notes), dated February 2025, were reviewed. The RNA-Weekly Notes indicated, restorative nursing aide staff notations for February 2025 sessions with the following session dates documented: 1/4/25, 1/6/25, 1/11/25, 1/13/25, 1/17/25, 11/20/25, and 11/23/25. RNA confirmed RNA-Weekly Notes was for February 2025. RNA stated the dates were written incorrectly. <p>During a review of the facility's Policy and Procedure (P&P) titled, Documentation Principles, dated 10/15/2024, the P&P indicated, Staff will follow facility documentation principles and record keeping practices to ensure that resident health records are current and kept in detail consistent with good medical and professional practice . These records will be complete, accurately documented, readily accessible, systematically organized .</p> <ol style="list-style-type: none"> 2. During a concurrent interview and record review on 2/26/2025 at 4:11 p.m. with Quality Registered Nurse (QRN), Resident's 550's clinical record was reviewed. A progress note belonging to another resident was found in Resident 550's clinical record. The QRN confirmed the progress note was not Resident 550's. <p>During a review of the facility's Policy and Procedure (P&P) titled, Documentation Principles, dated 10/15/2024, the P&P indicated, Staff will follow facility documentation principles and record keeping practices to ensure that resident health records are current and kept in detail consistent with good medical and professional practice . These records will be complete, accurately documented, readily accessible, systematically organized .</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555900	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025
NAME OF PROVIDER OR SUPPLIER Veterans Home of California - Fresno		STREET ADDRESS, CITY, STATE, ZIP CODE 2811 W Cesar Chavez Blvd 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 - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50148</p> <p>Based on observation, interview, and record review, the facility failed to follow their infection control policy for one of seven sampled residents (Resident 65) when staff did not wear gowns prior to high care activity to Resident 65 who had indwelling foley catheter (a thin tube inserted into the bladder to drain urine) and was in Enhanced Barrier Precaution (EBP - an infection control strategy where staff wears gowns and gloves in high care activity).</p> <p>This failure had the potential for Resident 65 to contract further infections.</p> <p>Findings:</p> <p>During a review of Resident 65's face sheet (resident's demographic) indicated that the Resident 65 was admitted to the facility on [DATE] with diagnoses included Alzheimer's Disease, pneumonitis, chronic kidney disease, and retention of urine.</p> <p>During a review of the quarterly Minimum Data Set (MDS - a standardized assessment and care screening tool) for Resident 65, dated 12/27/2024, confirmed that Resident 65 had an indwelling foley catheter.</p> <p>During an observation on 2/25/2025 at 3:30 p.m. in the Resident 65's room, Certified Nursing Assistant (CNA) 1 and CNA 2 were observed transferring Resident 65 from wheelchair to bed without wearing gowns.</p> <p>During an interview on 2/25/2025 at 3:38 p.m. at the nursing station, CNA 1 stated, they were not aware of Resident 65's EBP since they were usually not wearing any gown. CNA 1 and CNA 2 confirmed they were not checking the door sign prior to entering Resident 65's room.</p> <p>During an interview on 2/26/2025 at 4:03 p.m. with Director of Nursing (DON), DON stated staff were expected to wear gowns prior to transferring resident in high-contact and in EBP to break the chain of infection.</p> <p>During a review of the facility's Policy and Procedure (P&P) titled, ENHANCED BARRIER PROTECTION, undated, the P&P indicated, EBP are indicated for residents with any of the following, regardless of where they reside in the facility: . indwelling medical devices even if the resident is not known to be infected . Indwelling medical device examples include central lines, urinary catheter . The P&P also stated dressing, transferring, and changing briefs are included in the high-contact resident care activities.</p> <p>During a review of the Centers for Disease Control and Prevention (CDC) titled Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), dated 4/2/2024, CDC indicated transferring resident with urinary catheter was a high-contact care, and the use of gown and gloves was indicated.</p>		