STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555920	A. Building B. Wing	11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evergreen Care Center	5265 East Huntington Avenue Fresno, CA 93727

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48713 Based on interview and record review the facility failed to ensure residents were free from free from abuse for one of three sampled residents (Resident 1), when certified nursing assistant (CNA)1 was observed hitting Resident 1 with a closed fist. This failure resulted in Resident 1 being physically harmed on the right thigh causing unnecessary mental trauma and physical pain to the area. Findings: During a record review of Resident 1 ' s Nurses Note, dated 11/1/24, the nurses note indicated, . CNA 1 and CNA 2 continued to change Resident 1, Resident 1 ' s aggression increased, Resident 1 began kicking, hitting, and scratching CNA 1. Resident 1 made contact multiple times while swinging at CNA 1, including Kicking CNA 1 in the side of the face and scratching her hand. CNA 1 finished changing Resident 1 and left the room. Resident 1 stated to director of nursing (DON) and assistant administrator, that CNA 1 hit her with a closed fist 2 times on her right upper thigh before CNA 1 left the room . During a review of Resident 1's Admission Record (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), the AR indicated Resident 1 was admitted to the facility on [DATE] with diagnosis for hemiplegia (severe or complete loss on one side of the body), epilepsy (brain disorder with sudden alteration of behavior due to change in the brain) morbid obesity, muscle weakness, Major Depressive disorder (condition that causes a persistent feeling of sadness and loss of interest in activities) . During a review of Resident 1's Minimum Data Set [MDS a resident assessment tool used to identify cognitive (mental processes) and physical functional level assessment] dated 9/6/24, the MDS indicated, Resident 1's Brief Interview for Mental Status (BIMS screening tool used to assess resident cognitive level) score was 14 out of 15 (0 - 7 indicated severe cognitive impairment [memory loss, poor decision making skills] 8-12 moderate cognitive impairment, (13 -15) cognitively intact) which indicated Resident 1 was cognitively intact. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/13/24 at 11:21 a.m. with Resident 1, Resident 1 recalled incident that occurred on 11/1/24 and stated CNA 1 had hit her twice on the right hip with a closed fist. Resident 1 stated CNA 1 and CNA 2 had entered her room to provide personal hygiene care assistance, Resident 1 stated she was upset about something that had happened during care but could not recall what led to the incident. Resident 1 stated she kicked CNA 1 so that CNA 1 could leave the room. Resident 1 stated CNA 2 was present in the room and assisting with care when the incident occurred. Resident 1 stated CNA 2 told CNA 1 to stop providing care when CNA 1 hit Resident 1 with a closed fist. Resident 1 stated she felt pain at the time of incident, but the pain had subsided and no other physical injuries were noted. During an interview on 11/13/24 at 11:31 a.m. with CNA 3, CNA 3 stated Resident 1 was not verbally or physically aggressive toward staff. CNA 3 stated Resident 1 ' s behavior on the day of incident on 11/1/24, was not normal behavior for Resident 1. CNA 3 stated it was not appropriate when CNA 1 hit Resident 1 when Resident 1 was exhibiting aggressive behaviors. CNA 3 stated it was the facility process to attempt to redirect the resident who was experiencing behaviors and if unsuccessful, step away from the situation and allow resident to calm down and offer care at a later time. CNA 3 stated when CNA 1 hit Resident 1, it was considered abuse. During an interview on 11/13/24 at 11:55 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated the facility process was for staff to recognize when a resident was exhibiting behaviors such as aggression to allow the resident to calm down before attempting to provide care. LVN 1 stated the incident that occurred on 11/1/24 was considered abuse when CNA 1 hit Resident 1 during care. During a concurrent interview and record review with the Director of Staff Development (DSD), the facility ' s in service titled, Freedom and abuse and Neglect, dated 5/3/24, the in service indicated CNA 1 was in serviced on understanding resident rights, explanation of the types of abuse and what constitutes abuse. The DSD stated the abuse training was completed at least 3-4 times a year and as needed to ensure staff was trained on identifying abuse. During an interview on 11/13/24 at 12:56 p.m. with the administrator (ADM), the ADM stated the facility expectation was for staff to assess the situation and exit the room as needed. The ADM stated it was the facility expectation for staff to back away call for assistance if the residents weree exhibiting behaviors and allow residents the space they are requesting. The ADM stated CNA 1 had been terminated from the facility and last day of employment was 11/1/24. During a telephone interview on 11/14/24 at 12:34 p.m. with CNA 2, CNA 2 stated on 11/1/24, CNA 1 was observed, hitting Resident 1 multiple times on the right thigh using a closed fist. CNA 2 stated that on 11/1/24, CNA 1 requested the assistance of CNA 2 to provide care for Resident 1. CNA 2 stated Resident 1 was exhibiting behaviors toward CNA 1 which included attempts to remove CNA 1 from providing care. CNA 2 stated that Resident 1 was angry and was resisting care from CNA 1. CNA 2 stated that Resident 1 hit CNA 1 and attempted to keep hitting her until CNA 1 restrained Resident 1 ' s arm. CNA 2 stated that CNA 1 was then observed hitting Resident 1 with a closed fists on Resident 1 ' s right side of leg. CNA 2 stated that the incident was reported right away because it was abuse when CNA 1 hit Resident 1. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility ' s policy and procedure (P&P) titled, Abuse, Neglect and Exploitation, dated 2024, the P&P indicated, . It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect . abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse . During a review f the facility ' s P&P titled, Resident Rights, dated 2024, the P&P indicated, . The resident has the right to make choices about aspects of his or her life in the facility that are significant to the resident . The resident has a right to a safe, clean, comfortable, and homelike environment, including but not limited to receiving treatment and supports for daily living safely .