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	03/11/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48713 Based on observation, interview and record review, the facility failed to protect and promote the rights of residents' privacy for two of nine sampled residents (Resident 1 and Resident 2) when the facility did not provide a private area for Resident 1 and Resident 2 to discuss their personal health information. This failure had the potential to result in health information for Resident 1 and Resident 2, to have been overheard by other unrelated staff and residents in the facility resulting in lack of confidentiality and privacy. Findings: During a review of Resident 1's Admission Record (AR- a summary of information regarding a resident 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 Major Depressive Disorder (intense feeling of sadness), Morbid Obesity (excessive weight), Anxiety (excessive worry and fear), insomnia (inability to sleep), and alcohol abuse. 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 2/23/25, the MDS indicated, Resident 1's Brief Interview for Mental Status (BIMS -screening tool used to assess resident cognitive level) score was 15 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. During an interview on 3//11/25 at 12:46 p.m. with Resident 1, Resident 1 stated there was a concern regarding the lack of privacy provided within the facility during personal conversations and medical visits. Resident 1 stated during conversations with the social services director (SSD), she was not able to discuss private health information due to Resident 1's roommate being in the room, staff going in and out of the room and the SSD not having an office with enough space to accommodate any resident. Resident 1 stated there were instances when she heard conversations related to other residents in the facility about their personal medical information. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555920	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/11/2025
NAME OF PROVIDER OR SUPPLIER Evergreen Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 5265 East Huntington Avenue Fresno, CA 93727	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/11/25 at 1:31 p.m. with Resident 2, Resident 2 stated she felt there was no privacy provided in the facility for private conversations unless roommates were removed from the room. Resident 2 stated she would meet with facility physicians in her room but felt her privacy curtain was not enough to keep her health information private from staff and other residents. Resident 2 stated the SSD did not have a private area to meet and accommodate for the privacy of residents. During a review of Resident 2's AR, the AR indicated, Resident 2 was admitted to the facility on [DATE] with diagnosis for Morbid Obesity (excessive weight), Anxiety, and other stimulant abuse. During a review of Resident 2's MDS dated [DATE], the MDS indicated, Resident 2's BIMS score was 15 out of 15 which indicated Resident 2 was cognitively intact. During a concurrent observation and interview on 3/11/25 at 3:25 p.m. with the SSD, in the SSD's office. The office was observed located in the hallway between two resident rooms and across the hall from two other resident rooms. The SSD office appeared to contain a desk with drawers and desk chair. When the SSD opened the door of her office, there was no room for surveyor and SSD to conduct an interview privately with the door closed. The SSD advised to move interview to the facility conference room located outside in the back of the facility. The SSD stated there was a concern that private medical and mental health information was discussed in an area without privacy. The SSD stated the office space provided was too small to accommodate a resident with enough privacy to discuss private information. The SSD stated she had voiced concerns regarding the lack of privacy and was directed to conduct private health conversations with residents in their assigned rooms. The SSD stated there was no privacy for residents in their rooms when there were other roommates or staff present during the room visits. During an interview on 3/11/24 at 4:38 p.m. with the Administrator (ADM) and assistant administrator (AADM), the ADM and AADM stated all residents in the facility had a right to privacy and if the room that was provided to the SSD was not big enough or was a concern, the facility could provide the SSD with another office to accommodate the SSD and residents to ensure their privacy. During a record review of the facility's policy and procedure (P&P) titled, Confidentiality of Personal and Medical Records, dated 2024, the P&P indicated, . This facility honors the resident's right to secure and confidential personal and medical records. This includes the right to confidentiality of all information contained in a resident's records, regardless of the form of storage or location of the record . Employees should discuss confidential information about residents only during the course of business with other employees or contracted professionals, on a need to know basis. Information regarding one resident should not be shared with other residents or visitors . Employees should not discuss resident information in public or semi-public areas . (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of the facility's P&P titled, Resident Rights, dated 2025, the P&P indicated, . The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overhead. This includes the right to retain and use a cellular phone at the resident's own expense . The resident has the right to have reasonable access to, and privacy of, their use of electronic communication such as email and video communications and for internet research . The resident has a right to personal privacy and confidentiality of his or her personal and medical records . Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident . The resident has a right to secure and confidential personal and medical records . Based on observation, interview and record review, the facility failed to protect and promote the rights of residents' privacy for two of nine sampled residents (Resident 1 and Resident 2) when the facility did not provide a private area for Resident 1 and Resident 2 to discuss their personal health information. This failure had the potential to result in health information for Resident 1 and Resident 2, to have been overheard by other unrelated staff and residents in the facility resulting in lack of confidentiality and privacy. Findings: During a review of Resident 1's Admission Record (AR- a summary of information regarding a resident 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 Major Depressive Disorder (intense feeling of sadness), Morbid Obesity (excessive weight), Anxiety (excessive worry and fear), insomnia (inability to sleep), and alcohol abuse. 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 2/23/25, the MDS indicated, Resident 1's Brief Interview for Mental Status (BIMS -screening tool used to assess resident cognitive level) score was 15 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. During an interview on 3//11/25 at 12:46 p.m. with Resident 1, Resident 1 stated there was a concern regarding the lack of privacy provided within the facility during personal conversations and medical visits. Resident 1 stated during conversations with the social services director (SSD), she was not able to discuss private health information due to Resident 1's roommate being in the room, staff going in and out of the room and the SSD not having an office with enough space to accommodate any resident. Resident 1 stated there were instances when she heard conversations related to other residents in the facility about their personal medical information. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/11/25 at 1:31 p.m. with Resident 2, Resident 2 stated she felt there was no privacy provided in the facility for private conversations unless roommates were removed from the room. Resident 2 stated she would meet with facility physicians in her room but felt her privacy curtain was not enough to keep her health information private from staff and other residents. Resident 2 stated the SSD did not have a private area to meet and accommodate for the privacy of residents. During a review of Resident 2's AR, the AR indicated, Resident 2 was admitted to the facility on [DATE] with diagnosis for Morbid Obesity (excessive weight), Anxiety, and other stimulant abuse. During a review of Resident 2's MDS dated [DATE], the MDS indicated, Resident 2's BIMS score was 15 out of 15 which indicated Resident 2 was cognitively intact. During a concurrent observation and interview on 3/11/25 at 3:25 p.m. with the SSD, in the SSD's office. The office was observed located in the hallway between two resident rooms and across the hall from two other resident rooms. The SSD office appeared to contain a desk with drawers and desk chair. When the SSD opened the door of her office, there was no room for surveyor and SSD to conduct an interview privately with the door closed. The SSD advised to move interview to the facility conference room located outside in the back of the facility. The SSD stated there was a concern that private medical and mental health information was discussed in an area without privacy. The SSD stated the office space provided was too small to accommodate a resident with enough privacy to discuss private information. The SSD stated she had voiced concerns regarding the lack of privacy and was directed to conduct private health conversations with residents in their assigned rooms. The SSD stated there was no privacy for residents in their rooms when there were other roommates or staff present during the room visits. During an interview on 3/11/24 at 4:38 p.m. with the Administrator (ADM) and assistant administrator (AADM), the ADM and AADM stated all residents in the facility had a right to privacy and if the room that was provided to the SSD was not big enough or was a concern, the facility could provide the SSD with another office to accommodate the SSD and residents to ensure their privacy. During a record review of the facility's policy and procedure (P&P) titled, Confidentiality of Personal and Medical Records, dated 2024, the P&P indicated, . This facility honors the resident's right to secure and confidential personal and medical records. This includes the right to confidentiality of all information contained in a resident's records, regardless of the form of storage or location of the record . Employees should discuss confidential information about residents only during the course of business with other employees or contracted professionals, on a need to know basis. Information regarding one resident should not be shared with other residents or visitors . Employees should not discuss resident information in public or semi-public areas . (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of the facility's P&P titled, Resident Rights, dated 2025, the P&P indicated, . The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overhead. This includes the right to retain and use a cellular phone at the resident's own expense . The resident has the right to have reasonable access to, and privacy of, their use of electronic communication such as email and video communications and for internet research . The resident has a right to personal privacy and confidentiality of his or her personal and medical records . Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident . The resident has a right to secure and confidential personal and medical records .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48713 Based on interview and record review the facility failed to develop and implement a comprehensive person-centered care plan for Trauma informed Care (an approach to delivering care that involves understanding, recognizing and responding to the effects of all types of trauma) for one of nine sampled residents (Resident 1), when the facility's admitting nurse and social services director (SSD) identified Resident 1's history of trauma upon admission and did not create a care plan to recognize trauma and triggers that impacted Resident 1's care. This failure resulted in Resident 1 experiencing triggers that caused her to relive past traumas during her care in the facility. Findings: During a review of Resident 1's Admission Record (AR- a summary of information regarding a resident 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 Major Depressive Disorder (intense feeling of sadness), Morbid Obesity (excessive weight), Anxiety (excessive worry and fear), insomnia (inability to sleep), alcohol abuse. 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 2/23/25, the MDS indicated, Resident 1's Brief Interview for Mental Status (BIMS screening tool used to assess resident cognitive level) score was 15 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. During an interview 3/11/25 at 2:06 p.m. with certified nursing assistant (CNA) 1, CNA 1 stated she had cared for Resident 1 in the past. CNA 1 stated Resident 1 liked things done a certain way during her care times. CNA 1 stated she was not aware of any trauma or triggers associated with Resident 1. CNA 1 stated it was important to know Resident 1 had experienced some type of trauma to identify triggers that impacted her daily life and provide the care needed. CNA 1 stated it was important to make a safe space for the residents when they were in the facility. CNA 1 stated it was important to establish a relationship with the residents and not dismiss resident attempts to share feelings or experiences. During a concurrent interview and record review on 3/11/25 at 2:23 p.m. with licensed vocational nurse (LVN) 2, Resident 1's Care Plan (CP), dated 2/18/25 was reviewed. The CP indicated the facility had not created a care plan for trauma informed care. LVN 1 stated there should have been a care plan to address the trauma in Resident 1's past and the associated triggers. LVN 1 stated it was important to have a care plan to be aware of Resident 1's needs to safely provide care. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/11/25 at 2:44 pm with LVN 2, LVN 2 stated the facility process for trauma informed care was to identify resident's past trauma to establish the plan of care. LVN 2 stated, when the care plan for trauma informed care was not created for Resident 1, the facility staff were not aware of Resident 1's traumatic history and environmental triggers that she was exposed to. LVN 2 stated the process included speaking with the resident, notifying the physician and creating a plan of care individualized to Resident 1's needs. During an interview on 3/11/25 at 3:25 p.m. with the SSD, the SSD stated, Resident 1 had verbalized the history of past trauma, and a plan of care should have been established at that moment upon admission. The SSD stated there was no care plan to address Resident 1's past trauma and triggers. The SSD stated there should have a care plan implemented on admission to properly care for Resident 1. During an interview on 3/11/25 at 4:38 p.m. with the administrator (ADM), the ADM stated there was concern for the lack of trauma informed care plan for Resident 1. The ADM stated Resident 1's trauma should have been identified and a plan of care should have been created to establish the proper care. During a telephone interview on 3/12/25 at 11:43 a.m. with clinical resource (CR), the CR stated the facility process was to identify resident traumas on admission and evaluate the resident for plan of care. The CR indicated the purpose of identifying trauma on admission was to establish a plan of care to properly care for residents and prevent further trauma and triggers. The CR stated the expectation was for the admitting nurse and SSD to follow up with Resident 1's reported history of trauma and triggers upon admission and create an individualized care plan. During a telephone interview on 3/13/25 at 11:27 a.m. with the MDS/LVN, the MDS/LVN stated the facility process was to create a baseline care plan upon admission and during resident's stay in the facility when changes occur. The MDS/LVN stated the expectation was to identify resident trauma and triggers, create a care plan, and notify physician to properly create a plan of care. During a telephone interview on 3/13/25 at 1:39 p.m. with the director of staff development (DSD), the DSD stated it was the expectation that a baseline care plan be created to address Resident 1's history of trauma. The DSD stated it was important for all staff to be aware of possible triggers and interventions to address Resident 1's trauma and to avoid re-traumatization. During a concurrent telephone interview and record review on 3/13/25 at 2:29 p.m. with the SSD, Resident 1's, Trauma Informed Care Evaluation, dated 7/2024 was reviewed. The evaluation indicated, . I have been thru a lot of abuse in the past, there have been a lot of traumatic experiences . Score 18 . A Positive screen is a total score of greater than or equal to 14. Notify the resident's primary care physician and interested party of a positive screen . The SSD stated there was no care plan created to address Resident 1's trauma and triggers even after Resident 1 had indicated she had a history of trauma and scored high in the trauma evaluation. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of the facility's policy and procedure (P&P) titled, Comprehensive Care Plans, dated 2022, the P&P indicated, . It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment . Person-centered care means to focus on the resident as the locus of control and support the resident in making their own choices and having control over their daily lives . Individualized interventions for trauma survivors that recognizes the interrelation between trauma and symptoms of trauma, as indicated. Trigger-specific interventions will be used to identify ways to decrease the resident's exposure to triggers which re-traumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident . The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the resident's progress. Alternative interventions will be documented, as needed . Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made . During a record review of the facility's policy and procedure (P&P) titled, Trauma Informed Care, dated 2023, the P&P indicated, . It is the policy of this facility to provide care and services which, in addition to meeting professional standards, are delivered using approaches which are culturally-competent, account for experiences and preferences, and address the needs of trauma survivors by minimizing triggers and/or re-traumatization . Trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being . Trauma-Informed Care is an approach to delivering care that involves understanding, recognizing and responding to the effects of all types of trauma. A trauma-informed approach to care delivery recognizes the widespread impact and signs and symptoms of trauma in residents, and incorporates knowledge about trauma into care plans, policies, procedures and practices to avoid re-traumatization . The facility will work to facilitate the principles of trauma informed care which include, Safety - Ensuring residents have a sense of emotional and physical safety. Trustworthiness and transparency - Efforts to establish a relationship based on trust, and clear and open communication between the staff and the resident . Collaboration an emphasis on partnering between residents and/or his or her representative, and all staff and disciplines involved in the resident's care in developing the plan of care . The facility will use a multi-pronged approach to identifying a resident's history of trauma, as well as his or her cultural preferences. This will include asking the resident about triggers that may be stressors or may prompt recall of a previous traumatic event . The facility will collaborate with resident trauma survivors, and as appropriate, the resident's family, friends, the primary care physician, and any other health care professionals (such as psychologists and mental health professionals) to develop and implement individualized care plan interventions . The facility will identify triggers which may re-traumatize residents with a history of trauma. Trigger-specific interventions will identify ways to decrease the resident's exposure to triggers which re-traumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident, and will be added to the residents care plan . The facility will evaluate whether the interventions have been able to mitigate (or reduce) the impact of identified triggers on the resident that may cause re-traumatization . (continued on next page)

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F 0656

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Based on interview and record review the facility failed to develop and implement a comprehensive person-centered care plan for Trauma informed Care (an approach to delivering care that involves understanding, recognizing and responding to the effects of all types of trauma) for one of nine sampled residents (Resident 1), when the facility's admitting nurse and social services director (SSD) identified Resident 1's history of trauma upon admission and did not create a care plan to recognize trauma and triggers that impacted Resident 1's care.

This failure resulted in Resident 1 experiencing triggers that caused her to relive past traumas during her care in the facility.

Findings:

During a review of Resident 1's Admission Record (AR- a summary of information regarding a resident 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 Major Depressive Disorder (intense feeling of sadness), Morbid Obesity (excessive weight), Anxiety (excessive worry and fear), insomnia (inability to sleep), alcohol abuse.

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 2/23/25, the MDS indicated, Resident 1's Brief Interview for Mental Status (BIMS screening tool used to assess resident cognitive level) score was 15 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.

During an interview 3/11/25 at 2:06 p.m. with certified nursing assistant (CNA) 1, CNA 1 stated she had cared for Resident 1 in the past. CNA 1 stated Resident 1 liked things done a certain way during her care times. CNA 1 stated she was not aware of any trauma or triggers associated with Resident 1. CNA 1 stated it was important to know Resident 1 had experienced some type of trauma to identify triggers that impacted her daily life and provide the care needed. CNA 1 stated it was important to make a safe space for the residents when they were in the facility. CNA 1 stated it was important to establish a relationship with the residents and not dismiss resident attempts to share feelings or experiences.

During a concurrent interview and record review on 3/11/25 at 2:23 p.m. with licensed vocational nurse (LVN) 2, Resident 1's Care Plan (CP), dated 2/18/25 was reviewed. The CP indicated the facility had not created a care plan for trauma informed care. LVN 1 stated there should have been a care plan to address the trauma in Resident 1's past and the associated triggers. LVN 1 stated it was important to have a care plan to be aware of Resident 1's needs to safely provide care.

During an interview on 3/11/25 at 2:44 pm with LVN 2, LVN 2 stated the facility process for trauma informed care was to identify resident's past trauma to establish the plan of care. LVN 2 stated, when the care plan for trauma informed care was not created for Resident 1, the facility staff were not aware of Resident 1's traumatic history and environmental triggers that she was exposed to. LVN 2 stated the process included speaking with the resident, notifying the physician and creating a plan of care individualized to Resident 1's needs.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/11/25 at 3:25 p.m. with the SSD, the SSD stated, Resident 1 had verbalized the history of past trauma, and a plan of care should have been established at that moment upon admission. The SSD stated there was no care plan to address Resident 1's past trauma and triggers. The SSD stated there should have a care plan implemented on admission to properly care for Resident 1. During an interview on 3/11/25 at 4:38 p.m. with the administrator (ADM), the ADM stated there was concern for the lack of trauma informed care plan for Resident 1. The ADM stated Resident 1's trauma should have been identified and a plan of care should have been created to establish the proper care. During a telephone interview on 3/12/25 at 11:43 a.m. with clinical resource (CR), the CR stated the facility process was to identify resident traumas on admission and evaluate the resident for plan of care. The CR indicated the purpose of identifying trauma on admission was to establish a plan of care to properly care for residents and prevent further trauma and triggers. The CR stated the expectation was for the admitting nurse and SSD to follow up with Resident 1's reported history of trauma and triggers upon admission and create an individualized care plan. During a telephone interview on 3/13/25 at 11:27 a.m. with the MDS/LVN, the MDS/LVN stated the facility process was to create a baseline care plan upon admission and during resident's stay in the facility when changes occur. The MDS/LVN stated the expectation was to identify resident trauma and triggers, create a care plan, and notify physician to properly create a plan of care. During a telephone interview on 3/13/25 at 1:39 p.m. with the director of staff development (DSD), the DSD stated it was the expectation that a baseline care plan be created to address Resident 1's history of trauma. The DSD stated it was important for all staff to be aware of possible triggers and interventions to address Resident 1's trauma and to avoid re-traumatization. During a concurrent telephone interview and record review on 3/13/25 at 2:29 p.m. with the SSD, Resident 1's, Trauma Informed Care Evaluation, dated 7/2024 was reviewed. The evaluation indicated, . I have been thru a lot of abuse in the past, there have been a lot of traumatic experiences . Score 18 . A Positive screen is a total score of greater than or equal to 14. Notify the resident's primary care physician and interested party of a positive screen . The SSD stated there was no care plan created to address Resident 1's trauma and triggers even after Resident 1 had indicated she had a history of trauma and scored high in the trauma evaluation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555920	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/11/2025
NAME OF PROVIDER OR SUPPLIER: Evergreen Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 5265 East Huntington Avenue Fresno, CA 93727	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of the facility's policy and procedure (P&P) titled, Comprehensive Care Plans, dated 2022, the P&P indicated, . It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment . Person-centered care means to focus on the resident as the locus of control and support the resident in making their own choices and having control over their daily lives . Individualized interventions for trauma survivors that recognizes the interrelation between trauma and symptoms of trauma, as indicated. Trigger-specific interventions will be used to identify ways to decrease the resident's exposure to triggers which re-traumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident . The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the resident's progress. Alternative interventions will be documented, as needed . Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made . During a record review of the facility's policy and procedure (P&P) titled, Trauma Informed Care, dated 2023, the P&P indicated, . It is the policy of this facility to provide care and services which, in addition to meeting professional standards, are delivered using approaches which are culturally-competent, account for experiences and preferences, and address the needs of trauma survivors by minimizing triggers and/or re-traumatization . Trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being . Trauma-Informed Care is an approach to delivering care that involves understanding, recognizing and responding to the effects of all types of trauma. A trauma-informed approach to care delivery recognizes the widespread impact and signs and symptoms of trauma in residents, and incorporates knowledge about trauma into care plans, policies, procedures and practices to avoid re-traumatization . The facility will work to facilitate the principles of trauma informed care which include, Safety - Ensuring residents have a sense of emotional and physical safety. Trustworthiness and transparency - Efforts to establish a relationship based on trust, and clear and open communication between the staff and the resident . Collaboration an emphasis on partnering between residents and/or his or her representative, and all staff and disciplines involved in the resident's care in developing the plan of care . The facility will use a multi-pronged approach to identifying a resident's history of trauma, as well as his or her cultural preferences. This will include asking the resident about triggers that may be stressors or may prompt recall of a previous traumatic event . The facility will collaborate with resident trauma survivors, and as appropriate, the resident's family, friends, the primary care physician, and any other health care professionals (such as psychologists and mental health professionals) to develop and implement individualized care plan interventions . The facility will identify triggers which may re-traumatize residents with a history of trauma. Trigger-specific interventions will identify ways to decrease the resident's exposure to triggers which re-traumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident, and will be added to the residents care plan . The facility will evaluate whether the interventions have been able to mitigate (or reduce) the impact of identified triggers on the resident that may cause re-traumatization .

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0699

Level of Harm - Actual harm

Residents Affected - Few

Provide care or services that was trauma informed and/or culturally competent.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 48713

Based on observation, interview and record review the facility failed to provide Trauma informed care (an approach to delivering care that involves understanding, recognizing and responding to the effects of all types of trauma) for one of nine sampled residents (Resident 1) when Resident 1 verbalized a history of being a survivor of trauma upon admission on 2/18/25 and the facility staff did not recognize the severity of the trauma and did not implement effective interventions to avoid triggers (specific stimuli or events that cause an intense emotional reaction or psychological response) that impacted Resident 1.

This failure resulted in Resident 1 being exposed to triggers that caused her re-traumatization from past experiences with feelings of isolation, depression, lack of sleep and fear.

Findings:

During a review of Resident 1's Admission Record (AR- a summary of information regarding a resident 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 Major Depressive Disorder (intense feeling of sadness), Morbid Obesity (excessive weight), Anxiety (excessive worry and fear), insomnia (inability to sleep), alcohol abuse.

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 2/23/25, the MDS indicated, Resident 1's Brief Interview for Mental Status (BIMS screening tool used to assess resident cognitive level) score was 15 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.

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F 0699

Level of Harm - Actual harm

Residents Affected - Few

During a concurrent observation and interview on 3/11/25 at 12:46 p.m. with Resident 1, in Resident 1's room, Resident 1 was observed crying as she recalled events that transpired in the facility. Resident 1 stated she had a history of trauma due to sexual and physical abuse experienced in the past. Resident 1 stated, due to the past traumas, she was afraid to be around men she did not recognize. Resident 1 stated she was placed in a room across the hall from a male resident room. Resident 1 stated due to being so close to a male room, she was unable to sleep and was constantly worrying that the male residents would enter her room at night to harm her. Resident 1 stated she used to enjoy sitting out in the halls and wheeling herself around the facility but had since isolated herself in her room to keep away from the male residents in the hallways. Resident 1 stated there were other triggers that had caused her to experience episodes of anxiety which included worrying about the care other residents in the facility, were receiving. Resident 1 stated there were multiple requests to the assistant administrator to move away from the male residents, but efforts were unsuccessful. Resident 1 recalled an instance when a male was seen entering her room, in which Resident 1 responded by yelling and screaming for the male to exit her room. Resident 1 stated it was later learned, the male, was the psychologist that the facility had arranged for her to see but had not notified her of the visit. Resident 1 stated she felt alone, isolated and cornered in her own mind as she would attempt to voice her concerns to the facility staff in which they would reply, you don't have to be here, you can leave. Resident 1 stated she had wanted to leave the facility due to feeling desperate for someone to listen to her concerns and mental state, but no one was available in the facility.

During a review of Resident 1's MDS Section D- Mood, dated 2/23/25, the MDS indicated, . Feeling down, depressed, or hopeless, nearly every day, trouble falling asleep or staying asleep or sleeping too much, nearly every day, feeling bad about yourself or that you are a failure or have let yourself or your family down, nearly every day, trouble concentrating on things, such as reading the newspaper or watching television, nearly every day, Social Isolation, how often do you feel lonely or isolated from those around you? Enter code 1, Rarely .

During a review of Resident 1's, Progress Note (PN)-Admission, dated 2/18/25, the PN indicated, . Resident does state she has anxiety from past abuse and aggressive behaviors observed from others do trigger her and cause to be hypervigilant (alert to potential dangers) and fearful, cause her to zone out at which calling her name will snap her out of it .

During an interview 3/11/25 at 2:06 p.m. with certified nursing assistant (CNA) 1, CNA 1 stated she had cared for Resident 1 in the past. CNA 1 stated Resident 1 appeared to be angry and upset all the time and had once become angry with her for pulling the privacy curtain. CNA 1 stated Resident 1 would later apologize for the angry behaviors. CNA 1 stated Resident 1 liked things done a certain way and would stay in her room for activities. CNA 1 stated she was not aware of any trauma or triggers associated with Resident 1. CNA 1 stated she did not recall ever having education or in-services regarding trauma informed care. CNA 1 stated it was important to know Resident 1 had experienced some type of trauma to identify triggers that impacted her daily life. CNA 1 stated it was important to make a safe space for the residents when they were in the facility. CNA 1 stated it was important to establish a relationship with the residents and not dismiss resident attempts to share feelings or experiences.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0699 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review on 3/11/25 at 2:23 p.m. with licensed vocational nurse (LVN) 1, Resident 1's Care Plan (CP), dated 2/18/25 was reviewed. The CP indicated the facility had not created a care plan for trauma informed care. LVN 1 stated there should have been a care plan to address the trauma in Resident 1's past and the associated triggers. LVN 1 stated it was important to have a care plan to be aware of Resident 1's needs to safely care for the resident. LVN 1 stated Resident 1's feelings of isolation and triggers could have been prevented by creating a plan of care that included moving Resident 1 to a room closer to the nurse's station and away from male residents. LVN 1 stated the facility process when identifying trauma was to review residents past history, notify the physician, communicate and monitor the resident. During an interview on 3/11/25 at 2:44 pm with LVN 2, LVN 2 stated the facility process for trauma informed care was to identify resident's past trauma to establish the plan of care. LVN 2 stated, when the care plan for trauma informed care was not created for Resident 1, the facility staff were not aware of Resident 1's traumatic history and environmental triggers that she was exposed to. LVN 2 stated the process included speaking with the resident, notifying the physician and creating a plan of care individualized to Resident 1's needs. During an interview on 3/11/25 at 3:25 p.m. with the social services director (SSD), the SSD stated Resident 1 had verbalized concerns with not receiving the assistance needed to address her mental and physical health in the facility. The SSD stated, Resident 1 had verbalized the history of past trauma, and a plan of care should have been established at that moment. The SSD stated there was no care plan to address Resident 1's past trauma and triggers. The SSD stated they should have a care plan implemented on admission to properly care for Resident 1. During an interview on 3/11/25 at 4:38 p.m. with the administrator (ADM), the ADM stated there was concerns for the lack of trauma informed care plan for Resident 1. The ADM stated Resident 1's trauma should have been identified and a plan of care should have been created to establish the proper care. During a telephone interview on 3/12/25 at 11:43 a.m. with clinical resource (CR), the CR stated the facility process was to identify resident traumas on admission and evaluate the resident for plan of care. The CR stated the purpose of identifying trauma on admission was to establish a plan of care to properly care for residents and prevent further trauma and triggers. The CR stated the expectation was for all staff to be trained in trauma informed care. The CR stated the expectation was for the admitting nurse and SSD to follow up with Resident 1's reported history of trauma and triggers upon admission. During a telephone interview on 3/13/25 at 1:39 p.m. with the director of staff development (DSD), the DSD stated there were no in-services or related trainings for trauma informed care provided for the facility staff. The DSD stated it was important for staff to have had trauma informed care training because the staff needed to be aware of all types of traumas in order to properly provide care to all residents affected. The DSD stated it was important for staff to be educated to identify triggers that could have been avoided for Resident 1. During a review of Resident 1's, Social Services-Trauma Informed Care Evaluation, dated 2/19/25, the evaluation indicated, . I have been thru a lot of abuse in the past, there have been a lot of traumatic experiences . Score 18 . A Positive screen is a total score of greater than or equal to 14. Notify the resident's primary care physician and interested party of a positive screen . (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0699 Level of Harm - Actual harm Residents Affected - Few	During a concurrent telephone interview and record review on 3/13/25 at 2:29 p.m. with the SSD, Resident 1's, Trauma Informed Care Evaluation, dated 2/19/25 was reviewed. The evaluation indicated, . I have been thru a lot of abuse in the past, there have been a lot of traumatic experiences . Score 18 . A Positive screen is a total score of greater than or equal to 14. Notify the resident's primary care physician and interested party of a positive screen . The SSD stated the evaluation was completed upon admission to determine the level of trauma Resident 1 was presenting with in the facility. The SSD stated a high score on the evaluation indicated a high level of trauma presented. The SSD stated there was no care plan created to address Resident 1's trauma and triggers even after Resident 1 had indicated she had a history of trauma and scored high in the trauma evaluation. The SSD stated she could not recall why Resident 1's past trauma was not addressed in the interdisciplinary team (IDT-group usually consisting of physician, director of nurses, social services, resident/resident representative to collaborate in plan of care) meeting held on admission or why Resident 1's physician was not made aware at that time. The SSD stated it was important to document and follow up with any resident who reported a history of trauma. The SSD stated it was important to address Resident 1's trauma to avoid the triggers that were causing distress. The SSD stated it was important for all staff to receive the trauma informed care training in order to care for residents in the facility. During a review of Resident 1's, Independent Activity Monthly Record, dated 3/2025, the record indicated, . 3/1 resident was invited to activities for adult coloring, didn't want to join, 3/2 resident invited to activities, 3/4-3/5 resident invited to activities, 3/7 resident invited to activities, 3/9 resident was asleep didn't want to join activities, 3/10 -3/13 resident was invited to activities . refused . During a concurrent interview and record review on 3/14/25 at 11:22 a.m. with the activities director (AD), Resident 1's Independent Activity Monthly Record, dated 3/2025 was reviewed. The log indicated, . 3/1 resident was invited to activities for adult coloring, didn't want to join, 3/2 resident invited to activities, 3/4-3/5 resident invited to activities, 3/7 resident invited to activities, 3/9 resident was asleep didn't want to join activities, 3/10 -3/13 resident was invited to activities . refused . The AD stated Resident 1 stayed in her room most of the time even after activities are offered on a daily basis. The AD stated, Resident 1 would leave her room for a smoke break daily and would go back to her room to use her personal cellphone. The AD stated, Resident 1 would attempt to participate in some group activities but would become irritable (easily annoyed) and angry with other residents in the dining room, causing Resident 1 to go back to her room. During a review of Resident 1's, Care Plan (CP)-Activities, dated 2/24/25, the CP indicated, . [Resident 1] sets her own activity goal, she will attend group activities of choice, wheels around facility most of the day . During a review of Resident 1's, MDS Section F- Preferences for customary Routines and Activities, dated 2/23/25, the MDS indicated, . how important is it to you to do things with groups of people? Very important, how important is it to you to do your favorite activities? Very important, how important is it to you to listen to the music you like? Very important . (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0699 Level of Harm - Actual harm Residents Affected - Few	During a record review of the facility's policy and procedure (P&P) titled, Trauma Informed Care, dated 2023, the P&P indicated, . It is the policy of this facility to provide care and services which, in addition to meeting professional standards, are delivered using approaches which are culturally-competent, account for experiences and preferences, and address the needs of trauma survivors by minimizing triggers and/or re-traumatization . Trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being . Trauma-Informed Care is an approach to delivering care that involves understanding, recognizing and responding to the effects of all types of trauma. A trauma-informed approach to care delivery recognizes the widespread impact and signs and symptoms of trauma in residents, and incorporates knowledge about trauma into care plans, policies, procedures and practices to avoid re-traumatization . The facility will work to facilitate the principles of trauma informed care which include, Safety - Ensuring residents have a sense of emotional and physical safety. Trustworthiness and transparency - Efforts to establish a relationship based on trust, and clear and open communication between the staff and the resident . Collaboration an emphasis on partnering between residents and/or his or her representative, and all staff and disciplines involved in the resident's care in developing the plan of care . The facility will use a multi-pronged approach to identifying a resident's history of trauma, as well as his or her cultural preferences. This will include asking the resident about triggers that may be stressors or may prompt recall of a previous traumatic event . The facility will collaborate with resident trauma survivors, and as appropriate, the resident's family, friends, the primary care physician, and any other health care professionals (such as psychologists and mental health professionals) to develop and implement individualized care plan interventions . The facility will identify triggers which may re-traumatize residents with a history of trauma. Trigger-specific interventions will identify ways to decrease the resident's exposure to triggers which re-traumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident, and will be added to the residents' care plan . The facility will evaluate whether the interventions have been able to mitigate (or reduce) the impact of identified triggers on the resident that may cause re-traumatization . Based on observation, interview and record review the facility failed to provide Trauma informed care (an approach to delivering care that involves understanding, recognizing and responding to the effects of all types of trauma) for one of nine sampled residents (Resident 1) when Resident 1 verbalized a history of being a survivor of trauma upon admission on 2/18/25 and the facility staff did not recognize the severity of the trauma and did not implement effective interventions to avoid triggers (specific stimuli or events that cause an intense emotional reaction or psychological response) that impacted Resident 1. This failure resulted in Resident 1 being exposed to triggers that caused her re-traumatization from past experiences with feelings of isolation, depression, lack of sleep and fear. Findings: During a review of Resident 1's Admission Record (AR- a summary of information regarding a resident 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 Major Depressive Disorder (intense feeling of sadness), Morbid Obesity (excessive weight), Anxiety (excessive worry and fear), insomnia (inability to sleep), alcohol abuse. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0699 Level of Harm - Actual harm Residents Affected - Few	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 2/23/25, the MDS indicated, Resident 1's Brief Interview for Mental Status (BIMS screening tool used to assess resident cognitive level) score was 15 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. During a concurrent observation and interview on 3/11/25 at 12:46 p.m. with Resident 1, in Resident 1's room, Resident 1 was observed crying as she recalled events that transpired in the facility. Resident 1 stated she had a history of trauma due to sexual and physical abuse experienced in the past. Resident 1 stated, due to the past traumas, she was afraid to be around men she did not recognize. Resident 1 stated she was placed in a room across the hall from a male resident room. Resident 1 stated due to being so close to a male room, she was unable to sleep and was constantly worrying that the male residents would enter her room at night to harm her. Resident 1 stated she used to enjoy sitting out in the halls and wheeling herself around the facility but had since isolated herself in her room to keep away from the male residents in the hallways. Resident 1 stated there were other triggers that had caused her to experience episodes of anxiety which included worrying about the care other residents in the facility, were receiving. Resident 1 stated there were multiple requests to the assistant administrator to move away from the male residents, but efforts were unsuccessful. Resident 1 recalled an instance when a male was seen entering her room, in which Resident 1 responded by yelling and screaming for the male to exit her room. Resident 1 stated it was later learned, the male, was the psychologist that the facility had arranged for her to see but had not notified her of the visit. Resident 1 stated she felt alone, isolated and cornered in her own mind as she would attempt to voice her concerns to the facility staff in which they would reply, you don't have to be here, you can leave. Resident 1 stated she had wanted to leave the facility due to feeling desperate for someone to listen to her concerns and mental state, but no one was available in the facility. During a review of Resident 1's MDS Section D- Mood, dated 2/23/25, the MDS indicated, . Feeling down, depressed, or hopeless, nearly every day, trouble falling asleep or staying asleep or sleeping too much, nearly every day, feeling bad about yourself or that you are a failure or have let yourself or your family down, nearly every day, trouble concentrating on things, such as reading the newspaper or watching television, nearly every day, Social Isolation, how often do you feel lonely or isolated from those around you? Enter code 1, Rarely . During a review of Resident 1's, Progress Note (PN)-Admission, dated 2/18/25, the PN indicated, . Resident does state she has anxiety from past abuse and aggressive behaviors observed from others do trigger her and cause to be hypervigilant (alert to potential dangers) and fearful, cause her to zone out at which calling her name will snap her out of it . (continued on next page)

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F 0699 Level of Harm - Actual harm Residents Affected - Few	During an interview 3/11/25 at 2:06 p.m. with certified nursing assistant (CNA) 1, CNA 1 stated she had cared for Resident 1 in the past. CNA 1 stated Resident 1 appeared to be angry and upset all the time and had once become angry with her for pulling the privacy curtain. CNA 1 stated Resident 1 would later apologize for the angry behaviors. CNA 1 stated Resident 1 liked things done a certain way and would stay in her room for activities. CNA 1 stated she was not aware of any trauma or triggers associated with Resident 1. CNA 1 stated she did not recall ever having education or in-services regarding trauma informed care. CNA 1 stated it was important to know Resident 1 had experienced some type of trauma to identify triggers that impacted her daily life. CNA 1 stated it was important to make a safe space for the residents when they were in the facility. CNA 1 stated it was important to establish a relationship with the residents and not dismiss resident attempts to share feelings or experiences. During a concurrent interview and record review on 3/11/25 at 2:23 p.m. with licensed vocational nurse (LVN) 1, Resident 1's Care Plan (CP), dated 2/18/25 was reviewed. The CP indicated the facility had not created a care plan for trauma informed care. LVN 1 stated there should have been a care plan to address the trauma in Resident 1's past and the associated triggers. LVN 1 stated it was important to have a care plan to be aware of Resident 1's needs to safely care for the resident. LVN 1 stated Resident 1's feelings of isolation and triggers could have been prevented by creating a plan of care that included moving Resident 1 to a room closer to the nurse's station and away from male residents. LVN 1 stated the facility process when identifying trauma was to review residents past history, notify the physician, communicate and monitor the resident. During an interview on 3/11/25 at 2:44 pm with LVN 2, LVN 2 stated the facility process for trauma informed care was to identify resident's past trauma to establish the plan of care. LVN 2 stated, when the care plan for trauma informed care was not created for Resident 1, the facility staff were not aware of Resident 1's traumatic history and environmental triggers that she was exposed to. LVN 2 stated the process included speaking with the resident, notifying the physician and creating a plan of care individualized to Resident 1's needs. During an interview on 3/11/25 at 3:25 p.m. with the social services director (SSD), the SSD stated Resident 1 had verbalized concerns with not receiving the assistance needed to address her mental and physical health in the facility. The SSD stated, Resident 1 had verbalized the history of past trauma, and a plan of care should have been established at that moment. The SSD stated there was no care plan to address Resident 1's past trauma and triggers. The SSD stated they should have a care plan implemented on admission to properly care for Resident 1. During an interview on 3/11/25 at 4:38 p.m. with the administrator (ADM), the ADM stated there was concerns for the lack of trauma informed care plan for Resident 1. The ADM stated Resident 1's trauma should have been identified and a plan of care should have been created to establish the proper care. During a telephone interview on 3/12/25 at 11:43 a.m. with clinical resource (CR), the CR stated the facility process was to identify resident traumas on admission and evaluate the resident for plan of care. The CR stated the purpose of identifying trauma on admission was to establish a plan of care to properly care for residents and prevent further trauma and triggers. The CR stated the expectation was for all staff to be trained in trauma informed care. The CR stated the expectation was for the admitting nurse and SSD to follow up with Resident 1's reported history of trauma and triggers upon admission. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555920	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/11/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0699 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview on 3/13/25 at 1:39 p.m. with the director of staff development (DSD), the DSD stated there were no in-services or related trainings for trauma informed care provided for the facility staff. The DSD stated it was important for staff to have had trauma informed care training because the staff needed to be aware of all types of traumas in order to properly provide care to all residents affected. The DSD stated it was important for staff to be educated to identify triggers that could have been avoided for Resident 1. During a review of Resident 1's, Social Services-Trauma Informed Care Evaluation, dated 2/19/25, the evaluation indicated, . I have been thru a lot of abuse in the past, there have been a lot of traumatic experiences . Score 18 . A Positive screen is a total score of greater than or equal to 14. Notify the resident's primary care physician and interested party of a positive screen . During a concurrent telephone interview and record review on 3/13/25 at 2:29 p.m. with the SSD, Resident 1's, Trauma Informed Care Evaluation, dated 2/19/25 was reviewed. The evaluation indicated, . I have been thru a lot of abuse in the past, there have been a lot of traumatic experiences . Score 18 . A Positive screen is a total score of greater than or equal to 14. Notify the resident's primary care physician and interested party of a positive screen . The SSD stated the evaluation was completed upon admission to determine the level of trauma Resident 1 was presenting with in the facility. The SSD stated a high score on the evaluation indicated a high level of trauma presented. The SSD stated there was no care plan created to address Resident 1's trauma and triggers even after Resident 1 had indicated she had a history of trauma and scored high in the trauma evaluation. The SSD stated she could not recall why Resident 1's past trauma was not addressed in the interdisciplinary team (IDT-group usually consisting of physician, director of nurses, social services, resident/resident representative to collaborate in plan of care) meeting held on admission or why Resident 1's physician was not made aware at that time. The SSD stated it was important to document and follow up with any resident who reported a history of trauma. The SSD stated it was important to address Resident 1's trauma to avoid the triggers that were causing distress. The SSD stated it was important for all staff to receive the trauma informed care training in order to care for residents in the facility. During a review of Resident 1's, Independent Activity Monthly Record, dated 3/2025, the record indicated, . 3/1 resident was invited to activities for adult coloring, didn't want to join, 3/2 resident invited to activities, 3/4-3/5 resident invited to activities, 3/7 resident invited to activities, 3/9 resident was asleep didn't want to join activities, 3/10 -3/13 resident was invited to activities . refused . During a concurrent interview and record review on 3/14/25 at 11:22 a.m. with the activities director (AD), Resident 1's Independent Activity Monthly Record, dated 3/2025 was reviewed. The log indicated, . 3/1 resident was invited to activities for adult coloring, didn't want to join, 3/2 resident invited to activities, 3/4-3/5 resident invited to activities, 3/7 resident invited to activities, 3/9 resident was asleep didn't want to join activities, 3/10 -3/13 resident was invited to activities . refused . The AD stated Resident 1 stayed in her room most of the time even after activities are offered on a daily basis. The AD stated, Resident 1 would leave her room for a smoke break daily and would go back to her room to use her personal cellphone. The AD stated, Resident 1 would attempt to participate in some group activities but would become irritable (easily annoyed) and angry with other residents in the dining room, causing Resident 1 to go back to her room. (continued on next page)

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

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F 0699 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1's, Care Plan (CP)-Activities, dated 2/24/25, the CP indicated, . [Resident 1] sets her own activity goal, she will attend group activities of choice, wheels around facility most of the day . During a review of Resident 1's, MDS Section F- Preferences for customary Routines and Activities, dated 2/23/25, the MDS indicated, . how important is it to you to do things with groups of people? Very important, how important is it to you to do your favorite activities? Very important, how important is it to you to listen to the music you like? Very important . During a record review of the facility's policy and procedure (P&P) titled, Trauma Informed Care, dated 2023, the P&P indicated, . It is the policy of this facility to provide care and services which, in addition to meeting professional standards, are delivered using approaches which are culturally-competent, account for experiences and preferences, and address the needs of trauma survivors by minimizing triggers and/or re-traumatization . Trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being . Trauma-Informed Care is an approach to delivering care that involves understanding, recognizing and responding to the effects of all types of trauma. A trauma-informed approach to care delivery recognizes the widespread impact and signs and symptoms of trauma in residents, and incorporates knowledge about trauma into care plans, policies, procedures and practices to avoid re-traumatization . The facility will work to facilitate the principles of trauma informed care which include, Safety - Ensuring residents have a sense of emotional and physical safety. Trustworthiness and transparency - Efforts to establish a relationship based on trust, and clear and open communication between the staff and the resident . Collaboration an emphasis on partnering between residents and/or his or her representative, and all staff and disciplines involved in the resident's care in developing the plan of care . The facility will use a multi-pronged approach to identifying a resident's history of trauma, as well as his or her cultural preferences. This will include asking the resident about triggers that may be stressors or may prompt recall of a previous traumatic event . The facility will collaborate with resident trauma survivors, and as appropriate, the resident's family, friends, the primary care physician, and any other health care professionals (such as psychologists and mental health professionals) to develop and implement individualized care plan interventions . The facility will identify triggers which may re-traumatize residents with a history of trauma. Trigger-specific interventions will identify ways to decrease the resident's exposure to triggers which re-traumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident, and will be added to the residents' care plan . The facility will evaluate whether the interventions have been able to mitigate (or reduce) the impact of identified triggers on the resident that may cause re-traumatization .

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 48713 Based on interview and record review the facility failed to designate and employ a full time Director of Nursing (DON) for the facility from 12/2024 to 3/2025. This failure had the potential for all residents to result in inadequate residents ' care planning and supervision of the nursing department which placed all residents ' health and safety at risk. Findings: During an interview on 3/11/25 at 4:38 p.m. with the Administrator (ADM) and Assistant Administrator (AADM), the ADM and AADM stated there was no DON assigned to the facility since 12/2024. The ADM and AADM stated there was a DON that was supposed to start working full time in the facility, but due to unforeseen circumstances, the DON did not begin employment with the facility. The ADM and AADM stated the facility nursing consultant had been completing some DON duties 1-2 times per week but was not full time. ADM and AADM stated the facility should have had a DON from 12/2024 to 3/2025. The ADM stated there were Registered Nurses assigned as supervisor for the day, but were not completing any DON duties. During a telephone interview on 3/13/25 at 11:43 a.m. with the clinical resource (CR), the CR stated there was no DON employed for the facility. The CR stated she was assigned to assist the facility as needed during the week and would complete DON duties 1-3 days a week. The CR stated she was not the interim DON and did not work full time hours in the facility. During a record review of the facility ' s policy and procedure (P&P) titled, Nursing Services-Registered Nurse (RN), dated 2025, the P&P indicated, . It is the intent of the facility to comply with Registered Nurse staffing requirements . The facility will designate a Registered Nurse to serve as the Director of Nursing on a full-time basis . During a review of the facility ' s job description titled, Director of Nursing, dated 2023, the job description indicated, . position purpose, planning, organizing, developing and directing the overall operations of the Nursing Service Department in accordance with local, state and federal standards and regulations, established facility policies and procedures and as may be directed by the Administrator and the Medical Director, to provide appropriate care and services to the residents . Based on interview and record review the facility failed to designate and employ a full time Director of Nursing (DON) for the facility from 12/2024 to 3/2025. This failure had the potential for all residents to result in inadequate residents' care planning and supervision of the nursing department which placed all residents' health and safety at risk. Findings: (continued on next page)

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