

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 06/17/2025
NAME OF PROVIDER OR SUPPLIER Evergreen Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0774</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Help the resident with transportation to and from laboratory services outside of the facility.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to assist residents in making transportation arrangements to and from their provider appointments for three of seven sampled residents (Residents 24, 29 and 40) when:</p> <p>1. Residents 24 and Resident 40 missed their scheduled appointments due to the transportation arriving late and was not the preferred transportation company requested by Resident 24.</p> <p>This failure resulted in Resident 24 and Resident 40 having to re-schedule their appointments for later dates and caused anger and frustration to Resident 24 and Resident 40's Responsible Party (RP).</p> <p>2. Resident 29 was not picked up from his appointment by the scheduled transportation company. On 5/21/25 Resident 29 left for a 1:00 p.m. appointment at 12:45 p.m. and did not return to the facility until 5:30 p.m. due to Resident 29 waiting four hours for another transportation company to pick him up.</p> <p>This failure had the potential to place Resident 29 at risk of being exposed to harm and resulted in Resident 29 waiting an extended period of time to be picked up from his appointment causing extreme anger and stress to Resident 29.</p> <p>Findings:</p> <p>1. During a concurrent observation and interview on 6/10/25 at 12:23 p.m. with Resident 24, in Resident 24's room, Resident 24 was observed sitting in a wheelchair, dressed and speaking with her roommate. Resident 24 stated she had been at the facility for two years for a fractured back (broken bone in the spine) and broken femur (thigh bone) and knee. Resident 24 stated she has had trouble with her transportation to appointments. Resident 24 stated on two occasions she had missed her appointments when using (name of transport company, [Company A]) transport. Resident 24 stated she did not want to use that company anymore because she had to reschedule her appointments on two occasions. Resident 24 stated they had been late to pick her up on one of those occasions and the other time she asked about using another transport company, so they did not show up to pick her up and said she refused transportation. Resident 24 stated when she informed the Social Services Designee (SSD), she was told she needed to call and complain to her insurance about the transport company [Company A]. Resident 24 stated she used another transport company [Company B] for her dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney[s] have failed) appointments and had no problems with them, and [Company B] was who she wanted to use for her transportation.</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 0774</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 24's admission Record (AR - a document with personal identifiable and medical information), dated 6/12/25, the AR indicated, Resident 24 was admitted to the facility from an acute care hospital on 9/6/23 with diagnoses of end stage renal disease (a condition where the kidneys can no longer function on their own) and type 2 Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing).</p> <p>During a review of Resident 24's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 4/10/25, the MDS section C indicated, Resident 24 had a Brief Interview for Mental Status (BIMS - an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 15 out of 15 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07 indicates severe impairment, 99 indicates unable to complete the interview), which suggested Resident 24 was cognitively intact.</p> <p>During a concurrent interview and record review on 6/12/25 at 10:31 a.m. with the SSD Resident 24's Progress Notes dated 4/16/25 through 5/30/29 for appointments were reviewed. The Progress Notes indicated, on 5/30/25 Resident 24's appointment at the hospital radiology (use of imaging technology) department was rescheduled. The SSD stated residents could requested preferred transportation company, but it was not guaranteed. The SSD stated Resident 24's complaints were for not having a specific company for her transportation. The SSD stated transportation issues had been brought up with the administrator.</p> <p>During an interview on 6/12/25 at 2:22 p.m. with Certified Nursing Assistant (CNA) 3, CNA 3 stated he had not gone with residents to their appointments but had heard of a bus not showing up to pick up residents.</p> <p>During an interview on 6/12/25 at 3:27 p.m. with the Director of Staff Development (DSD)/Infection preventionist (IP), the DSD/IP stated usually a CNA went with residents to appointments. The DSD/IP stated they have had some issues with the transportation company [Company A or B]. The DSD/IP stated there was no good communication with [Company A], Company A would just leave without ringing the door bell in the front gate of the facility.</p> <p>During an observation on 6/10/25 at 10:29 a.m. in Resident 40's room, Resident 40 was observed asleep in bed, wearing a gown and ear plugs, Resident 40 did not answer questions asked.</p> <p>During a concurrent observation and interview on 6/10/25 at 11:53 a.m. with Resident 40 and Resident 40's family member (FM) in Resident 40's room, Resident 40 was observed in bed, dressed, wearing ear plugs and eating snacks. The FM stated Resident 40's transportation to appointments had been an issue. The FM stated one time the vehicle had a flat tire and Resident 40 missed his appointment. The FM stated Resident 40 was rescheduled and the SSD did not communicate to Resident 40 or his Responsible Party (RP) about him missing his appointment.</p> <p>(continued on next page)</p>		

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<p>F 0774</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 40's AR, dated 6/12/25, the AR indicated, Resident 40 was admitted to the facility from an acute care hospital on [DATE] with diagnoses of hemiplegia (paralysis [the loss of the ability to move and sometimes to feel anything] of one side of the body) and hemiparesis (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles), cerebral edema (swelling in the brain), speech disturbances, difficulty walking, anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), and major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities).</p> <p>During a review of Resident 40's MDS, dated 5/13/25, the MDS section C indicated, Resident 40 had a BIMS score of 10, which indicated Resident 40 was moderately impaired.</p> <p>During an interview on 6/11/25 at 9:05 a.m. with Resident 40's RP, the RP stated Resident 40 had been in the facility since December due to a stroke (cerebrovascular accident [CVA]-stroke, loss of blood flow to a part of the brain). The RP stated there was poor communication with the facility. The RP stated she had a lot of trouble with Resident 40's transportation to appointments and one appointment was for the neuroscience facility (study of the nervous system, including the brain and spinal cord). The RP stated transportation was often late for Resident 40's appointments. The RP stated she tried to go with Resident 40 to his appointments. The RP stated Resident 40's appointments had to be rescheduled when he was late because the transportation picked him up late and the facility did not tell her if Resident 40's appointment was rescheduled. The RP stated one appointment Resident 40 missed was in May and she was not notified. The RP stated she found out later that he missed his appointment and the facility rescheduled him. The RP stated one appointment in March that Resident 40 had rescheduled was for surgery on his skull, a skull replacement after his craniotomy (a surgical removal of part of the bone from the skull to expose the brain) that had been planned for one month. The RP stated she was notified by the physician at the hospital. The RP stated Resident 40 has had four to five issues with his transportation. The RP stated Resident 40 was to be transported in his wheelchair, but the transportation driver did not have the right equipment to fit the wheelchair in the vehicle, so they had to reschedule him. The RP stated the transportation driver came and pressed the button to enter facility, and no one at the facility knew Resident 40 had an appointment. The RP stated this happened last month.</p> <p>During a concurrent interview and record review on 6/12/25 at 10:31 a.m. with the SSD Resident 40's Progress Notes, dated 5/21/25 indicated , .(resident name) missed his appointment due to transportation issues. The SSD stated residents were schedule with a diagnosis code which the transportation company used to determine what type of vehicle to transport the resident in. The SSD stated Resident 40 used a special wheelchair that was large and allowed resident to recline. Resident 40 was picked up by transport in a small van which did not accommodate Resident 40 and was not able to transport Resident 40 to his appointment, which needed to be rescheduled. The SSD stated she notified the RP of Resident 40's rescheduled appointments, but did not document her conversations with Resident 40's RP.</p> <p>(continued on next page)</p>		

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<p>F 0774</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/17/25 at 9:41 a.m. with the Administrator (ADM) and the Assistant Administrator (AA), the ADM stated his expectation was for transportation to be scheduled through the third-party transportation company. The ADM stated he had not received any complaints regarding using the third-party transportation company. The ADM stated nurses were to assess the resident to see if they could go by themselves to their appointment and if they were able to transfer themselves in and out of the car. The ADM stated if the resident was not self-transferable, a CNA should have gone with the resident for safety. The ADM stated residents were not usually assessed if they were able to use their cell phone for opening texted links from the transportation company. The AA stated they monitored the resident's return time depending on the approximate time given for the appointment and when the resident left the facility. The AA stated the LOA log was not filled out for appointments, but only if the resident was leaving with a family member. The AA stated the LOA log should have been filled in anytime the resident left the facility, even for appointments. The ADM stated the facility called residents to see if they were ready to be picked up after their estimated appointment time frame. The AA stated the nurse was made aware of when the resident came back. The AA stated she was aware of Resident 29 not being picked up timely and had been trying to get another transportation company to go pick up Resident 29. The ADM stated residents could have gotten anxious about not getting picked up from their appointment. The ADM stated the ADM and AA were responsible for resident safety when they left the facility. The ADM stated if a resident regularly went alone to an appointment, then they could have gone by themselves, but it was a risk for the resident's safety if the resident was waiting for a long period of time to be picked up. The ADM stated they were responsible for communication between both parties, the provider's office and the transportation company. The ADM stated usually nurses would have noticed a resident had not returned from their appointment during medication pass and the CNAs should have noticed when they did their rounds to see if the resident was taking a long time at an appointment. The ADM stated staff should have notified the nurse and called the office and resident, if they had a cell phone to see if they were okay.</p> <p>During an interview on 6/17/25 at 11:45 a.m. with the ADM, the ADM stated for department head training they have resource consultants and other building staff that could have come and trained new department heads. The ADM stated the SSD had the previous SSD train her before she left. The ADM stated as a new staff department head, the SSD will need to focus on priorities and have time to get their system down. The ADM stated he felt the SSD needed some more training.</p> <p>During a record review of the Social Services Professional Competency Evaluation (CE), dated 2/10/25, the CE indicated, . (SSD Name) . will need more support and continuing training . needs ongoing education .</p> <p>During a review of the facility's job description titled, SSD dated 2023, the job description indicated, .The Social Service Designee will assist residents in obtaining transportation to medical appointments, upon discharge .</p> <p>During a review of the facility's job description titled, Charge Nurse, undated, the job description indicated, . schedules follow up appointments for residents and transportation needs as indicated .reports any incidents or unusual occurrences to the supervisor, unit manager, assistant director or nursing or director of nursing and participates in the investigative process as needed .</p> <p>(continued on next page)</p>		

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