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	07/09/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide adequate supervision to ensure safety for one of four sampled residents (Resident 1), when Resident 1 had an order for a one to one staff member supervision due to a physical altercation and the facility did not have staff scheduled on 7/6/25 for the afternoon shift (PM- 2:45 p.m.-11:15 p.m.), 7/6/25 for the night shift (10:45 p.m.-7:00 p.m.) and no staff scheduled for one to one on 7/7/25 afternoon shift.This failure placed Resident 1 at risk for injury from further altercations that could have occurred 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), Anxiety (excessive worry and fear), Blindness (both eyes), Glaucoma (eye condition that damages the nerves), hearing loss.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 6/12/2025, 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.During an interview on 7/8/25 at 2:21 p.m. with Resident 1, in Resident 1's room, Resident 1 recalled events that transpired in the facility. Resident 1 stated the bathroom was shared with the room next door as it had an entry door in both rooms. Resident 1 stated that on 7/1/25 he went to use the restroom, knocked on the door and since no one answered he proceeded to enter. Resident 1 stated he was pulling up his pants, when suddenly the restroom door leading into Resident 2's room opened. Resident 1 stated he then heard Resident 2 yelling profanity and slammed the restroom door. Resident 1 stated, Resident 2 was then heard yelling profanity and demanding that Resident 1 go to his room. Resident 1 stated he is blind and could not see what was happening and proceeded to tell Resident 2, to come toward him. Resident 1 stated, shortly after he felt punches on his body and began hitting back. Resident 1 stated he felt like he had hit Resident 2 once, but did not know where. Resident 1 stated he proceeded to pull up his pants once again when he suddenly felt two hands on his chest push him back causing him to fall and hit his head on the bathroom counter. Resident 1 stated that since the incident the facility had assigned a one to one staff member to him for safety but stated staff were not present every shift. Resident 1 stated there was no one to one staff assigned at times during the night. Resident 1 stated he would call out for staff prior to going to use the restroom multiple times throughout the night but no one was present to assist him.During a review of Resident 1's, Altercation Care Plan (CP), dated 7/1/25, the CP indicated, . Resident had an altercation with another resident. interventions: 1 to 1 close monitoring.During a review of Resident 1's, Order Summary report, dated 7/3/25, the Order Summary report indicated, . one to one monitoring.During a concurrent observation, interview and record review on 7/8/25 at 3:02 p.m. with the director of staff development (DSD), the facility schedule for staff dated 7/1/25-7/7/25 were reviewed on the DSD's computer documents. The staff schedules were not printed and indicated there was not a one on one staff member scheduled for 7/6/25 for the afternoon shift, 7/6/25 for the night shift and no staff scheduled for one to one on 7/7/25 afternoon shift. The DSD stated the schedules were not printed because they were kept on her computer. The review of the employee schedule on the computer, the one on one staff were not documented on the schedule. The DSD stated there were staff present in the facility for a one on one for the dates indicated but staff were not added to the schedule and staff had not signed in to the shift as working a one to one.During a concurrent interview and record review on 7/8/25 at 3:29 p.m. with licensed vocational nurse (LVN) 1, Resident 1's, Altercation Care Plan (CP), dated 7/1/25 and Order Summary report, dated 7/3/25. The CP indicated, . Resident had an altercation with another resident. interventions: 1 to 1 close monitoring. The Order Summary report indicated, . one to one monitoring. LVN 1 stated Resident was supposed to have a one-to-one staff member at all times. LVN 1 stated the purpose of the one-on-one staff member assigned to Resident 1 was to prevent further altercations and to ensure Resident 1's safety.During an interview on 7/8/25 at 3:35 p.m. with certified nursing assistant (CNA) 1, CNA 1 stated Resident 1 was assigned a one to one staff member at all times. CNA 1 stated the role of the one to one was to remain with the resident at all times and when the staff member assigned needed to step away