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	05/27/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to report an incident of bodily injury that required hospitalization for one of three sampled residents (Resident 1) when Resident 1 had an alleged fall on 5/13/26 and was sent to the hospital due to a head injury. This failure resulted in an inaccurate investigation and reporting to state agencies of events leading up to and resulting from Resident 1's fall with injury.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 blindness to the left eye, myocardial infarction(blood supply to the heart is blocked), heart failure, Peripheral Vascular disease (poor blood circulation in your legs and arms), difficulty in walking, need for assistance with personal care, absence of the right toes. 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 4/21/26, 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 interview and record review on 5/27/26 at 9:30 a.m. with the director of nurses (DON), Resident 1's electronic medical record (EMR) was reviewed. The EMR indicated Resident 1 had a reported fall on 5/13/26 that required hospital transfer for further evaluation after Resident 1 reported hitting his head when attempting to self-transfer from the commode to the bed. The DON stated the unwitnessed fall was not reported to state agencies because Resident 1 was alert with minor bleeding to the forehead. The DON stated the facility process was to report major injuries to the state agencies and even though Resident 1 was transferred to the acute care hospital with a head injury, it was considered a minor injury that the facility determined under their clinical judgment. During a review of Resident 1's document titled, Change in Condition Evaluation, dated 5/13/26, the document indicated, . Charge nurse immediately went to assess resident, resident was lying on the floor on his left side, resident was bleeding from left side head, provide pressure to left front of head bleeding stopped. [Resident 1] complains of headache pain 3out 10. [Resident 1] stated he was trying to transfer from bed to bedside commode and lost his balance and fell onto his left side of forehead. [Physician] notified via phone, [Physician] gave order to send [Resident 1] to acute hospital for further evaluation. The document indicated Resident 1 was found lying on the floor in his room with a head injury that required a hospital transfer. During an interview on 5/27/26 at 10:23 a.m. with Resident 2 in Resident 1's room, Resident 2 stated that on 5/13/26 Resident 1 was observed self-transferring from the commode to the bed. Resident 2 stated he observed Resident 1 losing his balance, hitting his head on the commode which caused his head to bounce off and hit the foot of the bed onto the floor. Resident 2 stated that Resident 1 was observed on different occasions to self-transfer without staff assistance. During an interview on 5/27/26 at 11:48 a.m. with the director of staff development (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555920	A. Building B. Wing	05/27/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(DSD), the DSD stated the facility process was to report falls with injury to the state agencies. The DSD stated the expectation was to report falls with injuries that required a hospital transfer for further evaluation. The DSD stated a head injury was a reason for a hospital transfer as it was considered a major injury. The DSD stated the process was to report the fall with injury to state agencies at the time of hospital transfer. During an interview on 5/27/26 at 12:15 p.m. with licensed vocational nurse (LVN) , LVN 1 stated the facility process for falls was to report to the state agencies when there was a fall with injury including a fall with a head injury that required a hospital transfer. LVN 1 stated that a head injury should have been reported to state agencies because the facility was unaware of the extent of the injuries. During a telephone interview on 5/28/26 at 10:00 a.m. with LVN 2, LVN 2 stated that on 5/13/26, Resident 1 had an unwitnessed fall in his room when Resident 1 was attempting to self-transfer. LVN 2 stated that Resident 1 had been noted to self-transfer to the commode in the past and was non-compliant with using his call light. LVN 2 stated Resident 1 required assistance with transferring to and from commode for supervision as he had a physician order for partial weight bearing to his foot. LVN 2 stated that Resident 1 was observed with a head injury on 5/13/26 that required a hospital transfer for further evaluation. LVN 2 stated the facility process was to report the incident to the administration staff who should have reported it to state agencies upon Resident 1's transfer to the hospital. During a telephone interview on 5/28/26 at 11:00 a.m. with certified nursing assistant (CNA) 1, CNA 1 stated that on 5/13/26 Resident had an unwitnessed fall in his room that resulted in a head injury. CNA 1 stated Resident 1 was attempting to self-transfer from the commode to the bed as he was previously seen doing in the past without supervision. CNA 1 stated Resident 1 was non-compliant with the use of the call light and would self-transfer from the commode to the bed. CNA 1 stated Resident 1 required supervision assistance with transfers due to being a fall risk. CNA 1 stated Resident 1 was observed with bleeding to the forehead after the unwitnessed fall and was transferred to the acute hospital for further evaluation. During a review of the facility's policy and procedure (P&P) titled, Compliance with Reporting Allegations of Abuse/Neglect/Exploitation, dated 2025, the P&P indicated, . It is the policy of this facility to report all allegations of abuse/neglect/exploitation or mistreatment, including injuries of unknown sources and misappropriation of resident property are reported immediately to the Administrator of the facility and to other appropriate agencies in accordance with current state and federal regulations within prescribed timeframes. The facility will identify events, occurrences, patterns and trends that may constitute, Neglect: Failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. The facility will investigate all allegations and types of incidents. in accordance to facility procedure for reporting/response. The facility will report all alleged violations and all substantiated incidents to the state agency and to all other agencies as required and take all necessary corrective actions depending on the results of the investigation. The facility will analyze the occurrences to determine what changes are needed, if any, to policies and procedures to prevent further occurrences. The Administrator or designee will: Notify the appropriate agencies immediately: as soon as possible, but no later than 24 hours after discovery of the incident. In the case of serious bodily injury, no later than 2 hours after discovery or forming the suspicion. Within 5 working days of the incident, report sufficient information to describe the results of the investigation, and indicate any corrective actions taken, if the allegation was verified.