STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555179	A. Building B. Wing	01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Point Healthcare & Wellness Centre LP	668 E. Bullard Fresno, CA 93710

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48713 Based on observation, interview, and record review the facility failed to maintain a safe, and homelike environment for 13 of 37 sampled residents when the ceiling light in the dining room was not working and did not provide adequate lighting to meet residents needs. This failure resulted for 13 residents in the facility who routinely used the dining room to have decreased visibility inside the dining room which had the potential to result in eye straining, falls and accidents. Findings: During an observation on 1/23/23 at 12:10 p.m. in dining room A, there were ten ceiling light box covers observed, there was one light box located on the back corner of the dining room that was not working. The back corner of the dining room did not have adequate lighting. During a concurrent observation and interview on 1/23/24 at 12:14 p.m. with Resident 87 in the dining room, the ceiling light above Resident 87's dining room table was observed off and area was observed with dim lighting. Resident 87 stated during dinner the dining room was dark and was difficult to see during meals. Resident 87 stated she had requested the facility to replace the light bulbs. During a review of Resident 87's Admission Record (a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), indicated Resident 87 was admitted to the facility on [DATE] diagnosis included, . Hemiplegia (paralysis of one side of the body) affecting the right dominant side . During a review of Resident 87's Minimum Data Set (MDS- a resident assessment tool used to identify cognitive (mental processes) and physical functional level assessment dated [DATE], the MDS indicated Resident 87'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 87 was cognitively intact. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 1/23/24 at 12:15 p.m. with Resident 73 in the dining room, the ceiling light above Resident 73's dining room table was observed off and area was observed with dim lighting. Resident 73 stated the dining room was too dark to eat during dinner and was a safety concern when moving around in the dining room. During a review of Resident 73's Admission Record, the Admission Record indicated, Resident 73 was admitted to the facility on [DATE], diagnosis included, . encounter for orthopedic aftercare (recovery program after surgery) following surgical amputation (removal of a limb) . legal blindness . During a review of Resident 73's MDS, dated [DATE], the MDS indicated Resident 73's Brief Interview for Mental Status score was 15 out of 15, indicating Resident 73 was cognitively intact. During a concurrent observation and interview on 1/24/24 at 3:28 p.m. with the Assistant Maintenance Supervisor (AMS) inside the dining room. The AMS stated the ceiling light had not worked for at least a year and was in the process for replacement approval from administration. The AMS did not provide the work order for the light fixture upon request and stated the maintenance supervisor would provide it. During an interview on 1/25/24 at 9:08 a.m. with the Maintenance Supervisor (MS), the MS stated dining room ceiling light had not worked for a year. The MS stated the back corner of the dining room was dark but had not received grievances or complaints from residents. The MS stated he was waiting to find the best pricing to fix the ceiling light. The MS did not provide the work order for the light fixture upon request. During a review of facility's, Resident Council Minutes (RCM), dated 1/16/24, the RCM indicated, . List of topics discussed and recommendations, and old business requiring further action . Maintenance light in dining room needs covers and light bulbs need to be replaced . During an interview on 1/26/24 at 9:30 a.m. with the Activities Director (AD), the AD stated the residents was concern of the dining room ceiling light not working. The AD stated the residents wanted to know when the facility would fix ceiling lights. The AD stated maintenance was notified of the ceiling lights not working. During an interview on 1/26/24 at 9:35 a.m. with the Director of Nurses (DON), the DON stated 13 residents routinely used the dining room. The DON stated the facility's expectation was to provide adequate lighting for residents to ensure safety when residents performed dining task. The DON stated maintenance was responsible to fix the ceiling light in dining room. The DON stated the residents concern was valid, the dining room was dark and was hard for residents to see during dinner. During a review of the facility's policy and procedure (P&P) titled, Maintenance Services, dated 1/1/12, indicated, . the maintenance is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times . maintaining the building in good repair and free from hazards . maintaining lighting levels that are comfortable . establishing priorities in providing repair service .

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	555179	A. Building B. Wing	01/26/2024

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40641 Based on interview and record review, the facility failed to ensure the Level I Preadmission Screening and Resident Review (PASRR-The State is required to ensure that every person entering a Medicaid certified Nursing Facility [NF] receives a Level I screening and if necessary a Level II evaluation to ensure that their NF residence is appropriate and to identify what specialized services they may need) was completed for one of five sampled residents (Resident 74) when Resident 74 was readmitted to the facility on [DATE]. This failure had the potential for Resident 74 to not receive the necessary and appropriate psychiatric level of treatment and evaluation in the facility. Findings: During a review of Resident 74's Admission Record (AR), dated 1/25/24, the AR indicated, Resident 74 was readmitted to the facility on [DATE] with diagnoses which included adjustment disorder with disturbance of conduct and depression (sadness). During a concurrent interview and record review on 1/25/24 at 10:24 a.m. with Minimum Data Set Nurse (MDSN), Resident 74's PASSR dated 8/5/23 was reviewed. The MDSN stated the PASSR was completed at the general acute care hospital (GACH) and a copy was sent to the facility when Resident 74 was admitted in the facility on 8/7/23. MDSN stated Resident 74 was sent out to GACH and was away for more than 24 hours and was readmitted in the facility on 10/30/23. MDSN stated she was not able to find a PASSR assessment for Resident 74 when readmitted in the facility and there should have been one. MDSN stated the facility staff are responsible for completing the PASSR assessment for resident readmitted to the facility. MDSN stated for new admission, GACH's are responsible for completing the assessment and send a copy to the nursing facility. MDSN stated the consequences of not having a PASSR completed was the facility will not get re-imburssed for services provided and missed opportunity to asses for mental health and not able to provide the care needed to address the mental health issue. During an interview on 1/26/24 at 2:05 p.m. with the admission director (AD), she stated Resident 74 was admitted to the GACH and readmitted back to the facility on [DATE]. AD stated there should have been a PASSR assessment completed when Resident 74 was readmitted and it was the responsibility of the facility staff to complete the assessment. AD stated it was the responsibility of the licensed nurse to complete the assessment. The AD stated, . No one has noticed that there was no PASSR assessment until now . During an interview on 1/26/24 at 5:05 p.m. with the administrator (ADM) 1, she stated the licensed nurses in the facility are responsible in completing a PASSR assessment for residents readmitted in the facility. ADM 1 stated her expectation was to make sure the PASSR was completed on the day of admission. ADM 1 stated PASSR assessment was important because it is a tool for mental health screening. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of facility's policy and procedure (P&P) titled, Pre-Admission Screening Resident Review (PASRR), dated 8/15/16, the P&P indicated, . PASRR must be completed by midnight of the date of admission or the facility will not be able to bill for any dates service . The facility MDS coordinator will be responsible to access and ensure updates to the PASRR is done .

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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** 40641 Based on observation, interview and record review, the facility failed to ensure a comprehensive, person-centered care plan (a plan that provides direction for individualized care of the resident) was developed and implemented to meet the identified needs for two of 37 sampled residents (Resident 11, Resident 12) when: 1. Resident 11 did not have a care plan for the change of texture of his dessert. This failure had the potential to result for Resident 11's dietary safety needs to go unmet which could lead to aspiration or choking, and poor oral intake. 2. Resident 12's care plan for the used of Quetiapine (a psychotropic [medications that affect the mind, emotions, behavior] medication used to treat several kinds of mental health conditions) did not identify a targeted behavioral goal (the actual undesirable/unwanted behaviors that occurs as a result of a medical behavior) This failure had the potential to result for Resident 12 to receive unnecessary psychotropic medication and decreased psychosocial wellbeing. Findings: 1. During a concurrent observation and interview on 12/23/24 at 12:14 p.m. in the dining room, Resident 11 was observed eating in the dining room. Resident 11's meal ticket indicated puree dessert. Resident stated he did not know what his dessert was and did not like it. During a review of Resident 11's Admission Record (AR), (a document containing pertinent resident profile information) dated 1/25/24, the AR indicated, Resident 11 was admitted to the facility on [DATE], with diagnoses which included convulsions, muscle weakness and paranoid schizophrenia (pattern of behavior where a person feels distrustful and suspicious of other people and acts accordingly). During a review of Resident 11's Minimum Data Set (MDS-a resident assessment tool used to identify resident cognitive, physical abilities and needs) assessment dated [DATE], the MDS assessment indicated Resident 11's Brief Interview for Mental Status (BIMS-screening tool used to assess resident cognition status) 0-15 scale (0-6 severe cognitive deficit, 7-12 moderate cognitive deficit, 13-15 no cognitive deficit) assessment score was 10 out of 15 which indicated Resident 11 had moderate cognitive deficit. During a concurrent interview and record review on 1/26/24 at 8:49 a.m. with the Dietary Supervisor (DS), she stated she was not aware when Resident 11's dessert texture was changed to puree and was not able to find documentations it was discussed to Resident 11. The DS stated there was no care plan for the change of diet texture and a care plan should have initiated. The DS stated it was her responsibility to initiate a care plan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 12/26/24 at 9:55 a.m. with Licensed Vocational Nurse (LVN) 1, Resident 11's Electronic Medical Record (EMR), undated was reviewed. LVN 1 stated she was not aware Resident 11's dessert texture was changed to puree. LVN 1 stated Resident 11's changed of dessert texture was not document on the EMR. LVN 1 stated the changed of dessert texture should have been care planned to monitor for aspiration and poor oral intake from the change of texture. During a concurrent interview and record review on 1/26/24 at 4:35 p.m. with the Director of Nursing (DON), Resident 11's EMR, undated was reviewed. The DON stated she was not aware Resident 11's dessert diet texture was changed. The DON stated there was no documentations in Resident 11's EMR to reflect the change. The DON stated the changed should have been care planned and the physician notified. During a review of the facility's policy and procedure (P&P) titled, Comprehensive Person-Centered Care Planning, dated 11/18, the P&P indicated, . Additional changes or updates to the resident comprehensive care plan will be made based on the needs of the resident . The comprehensive care plan will be periodically reviewed and revised . the comprehensive care plan will also be reviewed and revised at the following times: Onset of new problems . Other times as appropriate or necessary . 47205 2. During a review of Resident 12's Admission Record dated 1/25/24, indicated Resident 12 was admitted to the facility on [DATE] with diagnoses which included dementia (the loss of cognitive functioning - thinking, remembering, and reasoning - to such an extent that it interferes with a person's daily life and activities) with other behavioral disturbance (any persistent and repetitive pattern of behavior that violates societal norms or rules, seriously impairs a person's functioning), Depression (a constant feeling of sadness and loss of interest, which stops you doing your normal activities), schizoaffective disorder (a mental health disorder that is marked by a combination of hallucinations, mood disorder symptoms, such as depression or mania[elevated energy level or activity]) bipolar type (includes episodes of mania and sometimes major depression). During a review of Resident 12's Brief Interview for Mental Status assessment dated [DATE], the BIMS assessment score was 2 out of 15 which indicated Resident 12 had severe cognitive deficit. During an observation on 1/23/24, at 9:56 a.m., in Resident 12's room, Resident 12 laid in bed with eyes closed. Resident 12 did not respond when spoken to. During a review of Resident 12's Order Summary Report dated 1/25/24, the Order Summary Report indicated .Monitor target behaviors for use of Quetiapine (medication used to treat mental health conditions including bipolar disorder and schizophrenia) D/T [due to] bipolar disorder manifested by episodes of unusual change of mood from depress to mania or vice versa every shift indicate Y[yes] if behaviors exist, N[no] if no behaviors indicated . During a review of Resident 12's Medication Administration Record (MAR) dated 1/1/24, the MAR indicated no behaviors on day shift, 16 behaviors on evening shift and no behaviors on night shift between 1/1/24 and 1/24/24. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 12's Behavior Monitoring and Interventions Report dated 1/25/24, Behavior Monitoring and Interventions report indicated no behaviors observed for report .Date Range: 2024-01-01 to 2024-01-25 . During a concurrent interview and record review on 1/25/24, at 11:24 a.m., with Licensed Vocational Nurse (LVN) 3), Resident 12's Care Plan (CP), dated 10/1/22 was reviewed. The CP indicated, . Focus: The resident uses psychotropic medications (Quetiapine medications) r/t [related to] Behavior management DX [diagnosis] bipolar disorder . Interventions: Monitor/record occurrence of for target behavior symptoms q shift . LVN 3 stated Resident 12's CP did not identify specific behaviors nursing staff needs to monitor and did not specify the number of behavioral episodes when to notify the physician. LVN 3 stated the specific behavior, and the frequency of behavior should be documented, and care planned for the physician to review, provide appropriate medication therapy, and for nursing staff to implement behavioral interventions. During a telephone interview on 1/26/24 8:13 AM with Pharmacist (PharmD) 1, PharmD 1 stated Resident 12's Care Plan should have a targeted behavioral goal indicated for psychotropic medications to ensure resident safety and manage drug regimen to determine medication dosage effectiveness in controlling Resident 12's specific targeted behaviors. During a review of the facility's policy and procedure (P&P), titled, Comprehensive Person-Centered Care Planning, dated November 2018, the P&P indicated, . Policy It is the policy of this Facility to provide person-centered, comprehensive and interdisciplinary care that reflects best practice standards for meeting health, safety, psychosocial, behavioral, and environmental needs of residents in order to obtain or maintain the highest physical, mental and psychosocial well-being . Procedure .IV. Comprehensive Care Plan a. within 7 days from the completion of the comprehensive MDS [Minimum Data Set] assessment [a standardized assessment tool that measures health status in nursing home residents], the comprehensive care plan will be developed. All goals, objectives, interventions, etc. from the current baseline care plan will be included in the resident's comprehensive care plan

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40641 Based on observation, interview and record review, the facility failed to provide services which met professional standards of care for one of three sample residents (Resident 46) when the nasal cannula (a flexible tube that goes around your head and into your nose and helps deliver supplemental oxygen) and humidifier (a plastic bottle designed to attached to oxygen machines and add moisture to the end users oxygen) for Resident 46 was undated. This failure placed Resident 46 at risk for respiratory infection which could lead to serious medical condition. Findings: During a concurrent observation and interview on 1/23/24 at 9:45 a.m. in room [ROOM NUMBER] A during the initial tour, Resident 46 was lying in bed, with the oxygen concentrator (medical device that can help patient/resident breath) turned on and set at 2(two).5(five) L (liters-unit of measurement). The nasal cannula and humidifier did not have label with date when it was changed last. Resident 46 stated his nasal cannula tubing had not been replaced recently and was not sure how much oxygen he was supposed to be receiving. Resident 46 stated he needs the oxygen for his breathing. During a concurrent observation and interview on 1/23/24 at 10:40 a.m., with Licensed Vocational Nurse (LVN) 4, LVN 4 checked the oxygen nasal cannula and humidifier of Resident 46 and stated the nasal cannula and humidifier did not have label to indicate the date when it should be changed. LVN 4 stated the practice was for the night shift nurse to change the nasal cannula and humidifier once a week. LVN 4 stated the nasal cannula, and the humidifier should have been dated to ensure it has been changed. During a review of Resident 46's clinical record titled, Record of Admission, dated 1/25/24 Resident 46 was admitted to the facility on [DATE], with diagnoses which included, atrial fibrillation (irregular, often rapid heart rate that commonly causes poor blood flow), obstructive sleep apnea (throat muscles relax and block the airway). During an interview on 1/26/24 at 4:30 p.m. with the director of nursing (DON), the DON stated her expectation was for licensed nurses to follow the facility policy and practice to change the nasal cannula and humidifier weekly and label with the date it was changed. The DON stated it was an infection control issue. During a review of the facility's policy and procedure (P&P) titled, Oxygen Therapy, dated 11/17, the P&P indicated, .The humidifier and tubing should be changed no more than every 7 days and labeled with the date of change . Oxygen tubing, mask and cannulas will be changed no more than every seven (&) days and as needed. The supplies will be dated each time they are changed. Humidifier equipment will be maintained and/or changed per manufacturer's guidelines or no more than every 7 days. They will be dated each time they are changed . (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a professional reference review retrieved from https://www.emphysemafoundation.org/index.php/about-uss/privacy/97-therapeutic-toolbox-articles/519-managing-supplemental-oxygen-supplies#:~:text=Clean%20oxygen%20concentrator%20filters%20weekly,replace%20the%20nasal%20cannula%20immediately. titled, Managing Supplemental Oxygen Supplies, dated 2023, For people living with chronic obstructive pulmonary disease (COPD), supplemental oxygen is one of the most important therapies available when they experience reduced oxygen levels. But effectively managing oxygen can be challenging. To help, the National Heart, Lung, and Blood Institute (NHLBI), part of the National Institutes of Health (NIH), has published tips for doing so, including managing tubing, keeping supplies clean, and practicing oxygen safety . Keeping it clean . Ideally, nasal cannulas should be replaced every two weeks and the long oxygen tubing attached to stationary equipment every three months.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45977 Based on observation, interview, and record review, the facility failed to ensure one of two sampled residents (Resident 299) received treatment and care in accordance with professional standards of practice when Resident 299's serum glucose (a type of sugar in the body) were not reported to the physician according to the physician's orders. This failure placed Resident 99 at risk for hypoglycemia (when the level of glucose in the blood drops below what is healthy), or hyperglycemia (high blood glucose), and hospitalization . Findings: During a review of Resident 299's Admission Record, dated 1/25/24, the admission record indicated, Resident 299 was admitted to the facility on [DATE] with diagnoses which included muscle weakness, urinary tract infection (UTI- infection in any part of the urinary system-kidneys, ureters or bladder), diabetes mellitus (when the body can not produce enough hormone called insulin (used to regulate sugar in the body), or the insulin it produces is not effective), spinal stenosis (when the space inside the backbone becomes too small), heart failure (the heart is unable to pump blood around the body properly), and transient ischemic attacks (mini stroke or when there is a temporary disruption of the blood supply to a part of the brain). During a review of Resident 299's Minimum Data Set (MDS-a resident assessment tool used to identify resident cognitive [pertaining to reasoning memory and judgement] and physical functional level) assessment, dated 1/14/24, the MDS indicated Resident 299's Brief Interview for Mental Status (BIMS-screening tool used in nursing home to assess cognition) assessment score was 15 out of 15 (0-15 scale [0-6 severe cognitive deficit, 7-12 moderate cognitive deficit, 13-15 no cognitive deficit]) which indicated Resident 299 had no cognitive deficit. During a review of the facility's job description titled RN Staff Nurse, undated, the job description indicated, . provides nursing care as prescribed by physician/health care professional in accordance with the legal scope of practice, any Board of Licensing restrictions, and within established standards of care, polices and procedures . Administers professional services and provide care consistent with allowing residents to attain or maintain his or her highest practicable physical, mental, and emotional well-being utilizing the nursing process of assessing, planning, implementing, and evaluating patient care . completes medical treatments as indicated and ordered by the physician . During a concurrent observation and interview on 1/24/24, at 9:28 a.m., Resident 299 was lying in bed, in clean gown and in no apparent distress. Resident 299 stated, when she was at home, she had episodes where her serum glucose would get very low. Resident 299 stated, at the facility, the staff had been checking her Finger Stick Blood Sugar (FSBS - one method of glucose monitoring) for about a week but have stopped now. Resident 299 stated, she had talked to the physician about adjusting her insulin when she first was admitted . (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview, and record review, on 1/24/24, at 3:50 p.m., with Registered Nurse (RN) 1, Resident 299's physician orders titled Order Summary Report, dated 1/24, and Medication Administration Record, dated 1/24, were reviewed. RN 1 stated, the provider had adjusted the dosage of the insulin for Resident 299 when she was admitted . RN 1 stated, the treatment order was for Resident 299's to have FSBS before meals for 7 days, call the provider if the results are greater than 350 or less than 70 and then fax the results to the provider. RN 1 stated, in summary, during the 7 days, Resident 299 had one result of 84, two times greater than 300 and several in the 100 to 200 range. RN 1 stated, the ordered started on 1/9/24 and ended on 1/15/24. RN 1 stated, the results were not faxed to the provider. RN 1 stated, the provider's order was not followed. RN 1 stated, the provider did not have the information to evaluate the change in the medication. During a concurrent interview and record review on 1/25/24, at 10:30 a.m., with the Director of Nursing (DON), Resident 299's physician orders titled Order Summary Report, dated 1/24, and Medication Administration Record, dated 1/24, were reviewed. DON stated, she had not been able to find that the provider had been notified about the FSBS results for the 7 days. DON stated, the nurse did not follow the provider orders and the facility policies. During a review of the facility's Policy and Procedure (P&P) titled Physician Orders, August 21, 2020, the P&P indicated, . VIII. Whenever possible, the licensed nurse receiving the order will be responsible for documenting and carrying out the order . XII. Documentation pertaining to physician orders will be maintained [in] the Resident's medical record . XIII. The current month's administration records will be maintained in the MAR and TAR binders . During a professional reference review, retrieved from Lippincott Manual of Nursing Practice 10th Edition, dated 2014, page 16-17 indicated, Standards of practice General Principles .The practice of professional nursing has standards of practice setting minimum levels of acceptable performance for which its practitioners are accountable .These standards provide patients with a means of measuring the quality of care they receive .A deviation from the protocol should be documented in the patient's chart with clear, concise statements of the nurse's decisions, actions, and reasons for the care provided, including any apparent deviation . Legal claims most commonly made against professional nurses include the following departures from appropriate care: failure to assess the patient properly or in a timely fashion, follow physician orders, follow appropriate nursing measures, communicate information about the patient, adhere to facility policy or procedure, document appropriate information in the medical record . Failure to formulate or follow the nursing care plan . During a professional review titled, Does a Nurse Always Have to follow a Doctor's Orders? undated, retrieved from https://www.registerednursing.org/does-nurse-always-follow-doctors-orders/ indicated, .nurses cannot just randomly decide which order to follow and which not to follow. Unless there is a safety concern or an order that conflicts with personal or religious beliefs, failing to carry out orders can be grounds for discipline by the employer as well as the board of nursing, as it could be deemed 'neglect .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555179	A. Building B. Wing	01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Point Healthcare & Wellness Centre LP	668 E. Bullard Fresno, CA 93710

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 40641 Based on observation, interview and record review, the facility failed to store, prepare and serve food in accordance with professional standards for food safety when Dietary Supervisor (DS) did not wear a hairnet while walking around in the dry storage area inside the kitchen. This failure had the potential to cause foodborne illness to residents, staff and visitors. Findings: During a concurrent observation and interview on 1/23/24 at 8:50 a.m. with the DS and Registered Dietitian (RD) in the kitchen, DS was observed not wearing a hair net while walking around inspecting foods inside the dry storage room. DS excused herself after a few minutes and left the dry storage room. The RD stated the DS left because she was not wearing a hair net. The RD stated the practice and the expectation was for everyone who enters the kitchen to wear a hair net. During an interview on 1/25/24 at 9 a.m. with the Dietary Aide (DA), he stated the expectation was for hair net to be worn upon entry into the kitchen and wash hands before starting any work. The DA stated it was important to wear hair net to avoid hair falling on to foods served to resident. During an interview on 1/26/24 at 9:20 a.m. with DS, the DS stated she was not wearing a hair net when doing a walk through in the kitchen with surveyor and RD. The DS stated she forgot to put on a hair net and the practice was to wear a hair net before entering the kitchen. The DS stated it was an infection control issue and did not want any hair in residents food. The DS stated she wanted everything in the kitchen kept clean and sanitary. During an interview on 1/26/24 at 5:20 p.m. with the administrator (ADM) 1, she stated the expectation and practice was to ensure anyone entering the kitchen are expected to wear a hair net as soon as they set foot in the kitchen. ADM 1 stated it was an infection control issue and to ensure there are no hair in the food served to residents. During a review of facility's policy and procedure (P&P) titled, Dietary Department-Infection Control for Dietary Employee, dated 11/9/16, the P&P indicated, . To ensure that the dietary department is maintained in a sanitary condition in order to prevent food contamination and growth of disease producing organism and toxins . Personal cleanliness is required in sanitary food preparation A. Clean working attire will be worn B. Clean hair-covered with an effective hair restraint while in all kitchen and food storage areas. (And beard/mustache covering when applicable) .

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48713 Based on observation, interview and record review the facility failed to maintain complete and accurate medical records in accordance with accepted professional standards and practices for five of five sampled residents (Resident 24, Resident 36, Resident 80, Resident 42 and Resident 56) when Physician Orders for Life Sustaining Treatment (POLST- a portable form with instructions for emergency medical care that travels with a resident) was not completed in its entirety. These failures had the potential for Resident 24, Resident 36, Resident 80, Resident 42 and Resident 56's medical information to not be readily accessible and portable in case of an emergency. Findings: During a review of Resident 24's Physician Orders for Life Sustaining Treatment (POLST), dated 11/3/20, the back side of the POLST form that provides resident information, supervising physician, and additional contact information was not completed. During a review of Resident 24's Admission Record (a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), indicated Resident 24 was admitted to the facility on [DATE]. During a review of Resident 24's Minimum Data Set (MDS- a resident assessment tool used to identify cognitive (mental processes) and physical functional level assessment dated [DATE], the MDS indicated Resident 24'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 24 was cognitively intact. During a review of Resident 36's Physician Orders for Life Sustaining Treatment (POLST), dated 6/13/23, the back side of the POLST form was not completed. During a review of Resident 36's Admission Record, indicated Resident 36 was admitted to the facility on [DATE]. During a review of Resident 36's Minimum Data Set (MDS- a resident assessment tool used to identify cognitive (mental processes) and physical functional level assessment dated [DATE], the MDS indicated Resident 36's Brief Interview for Mental Status score was 3 out of 15 (0-7 indicated severe cognitive impairment - [memory loss, poor decision making-skills] which indicated Resident 36 had severe cognitive impairment. During a review of Resident 80's Physician Orders for Life Sustaining Treatment (POLST), dated 6/7/23, the back side of the POLST form was not completed. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 80's Admission Record, indicated Resident 80 was admitted to the facility on [DATE]. During a review of Resident 42's Minimum Data Set (MDS- a resident assessment tool used to identify cognitive (mental processes) and physical functional level assessment dated [DATE], the MDS indicated Resident 42's Brief Interview for Mental Status score was 15 out of 15 (13-15 cognitively intact) which indicated Resident 42 was cognitively intact. During a review of Resident 42's Physician Orders for Life Sustaining Treatment (POLST), dated 8/15/22, the back side of the POLST form was not completed. During a review of Resident 42's Admission Record, indicated Resident 42 was admitted to the facility on [DATE]. During a review of Resident 56's Physician Orders for Life Sustaining Treatment (POLST), dated 8/21/23, the back side of the POLST form was not completed. During a review of Resident 56's Admission Record, indicated Resident 56 was admitted to the facility on [DATE]. During a review of Resident 56's Minimum Data Set (MDS- a resident assessment tool used to identify cognitive (mental processes) and physical functional level assessment dated [DATE], the MDS indicated Resident 56's Brief Interview for Mental Status score was 6 out of 15 (0-7 indicated severe cognitive impairment). During a concurrent interview and record review on 1/24/24 at 9:27 a.m. with Licensed Vocational Nurse (LVN) 2, Resident 36's POLST form, dated 6/13/23 was reviewed. The POLST indicated, the back of the form was not completed to its entirety. LVN 2 stated it was expected that the POLST form be completed because the form gives information on Resident 36's code status and full treatment in an emergency. During a concurrent interview and record review on 1/24/24 at 9:30 a.m. with LVN 2, Resident 56's POLST form, dated 8/21/23 was reviewed. The POLST indicated, the back of the form was not completed. LVN 2 stated the back of the POLST form was not completed to its entirety and it was important to have the physician information filled out on the POLST to know the physician discussed the form with Resident 56 or resident representative (RP). During an interview on 1/24/24 at 10:14 a.m. with Registered Nurse Supervisor (RNS), the RNS stated it was important that the back of the POLST form to be completed with Nurse Practitioner (NP) or Physician information to know who the supervising health care provider was. RNS stated it was important to have additional contact information for the facility staff to know who to call in case of emergency. During an interview on 1/24/24 at 10:24 a.m. with LVN 1, LVN 1 stated it was important to have the backside of the POLST form completed to have signatures of completion and to make the form official. LVN 1 stated the facility process was for the nurse to initiate the POLST form completion and it was followed up by the social services department. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/24/24 at 10:49 a.m. with the Social Services Director (SSD), the SSD stated it was the responsibility of the social services department to ensure that the POLST form be completed to its entirety. The SSD stated the POLST should have been completed on the back to ensure staff was given the complete form during an emergency. During an interview on 1/26/24 at 20:49 a.m. with the Director of Nurses (DON), the DON stated it was the expectation for the POLST be completed to its entirety. The DON stated it was important to have the additional contact in the POLST if available during an emergency. During a review of the facility's policy and procedure titled, Physician Orders for Life-Sustaining Treatment (POLST), dated 6/3/2020, indicated, . A completed and signed POLST form is a legal physician order that is immediately actionable . The POLST form must be completed, signed, and dated, include the practitioner's medical license number and be signed by the resident, resident's representative or the resident's health care decision maker . During a review of a professional reference titled, American Nurses Association: Principles of Nursing Documentation, dated 2010, page 8 indicated, .Patient documentation frequently is used by professionals who are not directly involved with the patient's care. If patient documentation is not timely, accurate, accessible, complete, legible, readable, and standardized, it will interfere with the ability of those who were not involved in and are not familiar with the patient's care to use the documentation .