DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/03/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056288	A. BUILDING _____ B. WING _____	C 02/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HANFORD NURSING & REHABILITATION CENTER	[redacted] HANFORD, CA 93230

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health - Licensing and Certification, during the investigation of an Entity Reported Event (ERI): CA00461126 Representing the California Department of Public Health-Licensing and Certification: HFEN 35737. This inspection was limited to the specific ERI investigated and does not represent the findings of a full inspection of the facility. One deficiency was issued for ERI: CA00461126	F 000	F 000 This Plan of Correction is prepared in compliance with state and federal regulations, and is not intended to be an admission to or agreement of the allegations in the survey document.	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, clinical record and administrative document review, and legal definition of the term "ostensible agent" (apparent employee of facility but not hired by facility; with the legal definition below), the facility failed to identify hazards and prevent accidents when one resident (Resident 1) fell from a van lift while the non-medical transportation driver, an ostensible agent was	F 323	F 323 **How corrective actions will be accomplished for those residents found to have been affected by the deficient practice.** Resident one was assessed by paramedics at scene and transferred to AMC 10/7/2016 for evaluation with no negative findings, returned to facility 10/7/2016 on alert charting status post fall for 72 hours. Transportation agreement in place for all further transportation arrangements made for resident. Agreement states, transporter shall promptly and efficiently receive and transport passengers safely, within established schedules. Amended 4/13/16	

RECEIVED
APR 15 2016
CA DEPT. OF PUBLIC HEALTH
LICENSING & CERTIFICATION - FRESNO

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

DNS 3/21/16 Revised

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.

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F 323	Continued From page 1 loading Resident 1 on to a van lift without applying the safety restraints to Resident 1's recliner. This failure resulted in a fall which caused Resident 1 to have physical pain and be insecure about future transportation, and placed resident 1 and other residents, requiring non-medical transportation, at risk of injury caused by accidents. Findings: The facility policy and procedure titled, "Fall prevention Program," dated 10/10/14, indicated, "All Elders environment shall remain as free of accident hazard as is possible and all Elders will receive adequate supervision and assistive device to prevent accidents." Resident 1's face sheet indicated Resident 1 was re-admitted to the facility on 14. Diagnoses included: Hypertension (high blood pressure) with chronic (long lasting) kidney disease, end stage kidney disease, dependence on kidney hemodialysis (HD- medical procedure to remove fluid and waste products from the blood by the use of an artificial kidney) and obesity. Resident 1's physician orders dated 4/3/15, indicated Resident 1's HD would be done at a HD center, "...Dialysis [treatment for end stage kidney disease]four times per week on Tuesday, Wednesday, Thursday and Saturday. Resident 1's fall risk evaluation dated 10/7/15 and 11/16/15, indicated Resident 1 was at a moderate risk for falls.	F 323	**How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** All residents requiring transportation for dialysis services have the potential to be affected. A transportation agreement was facilitated between Mission Medical, Inc: dba Hanford Nursing and Rehabilitation Center and on 1/22/2016. Agreement states, transporter shall promptly and efficiently receive and transport passengers safely, within established schedules. **What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?** Transportation agreement in place as of January 22, 2016 to assure resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	

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F 323	Continued From page 2 Resident 1's MDS (Minimum Data Set- an assessment tool used to identify the level of care needed and given to a resident) assessment dated 8/21/15, indicated Resident 1 weighed 328 lbs (pounds) and had a cognitive (mental) summary score of 11 (which indicated moderate impairment). Resident 1 required total assistance of two people with bed, chair and wheelchair transfers. The MDS assessment indicated Resident 1 required total assistance of one person in locomotion (movement) from and to places outside of room. Resident 1's care plan (CP) made no notation of goals or interventions as to how the facility assessed or would assess the fall risk for Resident 1 during the transportation to and from medical appointments or treatments outside of the facility. On 10/21/15 at 3:40 p.m., during an interview the Assistant Administrator (AA) stated, Resident 1 had sustained a fall from the non-medical transportation vans' lift that caused Resident 1's Geri (recliner chair) chair to break from the fall. On 10/21/15 at 3:55 p.m., during an observation and concurrent interview, Resident 1 cried as she stated the events from her fall on 10/7/15, during her return from the HD center. Resident 1 stated, "That girl [the transportation driver] had trouble from the start, she pushed me into the van ... the chair flipped and I fell backwards...I have had trouble with her before. She transported me from the HD center about three months ago. I had a wound vac (treatment for wounds consisting of a pump that applies negative pressure to a wound) and the tubing got caught on the edge of the vans lift and the girl just yanked the tubing off, making	F 323	**How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system.** The nursing staff will continue to assess residents upon return from dialysis services. Executed transportation agreement will be maintained by the facility. Transportation Agreement brought to QAA committee and approved 2/23/2016. Any incidents, accidents, or concerns identified post transport will be forwarded to the QAA committee for review by the DNS. The QAA committee will develop an action plan as necessary. Responsible persons for monitoring: Administrator.	

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F 323	Continued From page 3 it come off from my leg." Resident 1 stated, "I just hope that this doesn't happen to anyone again, I was in so much pain after I fell and was very scared..." Resident 1 continued crying and stated she was still afraid of being dropped during transportation. On 10/21/15 at 4:30 p.m., during an interview, the Assistant Administrator (AA) stated, the facility did not have any contracts or written agreements for the transportation services provided to the residents of the facility. The AA stated the facility did not consider the transportation company drivers as part of the facility employees and the facility was not involved in the safety training received by the drivers to the transportation company. The AA stated the facility could not ensure residents remained safe when they were with the transportation company drivers. The AA stated the nurses did not communicate the fall risk of a resident to the transportation drivers and the facility did not assist in the loading of the residents on to the transportation van during pick up at the facility. On 10/21/15 at 5:30 pm., during an interview, the Director of Nursing (DON) stated the driver for the transportation company was the only person present during the transportation of Resident 1. The DON stated HD treatment appointments were considered as medical appointments needed to keep residents healthy. The DON stated she had not thought about the risks involved when transporting residents with staff who is unfamiliar with the resident's needs. The DON stated the facility sent staff to accompany residents to appointments when the resident was confused or if family was unavailable to attend. The DON stated the responsible party for	F 323		

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F 323	Continued From page 4 Resident 1 was unable to go with Resident 1 to her HD treatments. The DON was unable to answer how the facility was going to meet the resident's safety needs when being transported to and from the facility. On 1/20/16 at 1:40 p.m., during a telephone interview, the owner to the non-medical transportation company (ATC) stated, "My company provides non-medical transportation, the drivers are not EMT's (emergency medical technician)...I investigated the fall, safety protocols were not followed by the driver, the driver failed to inspect the chair prior to the transport and she failed to apply the brakes, because that is how the chair moved forward and fell from the lift...my husband performed an inspection of our van and determined that the vans belts and flaps were in working order. Through our investigation we identified that [the driver] failed to apply the brakes when she had placed the resident up on the lifter. Since our driver stated that the Geri chair breaks were not working ...we purchased a new Geri chair for the resident and our driver was after her . Safety is important and she failed to perform the safety check." Review of administrative document untitled and dated 10/9/15, indicated a typed written note from the driver who transported Resident 1 on 10/7/15. The document indicated, "...She is in a [Geri] chair so it is hard to load her in the van. I put her on the lifter ...I put the brakes on the [Geri] chair and the belt from the lifter to lift her up to the van...I took the belt and took the brakes off to roll her in the van...I was putting the belt to the side because we have to put the belt in front of her because it does not fit behind her. I went around	F 323		

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F 323	Continued From page 5 her to put the belt aside that is when I noticed the [Geri] chair moving...I couldn't hold her up because she was heavy and that is when she fell..." The facility policy and procedure titled, "Fall prevention Program," dated 10/10/14, indicated, "Elders identified at risk for falls shall have an individual plan of care that includes interventions to prevent falls from occurring...the IDT (interdisciplinary team-team composed of nurse, social worker, dietary aid, activity staff)...will further update care plan to minimize the risk of falls..." Review of legal definition terms, " Legal Dictionary " <http://legaldictionary.thefreedictionary.com/ostensible+agent> " Ostensible agent: n. a person who has been given the appearance of being an employee or acting (agent-[transportation company]) for another (principal-[facility]), which would make anyone dealing with the ostensible agent reasonably believe he/she was an employee or agent...Apparent authority since under the law of agency the employer (the principal) is liable for the acts of his employee (agent), if a person who is not an agent appears to an outsider (a customer-[Resident 1]) to have been given authority by the principal then the principal is stuck for the acts of anyone he allows to appear to have authority.	F 323		