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

[redacted] PRINTED: 09/10/2014
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
	055199	A. BUILDING _____ B. WING _____	C 09/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HORIZON HEALTH AND SUBACUTE CENTER	3034 E HERNDON FRESNO, CA 93720

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F 000	INITIAL COMMENTS Amended- Add Complaint CA00399694. The following reflects the findings of the California Department of Public Health-Licensing and Certification during an abbreviated survey for entity reported incident: CA00398469, CA00399694, CA00409874. Representing the California Department of Public Health: 28502, HFEN. The abbreviated survey was limited to the specific incident investigated and does not represent the findings of a full inspection of the facility. One deficiency was issued for CA00398469. One deficiency was issued for CA00399694. One deficiency was issued for CA00409874.	F 000	"Amendment" #2 (TA) **This plan of correction shall serve as the facility's written credible allegation of compliance.** **Preparation and/or execution of this plan of correction does not constitute admission by the provider or the truth of the facts set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required by the provisions of the Health and Safety Code Section 1280 and C.F.R.**	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise	F 279	**F279: The facility will develop comprehensive care plans for each resident that includes measurable objectives and time tables to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive care plan.** On 6/7/14 the RN Supervisor educated the LVN responsible for updating resident #1's care plan on how to implement new interventions. On 6/13/14 resident #1's care plan was reviewed and updated by the IDT to include appropriate interventions that would address the resident to resident altercation and prevent future interventions.	

Abbrd Delivered

RECEIVED
[redacted]
SEP 30 2014
4:47pm
CA DEPT. OF PUBLIC HEALTH
LICENSING & CERTIFICATION - FRESNO

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[redacted]	Administrator	9-26-14

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 279	Continued From page 1 be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record and administrative document review, the facility failed to review and revise the comprehensive care plan of one of three Residents (Resident 1) after an altercation with another resident. This failure resulted in the potential of not identifying and implementing interventions following each altercation meant to meet the needs of Resident 1 and could possibly have lead to injury and harm to other residents as well as Resident 1. Findings: Resident 1's nurse's notes dated 5/23/14 at 3:55 p.m., indicated Resident 1 was swinging his hand and grabbed another resident's left upper arm. Resident 1's care plan dated 3/20/13 and the care plan "revision on" 5/23/14 indicated under the column: "Focus... Actual: Compromised behavior r/t (related to) aggressive physical contact with staff and resident. 1.) Actual: grabbed the arm of a female resident and ran over her foot/toes with his wheelchair on 4/11/13. 2.) Resident to resident altercation...after backing into the other resident with the wheelchair on 5/6/14.	F 279	2. Residents with similar behaviors had their care plans reviewed through internal incident report documentation by the acting DON including the care plans. 3. Education was provided by the Chief Compliance Officer to the Licensed Nursing staff on 8/5/14, 8/6/14, and 8/7/14 (Exhibit A) regarding identification and accuracy of care planning to the resident's condition or change of condition. Nursing staff was educated on how to individualize each care plan to each resident, review and update as part of the weekly summary process. 4. Residents care plans will be reviewed by the IDT during the residents initial care plan conference and then on a quarterly basis or when resident changes are identified. Trends of non-compliance will be reported. Care plan review is being done by Medical Records designee when auditing new changed or discontinued orders. Care plans are also reviewed when Unit Managers and or new DON is auditing resident changes in condition.	

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F 279	Continued From page 2 3.) Actual grabbed arm of female resident on 5/23/14." Following the documented incidents on 4/11/13 and 5/6/14 the revised interventions were dated, 4/13/14 and 5/8/14, under the column "Interventions." The interventions dated 5/8/14 included monitoring Resident 1 when interacting with other residents; evaluating Resident 1 for pain when agitated; evaluating the need for toileting when agitated; a rest period in bed after lunch per family request. There were no revised interventions on the care plan dated after 5/8/14 on Resident 1's care plan to address the altercation on 5/23/14. On 6/5/14 at 2:07 p.m., during an interview, the Administrator (ADM) stated the facility met with Resident 1's family and the Ombudsman following the incident on 5/23/14 when Resident 1 grabbed another resident. The ADM stated the facility recommended the family take Resident 1 on outings more often and for longer periods of time. The ADM stated the staff had noted Resident 1 became agitated when his family left without telling him. The facility also encouraged the family to tell the resident when they were leaving the facility. On 6/5/14 at 2:14 p.m., during an interview, the ADM reviewed Resident 1's care plan and verified no revised interventions were documented following the incident on 5/23/14 in which Resident 1 grabbed another resident. The ADM stated new interventions "absolutely" needed to be documented on the care plan following the incident on 5/23/14. On 6/5/14 at 2:58 p.m., during an observation in Resident 1's room, Resident 1 was sitting in his	F 279	5. Findings of non-compliance of care planning issues noted by the Unit Manger or designee on the facility indecent report will be reported to the DON daily. Corrective action will be taken by DON/designee as appropriate. DON/designee will continue to monitor issues of non-compliance in comprehensive plan of care of each resident and report to the QA committee on a quarterly basis for evaluation of systems and need for further training of care planning until resolved. 6. Additional in-service training on care planning is scheduled for 10/1/14 and 10/2/14 by our Corporate Compliance Officer to the licensed nursing staff. Care Planning has been added to the new and annual orientation program. 7. The corrective action will be completed by October 9, 2014.	9/9/14

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F 279	Continued From page 3 wheelchair near his bed. Resident 1's right hand and arm were contracted and held close to his torso. Resident 1 only smiled when asked questions. On 6/5/14 at 3:05 p.m., during an interview the Licensed Nurse (LN) 1 reviewed Resident 1's current care plan under the heading "Focus" in the section, "Actual: Compromised behavior r/t aggressive contact with staff and resident..." revised 5/23/14 verified there was documentation of the incident between Resident 1 and another resident on 5/23/14 and verified no new interventions were developed and documented following the incident on that date. On 6/5/14 at 3:15 p.m., during an interview, LN 2 stated Resident 1 was able to self propel himself in his wheelchair. LN 2 stated Resident 1 had recently grabbed two residents' arms. LN 2 stated Resident 1's location was monitored by the staff and Resident 1 was redirected if he was off the unit or exhibiting aggressive behaviors toward others. On 6/5/14 at 4:15 p.m., during an interview, the Certified Nurse Assistant (CNA) stated Resident 1 had recently started grabbing other residents and the interventions were to monitor his behaviors and location. The CNA stated all staff on the unit monitor Resident 1's location but, "...sometimes he [Resident 1] gets by us." The facility policy and procedure titled, "CARE PLANNING / INTERDISCIPLINARY TEAM CARE PLANNING CONFERENCE" undated, indicated under "Policy - All residents will have a comprehensive care plan to meet their individual needs that is prepared by an interdisciplinary	F 279	**F281: The facility will continue to ensure services provided will meet professional standards.** 1. Resident #1 was discharged on 7/28/2014. Acting DON was informed by the family of resident #1 via telephone that medications sent home with resident #1 were not her medications. The acting DON verified with the family of resident #1 that the resident did not take any of the wrong medications. The LVN charge nurse reconciled in house medications reordered as needed. 2. Discharging Charge Nurse or designee will ensure that discharge medication sent home with any resident is reconciled and found to be accurate prior to reviewing it with resident or responsible party. The medication list and any medication cards with the resident will be reviewed with the res. and responsible party, who will sign a copy of the medication list released. A copy of the signed medication list will be kept in the resident's medical file. A Discharge Checklist (Exhibit B) will be completed by the discharging RN/LVN on all discharges.	

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F 279	Continued From page 4 Team within 7 days after the completion of the comprehensive assessment and periodically reviewed and revised after subsequent assessments...9. Care plans are revised per RAI [Resident Assessment Instrument- a tool to document resident abilities and function] schedules and as changes in the resident's condition dictates..."	F 279	3. An in-service was provided to the licensed nurses by the Unit Manager on 8/22/14 (Exhibit C) in regards to releasing correct and accuracy medication on discharge, completing the discharge packet and discharge checklist (Exhibit B). Additional in-services will be conducted by the DSD on October 14 and 16, 2014.	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record, administrative document and professional reference review, the facility failed to meet professional standards of quality when one of three sampled resident's (Resident 1) received medications prescribed for other residents when Licensed Nurse (LN) 2 released medications prescribed for Resident 2 and Resident 3 to Resident 1 upon discharge. This failure had the potential to affect the health and safety of Resident 1. Findings: On 8/19/14 at 10:30 a.m., during an interview, LN 3 stated "I offered to help [LN 2] with the discharge [of Resident 1]. She [LN 3] gave me the pack of meds and the paperwork. I did not review the medications individually." "My supervisor told me to always compare the medication card with the medication list."	F 281	4. Unit Manager will audit 50% of discharges, within 24 hours of discharge, per week for one month. If full accuracy is found then the audits will change to three charts a week for three months. Trends of inaccurately released medications on discharge will be immediately reported to the DON. DON and or Unit manager will notify physician and implement corrective action. DON will report finding to the QA committee on a quarterly basis. 5. Corrective action will be completed by October 9, 2014.	9/9/14

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F 281	Continued From page 5 On 8/19/14 at 10:50 a.m., during an interview, a Family Member (FM) stated Resident 1 was sent home with two different medications for high blood pressure. The FM stated there were two different people's name on the medications. The FM stated she had called the facility after taking Resident 1 home, and the staff asked her to return the medications back to the facility. On 8/19/14 at 10:50 a.m., during an interview, LN 2 stated, "I looked at the first card [card with medications] and it had her [Resident 1's] name [on the card] so I assumed the rest of the medications were hers too. ... two other medications for another two residents had been sent home with her [Resident 1]." During clinical record review on 8/19/14, there was no documented evidence Resident 1 had a diagnosis of hypertension (high blood pressure.) Resident 1's Transfer/Discharge Report dated 7/24/14 indicated a list of current medications. There was no medication used for high blood pressure listed. Review of a facility document containing medication labels to be faxed to pharmacy for discharge medication for Resident 1 included labels for high blood pressure medications (Carvedilol and Amlodipine) labeled as belonging to Resident 2 and Resident 3. The facility policy and procedure titled,..."Discharge With Medications," dated, 3/4/14, indicated under, "Policy: Medications are sent with the resident upon discharge from the facility only under conditions that protect the resident... B. The labels on discharge	F 281	**F323: The facility will continue to ensure that the resident's environment remains free of accidents.** 1. Upon notification of the incident the C.N.A. was immediately suspended pending investigation. It was determined it was an accident. On 5/16/14 the C.N.A. was counseled (Exhibit D) by the DON on safe lifting techniques. 2. Social Services conducted interviews with other residents that were cared for by the same C.N.A. and no negative reports were made. The Unit Manager conducted Safe Patient Handling In-services on 7/17/14 and 7/18/14 with licensed nurses and C.N.A. staff. 3. The DSD will review Safe Patient Handling procedures for newly hired staff and upon annual orientation. Clinical rounds are conducted daily by the new DON, Unit Managers and DSD observing how C.N.A.'s are handle, transfer and reposition residents. Corrective action is taken immediately upon observation as needed. 4. Starting in October 2014, Physical Therapy will conduct rounds two days a month observing safe patient handling by C.N.A.'s and conducting on the spot education to	

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F 281	Continued From page 6 medications are verified for completeness and accuracy by reconciling them against the most recent physician's orders." Review of professional reference, "Medline Plus" website http://www.nlm.nih.gov/medlineplus/ency/article/007484.htm indicated "SIDE EFFECTS OF BLOOD PRESSURE MEDICINES ... all medicines have side effects. Some common side effects of high blood pressure medicines include: Dizziness or light-headedness, Feeling tired, weak, drowsy, or a lack of energy, headache..."	F 281	the C.N.A. This practice will be done for three months and then reevaluated. . 5. Results of the spot checks and education will be provided to the new DON for performance evaluation and training needs. Identified trends will be brought to QA committee on a quarterly basis by the DON. 6. Corrective action will be complete by October 9, 2014.	9/9/14
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 resident and staff interview and clinical record review the facility failed to ensure nursing staff maintained an environment free of accidents when CNA 1 used a drawsheet (a small sheet) to reposition one of 4 Residents (Resident 1) and hit her head on the headboard of the bed. This failure had the potential to cause Resident 1 pain and injury.	F 323		

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F 323	Continued From page 7 Findings: On 5/14/14 at 2:10 p.m., during an interview, the Director of Nurses (DON) stated Resident 1 stated her head was still sore to touch from being bumped on the headboard. On 5/14/14 at 2:20 p.m., during an interview, Resident 1 stated on 5/14/14 (Using Resident 1's daughter as a translater) CNA 1 repositioned her by use of a drawsheet, CNA 1 pulled the sheet toward the headboard which caused Resident 1 to strike her head on the headboard of the bed. Resident 1 stated it had hurt her head and she had said,"Ouch." Resident 1 stated, "It hurt my head." Resident 1 stated her head felt tender. On 5/14/14 at 3:10 p.m., during an interview, CNA 1 stated Resident 1 had slid down in the bed. CNA 1 stated she took the edges of the drawsheet and pulled Resident 1 up in the bed. CNA 1 stated she did bump Resident 1's head on the headboard of the bed. CNA 1 stated Resident 1 said "ouch." The clinical record titled, "Progress Notes" dated 5/14/14 at 7 p.m., indicated, "...(Resident 1) complaint of pain/numbness to the right side of neck...3/10 pain scale [a scale used to describe the severity of pain using 1 as the least amount of pain and 10 as the most severe amount of pain] and described the numbness as heaviness." Resident 1's care plan titled, Activites of Daily Living (ADL's)... "Focus...Goals...Interventions" dated 10/22/13, indicated, "...Deficit related to limited mobility...bed mobility: the resident (Resident 1) requires two staff assistance with repositioning and turning in in bed."	F 323		