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| DEPART | MENT OF HEALTH | AND HUMAN SERVICES | 4 2 | |): 09/10/2014 1APPROVED |
| CENTER | RS FOR MEDICARE | & MEDICAID SERVICES | 1 Anylis | | . 0938-0391 |
| STATEMENT | OF DEFICIENCIES | (X1) FREE CONTROL OF THE CONTROL OF | W. The | M 1/741 | TE SURVEY |
| AND PLAN C | F CORRECTION | IDENTIFICATION NUMBER | BUILDING | | MPLETED |
| | • | Original | | X8-4 | c |
| | • | 055199 Pacifity Notifies | B. WING | | _ |
| NAME OF S | PROVIDER OR SUPPLIER | Name, ICITAL POLICE | ANT | TREET ADDRESS ONLY, STATEMEN CODE | /02/2014 |
| NAME OF I | -KOVIDER OR SUPPLIER | Dalo. | 9 | 034 E HERNDON WIGGOV OO | |
| HORIZOI | N HEALTH AND SUBA | ACUTE OF THE STATE STATE | MANA | 334 E HERNDON | |
| | | Name | | RESNO, CA 93720 | |
| (X4) ID | | ATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX | | Y MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE | COMPLETION DATE |
| TAG | REGULATORY OR L | SC IDENTIFYING INFORMATION) | TAG | CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | DAIL |
| | | | | | |
| | | | | " Ama i it a Ma | |
| F 000 | INITIAL COMMENT | rs . | F 000 | Amendment #2 | |
| | | | | This plan of correction shall serve as the | |
| | Amended- Add Co | mplaint CA00399694. | | facility's written credible allegation of | |
| | | | | compliance. | |
| | The following reflec | cts the findings of the California | .] | (compliance: | |
| | | lic Health-Licensing and | | Preparation and/or execution of this plan | |
| | | an abbreviated survey for | | 1 ±0 | |
| | entity reported incid | | | does not consulting | |
| | CA00399694, CA0 | | | admission by the provider or the truth of | |
| | 07.100000001, 07.10 | 5 10001 1. | | the facts set forth on the statement of | |
| | Representing the C | California Department of Public | | deficiencies. This plan of correction is | |
| | Health: 28502, HFE | | | prepared and/or executed solely because | |
| | | | | required by the provisions of the Health | |
| | The abbreviated su | rvey was limited to the specific | | and Safety Code Santing 1999 | |
| | | ed and does not represent the | | and Safety Code Section 1280 and C.F.R. | |
| | | spection of the facility. | 1 | N. | |
| | inidings of a fair ins | pedion of the radiity. | | | |
| | One deficiency was | s issued for CA00398469. | 1 | F270. | |
| | | s issued for CA00399694. | | F279: The facility will develop | 1 |
| | | s issued for CA00409874. | | comprehensive care plans for each | |
| F 279 | | | F 279 | resident that includes measurable | |
| SS=D | COMPREHENSIVE | | 1 2/3 | objectives and time tables to meet a | |
| 33-0 | COMI INCIDENCIAL | 2 OAKE I EARO | | resident's medical, nursing, mental and | |
| | A facility must use t | the results of the assessment | | psychosocial needs that are identified in | |
| | | and revise the resident's | | the comprehensive care plan. | |
| | comprehensive pla | n of care | 1.7 | | |
| | | Lync & |)Eliver | CI CONTRACTOR OF THE PART OF T | |
| | The facility must de | evelop a comprehensive care | CEI | on 67/14 the RN Supervisor | |
| | | ent that includes measurable | | - 101 | |
| | | etables to meet a residents | | updating resident #1's care plan on | |
| | | nd mental and psychosodial | | to implement new | |
| 1 | | | EP 3 0 2 | 014 interventions. On 6/13/14 resident | |
| | assessment. | | EP 3 0 2 | #1's care plan was reviewed and | |
| | | . | \\\(\lambda\)\(\lambda\) | updated by the IDT to include | , |
| | The care plan must | t describe the services that are | 7.7 | ! <u>' </u> | |
| 7 | | ttain or maintain the resident's | T. OF PUBL | IC HEAL Appropriate interventions that | |
| | | physical, mental, and ENSING & | | TION - FREGINO address the resident to | |
| , . | | peing as required under | | resident altercation and prevent | |
| | | ervices that would otherwise | | future interventions. | |
| | | | | | |
| LABORATOR | DIRECTOR'S OR PROVID | DER/SUPPLIER REPRESENTATIVE'S SIG | NATURE . | , TITLE! | (X6) DATE |

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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| 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 rone 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's care plan dated 3/20/14 at 3:55 p.m., indicated Resident 1's care plan facility and the residents care plan or revision or 5/23/14 indicated under 1's care plan facility failed another residents as well as Resident 1's care plan dated 3/20/13 and the care plan frevision on 5/23/14 indicated under the column: "Focus. Actual: Compromised behavior rt (related to) aggressive physical contact with staff and resident. This failure aggressive physical contact with staff and resident. | DEPART | MENT OF HEALTH | AND HUMAN SERVICES | | | | | | 0938-0391 |
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| NAME OF PROVIDER OR SUPPLIER MO PLAN OF CORRECTION NAME OF PROVIDER OR SUPPLIER HORIZON HEALTH AND SUBACUTE CENTER MO PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL RESULATIONY OR LSC IDENTIFYING INFORMATION) FRESNO, CA 93720 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, including the right to refuse treatment under \$483.10 including the right to refuse treatment to receive and revise the comprehensive care plan of one of three Resident \$1 and could possibly have lead to injury and harm to other residents as well as Resident \$1 and could possibly have lead to injury and harm to other residents as well as Resident \$1 store plan in revise to the plan in the resident \$1 store plan in revise to the resident \$1 store plan in revise to the resident \$1 store plan in the resident \$1 | | | & MEDICAID SERVICES | (V2) MUI | TIDIE | CONSTRI | | | |
| NAME OF PROVIDER OR SUPPLIER HORIZON HEALTH AND SUBACUTE CENTER CAMP DEPARTMENT CAMP | STATEMENT IND PLAN OI | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , , | | | | COMF | PLETED |
| HORIZON HEALTH AND SUBACUTE CENTER Majid D | | | 055199 | B. WING | | | • | 1 - | |
| ## PORIZON HEALTH AND SUBACUTE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL AGE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSc IDENTIFYING INFORMATION) F 279 | NAME OF P | NAME OF PROVIDER OR SUPPLIER | | | STR | EET ADD | DRESS, CITY, STATE, ZIP CODE | | |
| 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 (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 1. 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 snurse's notes dated 5/23/14 at 3:55 p.m., indicated Resident 1 was swinging his hand and grabbed another resident's leading the care plan conference and then on a quarterly basis or when resident, review being done by Medical Records designee when another or compliance will be reported. Care plan review is being done by Medical Records designee when anditing new changed or or condition, new changed or or compromised behavior or the facility new changed or compromised behavior or successful to the precision of | | | | | 303 | 4 E HER | NDON | | |
| PREFIX TAG 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 meat the needs of Resident 1 and could possibly have lead to injury and harm to other residents as well as 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 rft (related to) aggressive physical contact with staff and resident. | HORIZON | N HEALTH AND SUBA | ACUTE CENTER | | FRI | ESNO, (| CA 93720 | | |
| 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'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 or 5/23/14 indicated under the column: "Focus Actual: Compromised behavior r/t (related to) aggressive physical contact with staff and resident. | PREFIX | (EACH DEFICIENC) | Y MUST BE PRECEDED BY FULL | PREF | | (EA | ACH CORRECTIVE ACTION SHOUL SS-REFERENCED TO THE APPROI | D BE | (X5) COMPLETION DATE |
| and ran over her foot/toes with his wheelchair on also reviewed when Unit Managers | F 279 | be required under due to the resident §483.10, including under §483.10(b)(4) This REQUIREME by: Based on observarecord and adminifacility failed to revice comprehensive care Residents (Resident another resident. This failure results identifying and improvements of Resident 1. This failure results identifying and improvements of Resident 1. Findings: Resident 1's nurse p.m., indicated Resident 1. Findings: Resident 1's care plan "revision on" column: "Focus r/t (related to) agg staff and resident 1. | S483.25 but are not provided 's exercise of rights under the right to refuse treatment 4). INT is not met as evidenced ation, staff interview, clinical strative document review, the riew and revise the are plan of one of three ent 1) after an altercation with elementing interventions ercation meant to meet the total and could possibly have lead to other residents as well as e's notes dated 5/23/14 at 3:55 esident 1 was swinging his hand ther resident's left upper arm. plan dated 3/20/13 and the care 5/23/14 indicated under the Actual: Compromised behavior gressive physical contact with ed the arm of a female resident. | | 279 | 3. | had their care plans rethrough internal incident documentation by the actir including the care plans. Education was provided Chief Compliance Officer Licensed Nursing staff on 8/6/14, and 8/7/14 (Extregarding identification accuracy of care plannin resident's condition or cl condition. Nursing stateducated on how to indice each care plan to each review and update as part weekly summary process. Residents care plans reviewed by the IDT duresidents initial care conference and then on a basis or when resident chidentified. Trends of compliance will be report plan review is being Medical Records designated and its continued orders. Care | by the to the 8/5/14, nibit A) and g to the nange of aff was vidualize resident, t of the will be aring the e plan quarterly anges are f non-ted. Care done by the when ged or plans are | |

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2.) Resident to resident altercation...after backing into the other resident with the wheelchair on

4/11/13.

5/6/14.

Event ID: 463P11

Facility ID: CA040000914

If continuation sheet Page 2 of 8

and or new DON is auditing

resident changes in condition.

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

PRINTED: 09/10/2014 FORM APPROVED OMB NO. 0938-0391

| | S EOD MEDICARE | & MEDICAID SERVICES | | | 0 | MB NO. | 0938-0391 |
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| CENTERS FOR MEDICARE & MEDICATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDENTIF | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
| | 055199 | | B. WING | | | | , 2/2014 |
| | ROVIDER OR SUPPLIER | | | 30 | REET ADDRESS, CITY, STATE, ZIP CODE 134 E HERNDON RESNO, CA 93720 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 279 | 5/23/14." Following 4/11/13 and 5/6/14 dated, 4/13/14 and "Interventions." Thincluded monitorin with other resident pain when agitated toileting when agit lunch per family reinterventions on the on Resident 1's callercation on 5/23 On 6/5/14 at 2:07 Administrator (AD Resident 1's famil following the incid grabbed another if facility recommen on outings more of time. The ADM st Resident 1 became without telling him the family to tell the leaving the facility. On 6/5/14 at 2:14 ADM reviewed Region revised interversed interversed interversed following the incident 1 grabb stated new interversed incident on 5/23/16 incide | arm of female resident on the documented incidents on the revised interventions were 15/8/14, under the column e interventions dated 5/8/14 g Resident 1 when interacting is; evaluating Resident 1 for it; evaluating the need for ated; a rest period in bed after equest. There were no revised the care plan dated after 5/8/14 are plan to address the 3/14. p.m., during an interview, the M) stated the facility met with y and the Ombudsman ent on 5/23/14 when Resident 1 aresident. The ADM stated the ded the family take Resident 1 ated the staff had noted the agitated when his family left in. The facility also encouraged the resident when they were interested to 5/23/14 in which ed another resident. The ADM entions "absolutely" needed to on the care plan following the 14. | | 279 | 5. Findings of non-compliance of planning issues noted by the Manger or designee on the findecent report will be report the DON daily. Corrective will be taken by DON/designee continue to monitor issues of compliance in comprehensive of care of each resident and to the QA committee on a quibasis for evaluation of systemed for further training of planning until resolved. 6. Additional in-service training care planning is schedula 10/1/14 and 10/2/14 be Corporate Compliance Off the licensed nursing staff Planning has been added to and annual orientation programments. 7. The corrective action we completed by October 9, 20 | e. Unit acility ted to action nee as will f non-ee plan report arterly ns and of care and for care to c. Care to c. Care the new am. | 9/9/14 |
| | On 6/5/14 at 2:58 Resident 1's roor | B p.m., during an observation in n, Resident 1 was sitting in his | | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/10/2014 FORM APPROVED

| CENTER | S FOR MEDICARE | & MEDICAID SERVICES | | | <u>ON</u> | IB NO. | 938-039 |
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SU IDENTIFICATION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
| | | 055199 | B. WING | · | | 09/02/20 | |
| | ROVIDER OR SUPPLIER I HEALTH AND SUBA | ACUTE CENTER | | 30 | REET ADDRESS, CITY, STATE, ZIP CODE 34 E HERNDON RESNO, CA 93720 | | |
| (X4) ID PREFIX TAG | (FACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 279 | and arm were cont torso. Resident 1 or questions. On 6/5/14 at 3:05 p. Licensed Nurse (Licensed Nurse (Licensed Nurse (Licensed Nurse (Licensed Nurse (Licensed Nurse (Licensed Nurse plan uthe section, "Actual aggressive contact revised 5/23/14 versident on 5/23/14 interventions were following the incident on 6/5/14 at 3:15 stated Resident 1 in his wheelchair. I recently grabbed to Resident 1's locational Resident 1 was unit or exhibiting a others. On 6/5/14 at 4:15 Certified Nurse As had recently started the interventions wand location. The monitor Resident 1 get graphs of the planning / INTE planning Configuration of the plan | s bed. Resident 1's right hand racted and held close to his inly smiled when asked o.m., during an interview the N) 1 reviewed Resident 1's inder the heading "Focus" in I: Compromised behavior r/t with staff and resident" erified there was documentation ween Resident 1 and another 4 and verified no new developed and documented ent on that date. p.m., during an interview, LN 2 was able to self propel himself LN 2 stated Resident 1 had wo residents' arms. LN 2 stated on was monitored by the staff as redirected if he was off the ggressive behaviors toward p.m., during an interview, the esistant (CNA) stated Resident 1 and yere to monitor his behaviors CNA stated all staff on the unit 1's location but, "sometimes | | 279 | F281: The facility will continue to services provided will meet profestandards. 1. Resident #1 was discharged 7/28/2014. Acting DON informed by the family of resident #1 via telephone that medical sent home with resident #1 not her medications. The and DON verified with the family resident #1 that the resident did take any of the wrong medical The LVN charge nurse record in house medications reorder needed. 2. Discharging Charge Nurse designee will ensure that discondication sent home with resident is reconciled and for the accurate prior to review with resident or responsible. The medication list and medication cards with the reviewed with the reviewed with the reviewed with the reviewed with the responsible party, who will copy of the medication released. A copy of the medication list will be kept resident's medical file Discharge Checklist (Exhiwill be completed by discharging RN/LVN or discharges. | d on was ident ations were acting ly of ident ations. Incided as a contract of the contract of | |

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Event ID: 463P11

If continuation sheet Page SEP 3 1 114

Facility ID: CA04000001

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/10/2014 FORM APPROVED OMB NO. 0938-0391

| ND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING | PLETED |
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| 1 | 2/2044 |
| TO CODE | 2/2014 |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE | |
| HORIZON HEALTH AND SUBACUTE CENTER 3034 E HERNDON FRESNO, CA 93720 | |
| The state of the s | (VE) |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
| F 279 Continued From page 4 Team within 7 days after the completion of the comprehensive assessment and periodically reviewed and revised after subsequent assessment instrument- a tool to document resident abilities and function] schedules and as changes in the resident's condition dictates" F 281 483.20(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 residents (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). 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 on always compare the medication on discharge will 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, completing the discharge packet and discharge exhecklist (Exhibit B). Additional in-services will be conducted by the DSD on October 14 and 16, 2014. 4. Unit Manager will audit 50% of discharges, within 24 hours of discharge, within 24 hours of discharge will change to three charts a week for three months. Trends of inaccurately released medications on discharge 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. | 9/4/14 |

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Event ID: 463P11

Facility ID: CA04000014

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| | | & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPL | E CONSTRUCTION | | TE SURVEY |
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| NAME OF F | PROVIDER OR SUPPLIER | , , , | | STREET ADDRESS, CITY, STATE, 2 | IP CODE | |
| 11001701 | N HEALTH AND SUB | ACUTE CENTER | 1 | 3034 E HERNDON | | |
| HORIZOI | N HEALTH AND SUB | ACOTE CENTER | F | RESNO, CA 93720 | | |
| (X4) ID PREFIX TAG | (FACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN | TION SHOULD BE THE APPROPRIATE | (X5) COMPLETION DATE |
| | | | | F323: The facility will co | | 1 |
| F 281 | Continued From pa | age 5 | F 281 | that the resident's envir | onment remains | |
| | On 8/19/14 at 10:5 | 0 a.m., during an interview, a | | free of accidents. | | |
| | Family Member (Fl home with two different people's referent people | M) stated Resident 1 was sent erent medications for high the FM stated there were two name on the medications. The I called the facility after taking and the staff asked her to ions back to the facility. 50 a.m., during an interview, LN at the first card [card with thad her [Resident 1's] name assumed the rest of the hers too two other nother two residents had been | | 1. Upon notification the C.N.A. we suspended pending was determined in On 5/16/14 at counseled (Exhibit on safe lifting tect). 2. Social Service interviews with a were cared for be and no negative of the Unit Manage Patient Handling. | ces conducted other residents that by the same C.N.A. reports were made. reports were made of the conducted Safe g In-services on 8/14 with licensed | |
| | 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 | | | Handling proces hired staff are orientation. Clis conducted daily Unit Managers as how C.N.A.'s a and reposition reaction is taken observation as not starting in Octoor Therapy will condays a month observation. | ober 2014, Physical conduct rounds two serving safe patient | |
| 50511.5115 | 2567(02-99) Previous Version | | <u> </u> | Facility ID: CA040000014 | If continuation s | |
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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | CONSTRUCTION | COM | COMPLETED | | |
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| | | 055199 | B. WING | | ı | C 02/2014 | |
| | (EACH DEFICIENC REGULATORY OR I | ACUTE CENTER ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | 30 | REET ADDRESS, CITY, STATE, ZIP COI 34 E HERNDON RESNO, CA 93720 PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY) the C.N.A. This practice | ECTION HOULD BE PPROPRIATE | (X5) COMPLETION DATE | |
| | 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/0 07484.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" 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. | | F 323 | 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. | | 9/4/14 | |
| · | by: Based on resider record review the staff maintained a when CNA 1 used reposition one of her head on the h | ENT is not met as evidenced and staff interview and clinical facility failed to ensure nursing in environment free of accidents a drawsheet (a small sheet) to 4 Residents (Resident 1) and hit eadboard of the bed. | | | | | |
| | This failure had the pain and injury. | ne potential to cause Resident 1 | | | | | |
| FORM CMS-2 | 2567(02-99) Previous Versic | ns Obsolete Event ID: 463P | 11 Fac | Eility ID: CA040000014 | SEP 3 0 2 | eer Page, 7 of 8 | |

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

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| NAME OF PROVIDER OR SUPPLIER HORIZON HEALTH AND SUBACUTE CENTER STREET ADDRESS, CITY, STATE, 2IP CODE 3034 E HERNDON FRESNO, CA 93720 DEPROVIDER OR SUPPLIER GEACH DEPICIENCY MUST BE PRECEDED BY PULL TAG CONTINUED FROM THE CONTINUE OF PROPUBLISH OF CORRECTION AND ADDRESS OF THE PROPUBLISH PLAN OF CROSS REFERENCE OF THE PROPUBLISH PLAN | | TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ` ' | | LE CONSTRUCTION | CON | | |
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| PORTION HEALTH AND SUBACUTE CENTER SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY WIST BE PRECEDED BY FILL PROVIDERS PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CONFIDENCY) F323 Continued From page 7 Findings: On 574/1/4 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 was the head sheet toward the headboard which caused Resident 1 to strike her head on the headboard of the bed. Resident 1 stated her head felt tender. On 5/14/14 at 3:10 p.m., during an interview, CNA 1 stated Resident 1 stated fit had burt 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 in a slid vouch." 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 10 as the most severe amount of pain and 10 as the most severe amount of pain and 10 as the most severe amount of pain and 10 as the most severe amount of pain and 10 as the most severe amount of pain and 10 as the most severe amount of pain and 10 as the most severe amount of pain and 10 as the most severe amount of pain and 10 as the most severe amount of pain and 10 as the most severe amount of pain and 10 as the most severe amount of pain and 10 as the most severe amount of pain and 10 as the most severe amount of pain and 10 as the most severe | | | 055199 | B. WING | - | | 09/02/2014 | | |
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| dated 10/22/13, indicated, "Deficit related to limited mobilitybed mobility: the resident (Resident 1) requires two staff assistance with | F 323 | Findings: On 5/14/14 at 2:10 Director of Nurses stated her head was bumped on the head on the head of the stated of the stated of the stated had said, "Ouch." If head." Resident 1 On 5/14/14 at 3:10 1 stated Resident 1 On 5/14/14 at 3:10 1 stated Resident 1 On 5/14/14 at 3:10 1 stated Resident 1 The clinical record of the headboard of the headboard of the said "ouch." The clinical record 5/14/14 at 7 p.m., complaint of pain/neck3/10 pain sthe severity of pain and 10 as the and described the Resident 1's care Living (ADL's)" | p.m., during an interview, the (DON) stated Resident 1 as still sore to touch from being adboard. p.m., during an interview, on 5/14/14 (Using Resident 1's slater) CNA 1 repositioned her neet, CNA 1 pulled the sheet ward which caused Resident 1 on the headboard of the bed. it had hurt her head and she Resident 1 stated, "It hurt my stated her head felt tender. p.m., during an interview, CNA 1 had slid down in the bed. took the edges of the lled Resident 1 up in the bed. did bump Resident 1's head on the bed. CNA 1 stated Resident I titted, "Progress Notes" dated indicated, "(Resident 1) numbness to the right side of cale [a scale used to describe in using 1 as the least amount of e most severe amount of pain] in numbness as heaviness." plan titled, Activites of Daily FocusGoalsInterventions" | | 323 | | | | |
| | | dated 10/22/13, in limited mobilityb (Resident 1) requi | idicated, "Deficit related to led mobility: the resident lires two staff assistance with | | | | | ME | |