PRINTED: 03/29/2022
FORM APPROVED

California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA040000049	A. BUILDING: _____ B. WING _____	09/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DYCORA TRANSITIONAL HEALTH-MANCHESTER	3408 EAST SHIELDS AVENUE FRESNO, CA 93726

(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) COMPLETE DATE
A 000	Initial Comments The following reflects the findings of the California Department of Public Health during a staffing audit visit for 24 randomly selected days from 10/01/2019 to 12/31/2019. Representing the Department: R.H., Associate Governmental Program Analyst. Welfare and Institutions (W&I) Code section 14126.022 sets forth the Department's authority to conduct audits of direct caregiver nursing services provided to residents of skilled nursing facilities, and to establish procedures for conducting such audits through All Facility Letters (AFLs). <http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14126.022.&lawCode=WIC> AFL 19-16, setting forth the audit process and guidelines for facilities is available through the following link: <https://www.cdph.ca.gov/Programs/CHCQ/LCP/CDPH%20Document%20Library/AFL-19-16.pdf> Health and Safety Code (HSC) 1337-1338.5, sets forth the requirements for Certified Nurse Assistants is available through the following link: <https://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?division=2.&chapter=2.&lawCode=HSC&article=9> W&I section 14126.022 requires the Department to assess an administrative penalty to a SNF if the Department determines that the SNF fails to meet the DHPPD requirements pursuant to HSC sections 1276.5 or 1276.65. The Department shall assess an Administrative penalty to any facility that fails to meet the applicable standard	A 000	Dycora Transitional Health and Living Manchester submits this response and Plan of Correction as a part of the requirements under State and Federal law. The Plan of Correction is submitted in accordance with specific regulatory requirements; it shall not be construed as admission of any alleged deficiency cited or any liability. The provider submits this Plan of Correction with the intention that it is inadmissible by any third party in any civil, criminal action or proceedings against the provider of its employees, agents, officers, directors or shareholders. The provider reserves the right to challenge the cited findings if at any time the provider determines that the disputed findings are relied upon in a manner adverse to the interest of the provider either by governmental agencies or third party. Any changes to provider policy or procedures should be considered to be subsequent remedial measures as that concept is employed in rule 407 of the federal rules of evidence and California evidence code section 1151 and should be inadmissible in any proceedings.	

Licensing and Certification Division

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jeanne Gordon | TITLE: Administrator | (X6) DATE: 4/5/22

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A 000	Continued From page 1 for staffing requirements on any given day. The applicable standard is 3.5 DHPPD and 2.4 DHPPD (CNA), unless an approved Workforce Shortage or Patient Needs Waiver is granted. Based on record review and interview, the above nursing facility was found in compliance with HSC 1276.65(c)(1)(C), the requirement for 2.4 Direct Care Service Hours Per Patient Day for Certified Nurse Assistants based on an approved waiver. Final Audit Result: Total Distinct Non-Compliant Day(s) = 12	A 000	A 200 Immediate measures and systemic changes 1. The dates listed are from 2019 and cannot be remedied, 2. Ads have been placed for C.N.A's and Licensed nurses 3. The administrator will review what the ppd staffing is each day at stand up & on Fri review the staffing for the weekends/holidays 4. The administrator will educate the staffer to notify the administrator or DON if the facility is in jeopardy of not meeting the 2.4/3.5.	
A 200	HSC 1276.65(c)(1)(B) SAS - 3.5 Standard (B) Effective July 1, 2018, skilled nursing facilities, except those skilled nursing facilities that are a distinct part of a general acute care facility or a state-owned hospital or developmental center, shall have a minimum number of direct care services hours of 3.5 per patient day, except as set forth in Section 1276.9. This Statute is not met as evidenced by: Facility failed to meet 3.5 direct care service hours per patient day (DHPPD), pursuant to HSC 1276.65(c)(1)(B) for 12 of 24 days. The statute was not met as evidenced by the following findings: The Director of Nursing (DON) failed to delineate time spent providing nursing services to skilled nursing care patients beyond the hours required	A 200		

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A 200	Continued From page 2 to carry out the duties of the DON position per AFL 19-16, section II, D.5. The Director of Staff Development (DSD) failed to delineate time spent providing nursing services to skilled nursing care patients beyond the hours required to carry out the duties of the DSD position per AFL 19-16, section II, F.1.i. Documents/records, other than payroll records, were incomplete, illegible, or inaccurate [AFL 19-16, section II, B.1]. Time spent providing direct care could not be verified. Failure to provide the information has resulted in the exclusion of all service hours for such employees. Per HSC, section 1337.2 (f) "...It shall be unlawful for any person not certified under this article to hold himself or herself out to be a certified nurse assistant." CDPH found staff with lapsed, suspended, expired or revoked certifications. This necessitated excluding all service hours for such employees per AFL 19-16, section II, D.3). Time spent providing nursing services could not be verified. Failure to provide the information has resulted in the exclusion of all service hours for such employees per AFL 19-16, section II, A. The total number of actual direct care nursing hours performed by direct caregivers per patient day divided by the average census during the patient day failed to meet DHPPD Staffing Standard(s) per AFL 19-16. Review of the documentation provided for audited day(s) resulted in the following Non-Compliant DHPPD result:	A 200	MONITORING 1. The administrator will meet with the scheduler at least weekly to review for any staffing needs. 2. The facility will hold a recruitment and retention meeting at least quarterly or as needed to maximize efforts to recruit and retain employees and report the recommendations to the QAPI Committee. DATE CERTAIN 4/28/22	