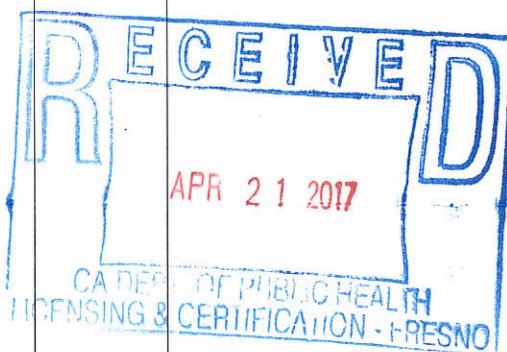


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/14/2017  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>055199</b>		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/11/2017</b>	
NAME OF PROVIDER OR SUPPLIER  <b>HORIZON HEALTH AND SUBACUTE CENTER</b>				STREET ADDRESS, CITY, STATE, ZIP CODE <b>3034 E HERNDON</b> <b>FRESNO, CA 93720</b>			
(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	<b>INITIAL COMMENTS</b>  <p>The following reflects the findings of California Department of Public Health-Licensing and Certification, during an abbreviated survey for complaint: CA00513350</p> <p>Representing the California Department of Public Health-Licensing and Certification: Federal ID 31651, HFEN.</p> <p>The abbreviated survey was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility.</p> <p>No deficiencies were issued for complaint number: CA00513350</p>			F 000			



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

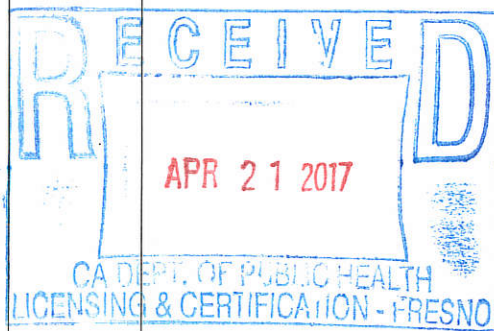
*[Signature]* *Administrator* *04/17/17*

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.

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

PRINTED: 04/14/2017  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>555311</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/11/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>DOS PALOS MEMORIAL SKILLED NURSING FACILITY</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2118 MARGUERITE ST</b> <b>DOS PALOS, CA 93620</b>		
(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	<p><b>INITIAL COMMENTS</b></p> <p>The following reflects the findings of the California Department of Public Health - Licensing and Certification during an ABBREVIATED SURVEY of two Entity Reported Incidents (ERI).</p> <p>ERI CA00498563 and ERI CA00518103.</p> <p>Representing the California Department of Public Health: Federal ID 36476, Health Facilities Evaluator Nurse.</p> <p>The ABBREVIATED SURVEY was limited to the specific incidents investigated and does not represent the findings of a full inspection of the facility.</p> <p>No deficiencies were issued for ERI CA00498563 and ERI CA00518103.</p>	F 000			



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

*Patricia Keup RN*

*DON*

*4/17/17*

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.

*D*