	<u>HS FOR MEDICARE</u> FOF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		Original OMB NO. 0938-039
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	Dele: 21 9715110
		056288	B. WING	Time: 4: 1 PM C Notified Sp. Vinc. The Eq. 10.4 (452) 02/26/2016
AME OF	PROVID E R OR SUPPLIER		T	STREET ADDRESS, CITT, STATE, ZIP CODE
IANFOF	RD NURSING & REHA	BILITATION CENTER		1007 WEST LACEY BLVD HANFORD, CA 93230
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (XS) (EACH CORRECTIVE ACTION SHOULD BE COMPLETION
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) COMPLÉTION DATE
F 000	INITIAL COMMENT	rs .	FOO	
	The fellowing	een tha findiage of the	[compliance with the same and interest of the art VE
		ets the findings of the ent of Public Health-Licensing		1.000
	and Certification du	ring a RECERTIFICATION		admission to or agreement of the allegations in the survey document.
	survey.]	10 10 1
		alifornia Department of Public		F 221 APR - 8 2016
		N, 20362 HFEN, 36067		How corrective actions will be
1	TITEN, 30244 TIPE!	N, and 36578 HFEN.		accomplished for three CASAERT COEPUBLIC HEAL
	Capacity: 124			have been affected SING & GERTLE CATION - F
	Census: 85 Sample: 17			practice.
	Random: 5	k		The IDT completed a Physical
				The IDT completed a Physical Restraint/Enabler Assessment for resident
		dent (ERI) Regulatory ed for the following ERI during		10 on 2/24/16, reviewed and revised the
	the Recertification S			residents' plan of care to reflect her current
	- O 4 6 0 4 mm 4 0 0 1 1 1 1			status. Resident's 10's MDS was revised by
	CA00477100: No de	eficiency was issued.		MDS coordinator to reflect the resident use
	Complaint investiga Survey:	ted during the Recertification		of physical restraint devices. How the facility will identify other
	70 4 00 4 500 424 Durbon			residents having the potential to be
	issued - F 314.	tantiated with one deficiency		affected by the same deficient practice
F 221	483.13(a) RIGHT TO PHYSICAL RESTRA		F 22	and what corrective action will be taken.
SS=D				The IDT completed a review of all residents
		e right to be free from any		who utilize full bilateral side rails on
		nposed for purposes of ience, and not required to	1.0	2/24/16. All residents' current Physical
	treat the resident's r			Restraint/Enabler Assessment were reviewed to ensure that they reflect residents
	•			current status. The IDT was in-serviced on i
	This PEOURPEMEN	T is not met as evidenced		physical restraint use and reduction 2/29/16
	by:	I I I IIOF HIGT TO CAMPHIOGO		by the regional director of clinical services.
	Based on observati	on, staff interview, and clinical		Amereled 41-116 W
PATORY	MIRECTORS OF PROVIDE	ER/SUPPHIED REPRESENTATIVE'S SIGN	ATURE	THE 2W DUS 3/25/169

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:Z1PB1

Facility ID: CA040000017

If continuation sheet Page 1 of 26

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDI	NG	C
		056288	B. WING		02/26/2016
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	
HANFOR	ID NURSING & REHA	BILITATION CENTER		1007 WEST LACEY BLVD HANFORD, CA 93230	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDENCE)	D BE COMPLETION
F 221	failed to ensure one (Resident 10) was it used for purposes of Resident 10 was re sideralls without into minimize their usag This failure violated of a physical restrai Findings: Resident 10's clinic readmitted to the fa diagnoses of Alzhei heart failure, and dy swallowing). Review of Resident dated 2/14/16, indic order: "SIDE RAILS UP X [related to] MUSCLI TO ALZHEIMER'S of related to ALZHEIM WEAKNESS GENE dated 3/27/13, and of Review of Resident "MDS" [Minimum Di used to assess peri and physical functio Resident 10 had no use. Review of Resident	document review, the facility of two sampled residents are from physical restraints of convenience, when strained with full bilateral ervention to reduce or e. Resident 10's right to be free ant. All record indicated she was cility on 3/26/13, with mer's dementia, hypertension, sphagia (difficulty 10's Order Summary Sheet ated the following physician 2 FOR BED MOBILITY R/T E WEAKNESS SECONDARY every day and night shift ER'S DISEASE MUSCLE RALIZED." The order was	F 22	What measure will be put into per what systemic changes the facilimake to ensure that the deficient process does not recur? IDT will follow Hanford Nursing Rehabilitation's policy and processing physical restraint us reduction. All residents utilizing prestraints will be reassessed quarterly IDT and as needed to assure they from the use of physical restraint purpose of convenience. The prestraint audit will be completed by Records Director on admission, quand as needed. How the facility plans to monit performance to make sure that so are sustained. The facility must deplan for ensuring that correct achieved and sustained. This plan rimplemented, and the corrective evaluated for its effectiveness. The correction is integrated into the assurance system. Any findings identified in the records audit of the Physical Restrain will be brought to the Quality Assurance in the process of the process of the process are identified Quality Assurance Committee the develop and implement an action prompliance as peaced.	and occedure e and obysical by the are free cuts for obysical Medical carterly, tor its clutions welop a cion is aust be action plan of quality medical t Audit surance three by the y will
ORM CMS-25	67(02-99) Previous Versions				ation sheet Page 2 of 26
			,		PUBLIC HEALTH IFICATION - FRESNO

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO	. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	COM	E SURVEY APLETED
		056288	B. WING		· I	C /26/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	UE/	20/2010
HANFOF	RD NURSING & REHA	BILITATION CENTER		1007 WEST LACEY BLVD HANFORD, CA 93230		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRIED TO THE APPRO	ULD BE	(X5) COMPLETION DATE
F 221	restraint devices in On 2/23/16 at 1:50 Resident 10 was obtall bilateral sideralia On 2/23/16 at 3 p.m Certified Nurse Ass for Resident 10 on a whether Resident 1 turning, he stated, " On 2/23/16 at 4 p.m Charge Nurse (CN) whether Resident 1 She further stated s CNA staff. On 2/24/16 at 7:40 a Resident 10 was obtatching television, bed. Resident 10's Care under Focus, "The restraints full side ra Mobility r/t Muscle V Interventions it indicestraint use per po- continuing risks/ben to restraint, need for restraint useObs MD as needed char of restraint, less res appropriate," On 2/24/16 at 10 a.u On 2/24/16 at 10 a.u	Resident 10 had no physical use. p.m., during an observation, served lying in her bed with in place. n., during an interview, istant (CNA) 1 stated he cared a regular basis. When asked 0 utilized her sideraits for Not really. n., during an interview, 1 stated she did not know 0 utilized her siderails to turn. he would have to ask the a.m., during an observation, served lying in her bed, both full siderails up on her Plan dated 2/23/16, indicated resident uses physical als x 2 (SRX2) for Bed Veakness. Under ated, "Evaluate resident's icy. Evaluate/record refits of restraint, alternatives ongoing use, reason for erve for/document/report to ges regarding effectiveness trictive device, if	F 2			
-ORM CMS-25	Observation and inte	Obsolete Event ID: Z1PB11			ivation sheet	Page 3 of 25
		,		CA DEPT.	OF PUBL	IC HEALTH ATION - FRESNO

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
		056288	B. WING						C	40
NAME OF F	PROVIDER OR SUPPLIER	,		Ī	STREET ADDRESS	S, CITY, ST	ATE, ZIP CODE		2/26/20	716
HANFOR	d Nursing & Reha	BILITATION CENTER	·		1007 WEST LAC	EY BLVD				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROV (EACH C	TIDER'S PLA CORRECTIV EFÉRENCE	N OF CORRE E ACTION SHO D TO THE APP CIENCY)	OULD BÉ COM		X5) *LETION ATE
F 221	second staff person and physically turne assist the staff and siderails. CNA 2 ma Resident 10 to use On 2/24/16 at 4 p.m Director of Nursing bilateral side rails w measures. On inqui stated Resident 10 history of accidents been identified for F physical restraint. OResident 10's siderabed is an older mod ground. When aske toward restraint red the facility had no directly had no	every two hours. CNA 2 and a rentered Resident 10's room at her. Resident 10 did not made no effort to use her ade no attempt to prompt her siderails. In, during an interview, the (DON) stated Resident 10's were in place for safety iry regarding safety, she had no history of falls, no and no safety issues had resident 10 necessitating a printher inquiry, she stated alls were in place because her del, and sat higher from the add about interventions taken uction measures, she stated ocumentation of reduction or es. p.m., during an interview, the MDSC) stated the facility used then to evaluate quarterly the restraints. The assessments document titled, "Physical eview" dated 11/30/15, commendations, "1. Continue	Fí	222	1					
	continue with Restra during assessment Reduction not appro	for muscle weakness, aints, attempted to reduce and not indicated at this time. opriate this quarter, monitor					EC	E 1 V	V E	
*ORM CM8-25	67 (02-99) Previous Versions	Obsolete Event ID: 21 PB11	·	F	ecility ID: CA040000	C)		= 8 20 F PUBLIC RTIFICAT)16 HEAL	H

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

	OF DEFICIENCIÉS OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		056288	B. WING	}	•		C
	PROVIDER OR SUPPLIER D NURSING & REHA	BILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1007 WEST LACEY BLVD HANFORD, CA 93230	<u> </u>	26/2016
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)		(X5) COMPLETION DATE
F 221	Continued From participation of heads assessment who assessment is comparate of the distribution of heads assessment is comparate of the assessment when the assessment is comparate of the assessment of the assessment is comparate of the assessment of the assessme	ge 4 as needed] and quarterly." p.m., during an interview, the umentation was available on need in the above document. Int titled, "Physical Restraints" ndicated under Policy, "Facility is right to be free from any imposed for purposes of purposes of the process of the pro		22	F 278 How corrective actions accomplished for those resident have been affected by the practice. Resident 5,7,8,10 and 19's mo MDS were immediately updated to the current use of restraint device MDS coordinator. DNS and coordinator were in serviced immediately updated to the current use of restraint device MDS coordinator.	will be sound to deficient oreflected tes by the domain of	DATE
	Under Medicare and	d Medicaid, an individual who					W /
FORM CMS-25	67 (02-99) Previous Versions ·	Obsolete Event ID: Z1PB11		F	APR CA DEPT. OF LICENSING & CEF	PUBLIC	6 HEALTH

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
ļ		ASCADD	B. WING			C
NAME OF	PROVIDER OR SUPPLIER	056288	Ø. 99 (19C		TREET ADDRESS, CITY, STATE, ZIP CODE	02/26/2016
l	•		•	ı	007 WEST LACEY BLVD	
HANFOR	d Nursing & Reha	BILITATION CENTER		F	ANFORD, CA 93230	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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 APPROP DEFICIENCY;	BE COMPLETION
· F 278	willfully and knowing false statement in a subject to a civil mo \$1,000 for each asswillfully and knowing to certify a material resident assessment penalty of not more assessment.	gly certifies a material and a resident assessment is oney penalty of not more than sessment; or an individual who gly causes another individual and false statement in a ant is subject to a civil money than \$5,000 for each	f:	278	How the facility will identify residents having the potential affected by the same deficient and what corrective action will be. All residents who utilize full bilater rails as restraints have the potential affected by the deficient practice 2/26/2016 the MDS coordinator re and revised section "p" of all MDS's residents utilizing full bilateral side in reflect current use of restraint devices.	to be practice taken. all side to be On viewed of all rails to
	This REQUIREMENt by: Based on observat administrative docu to accurately reflect sampled residents (Resident 8, Resident 8 ampled random reside rails used as a not recorded on the (MDS) assessment resident's cognitive 1. Resident 5's MDS 2. Resident 7's MDS 3. Resident 8's MDS and 12/9/15 4. Resident 10's MDS and 11/30/15 5. Random Resider dated 9/10/15 and 1	ion, interview and clinical and ment review, the facility failed the status for four of 17 (Resident 5, Resident 7, at 10), and one of five sidents (Resident 19), when physical restraint device were following Minimum Date Set (a periodic assessment of and physical function): 3 assessment dated 1/18/16 assessment dated 2/1/16 assessment dated 3/28/15, assessments dated 9/4/15, at 19's MDS assessment			What measure will be put into p what systemic changes the facili make to ensure that the deficient p does not recur? MDS coordinator's employment Outside corrective evaluated for its effectiveness. The process of section "P" during resident's questraint review to assure accurate cophysical restraints. How the facility plans to monit performance to make sure that so are sustained. The facility must deplan for ensuring that correct achieved and sustained. This plan implemented, and the corrective evaluated for its effectiveness. The process of the process	lace or ty will bractice was usulting lization ding of a audit earterly ding of tor its lutions velop a ion is sust be action blan of
FORM CMS-25		ondary to the use of side rails		Fac		8 2016 UBLIC HEALTH FICATION - FRESNO

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

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATÉ SURVEY COMPLETED
		056288	B. WING		C 02/26/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	02/20/2010
				1007 WEST LACEY BLVD	
HANFOR	D NURSING & REHA	BILITATION CENTER		HANFORD, CA 93230	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 278	as a physical restra Findings: 1. Resident 5's clin admitted to the facil diagnosis of anoxic (deformity and stiffred to the facility and stiffed to the facility swallowing on 2/23/16 at 10:50 in Resident's 5's root bed with two full side on 2/23/16 at 4 p.m. Resident 5 stated simore easily with both on 2/24/16 at 11:30 interview and docum MDS Annual assess reviewed, the MDS section "P, Physical bilateral side rail use MDSC stated the side oded as a physical mistake. She further thought if they [the restraint] it was redefinitionthey [the probably all wrong." On 2/26/16 at 2:45 probably all wrong." On 2/26/16 at 2:45 probably all wrong."	int. ical record indicated she was ity on with a brain damage, contractures less of joints), unspecified, aphasia (loss of ability to ess speech), and dysphagia g). a.m., during an observation om, the resident was laying in erails up. I., during an interview, he felt safer and could move th side rails up. a.m., during a concurrent ment review, Resident 5's sment dated 1/18/16 was Coordinator (MDSC) stated Restraints" did not indicate erails should have been restraint, this was her er stated, "I didn't realize! esident] couldn't get out [of the a restraint	F 278	will be brought to the Quality As Committee meeting quarterly for quarters. If concerns are identified Quality Assurance Committee the develop and implement an action prompliance as needed. Responsible persons for monitoring and Administrator.	three by the cy will lan for
*QRM CM\$-25(87 (02-99) Previous Verslons (Obsolate Event ID: Z1PB11	Fac	APR - 8	2016
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CENTE	TO FUR MEDICANE	A MEDICAID SERVICES					MIR NO	<u>. บรรช-บรรา</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		CON	E SURVEY
		056288	B. WING	·			1	C /26/2016
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	STA	EET ADDRESS, CO	TY, STATE, ZIP CODE		<u> </u>
HANFOR	D NURSING & REHA	BILITATION CENTER			7 West Lacey B NFORD, CA 932			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORR	R'S PLAN OF CORRECTION RECTIVE ACTION SHOUL RENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 278	Continued From pa		F2	278				
	indicated, "Side rails mobility R/T [related	ian orders dated 12/15/14, s up x 2 [bilateral side rails] for i to] muscle weakness porosis every day and night 15/14."						
		ent 7 was observed in bed with its up times two. He gripped						
		m., during an observation, his bed with bilateral 3/4 side						
	admitted to the facil	record indicated he was ity on 9/8/14, with a diagnosis ire ulcers, above the knee tory of falling.						
	For The Use Of Res Type Of Restraint: [3	nt titled "Resident Information straints", dated 1/29/16, under 3/4 side rails up times 2 for to muscle weakness ntia]."						
·		al Restraint/Enabler review ted "Yes" "Restraints currently						
l	2/11/16,	Summary dated 2/3/16, and ere used in the last 7 days -	٠.					,
		Summary Report, dated there was no physician order) ECEI	V [
ORM CMS-250	87 (02-99) Právious Verzions (Obsolete Event ID:Z1PB11		Facility	ID: CA04000017	If continue		Parelle
			ì			APR - 8	2016	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTEDO ECO MEDICADE & MEDICAD CEDACEO

	-DICARE	A MEDICAID SERVICES	<u> </u>				<u> </u>	<u>VIB NU,</u>	0930-038	ㅗ
STATEMENT OF DEFICIEN AND PLAN OF CORRECTK		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ECONSTRUCTION				SURVEY PLETED	
		056268	B. WING	·				02/2) 26/2016	
NAME OF PROVIDER OR	SUPPLIER	<u></u>		Şī	REET ADDRESS, CIT	TY, STATE, ZIP C	ODE			7
HANFORD NURSING	& REHA	BILITATION CENTER		1	007 WEST LACEY E ANFORD, CA 932					
PREFIX (EACH	DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	DX	(EACH CORR CROSS-REFER	R'S PLAN OF CO! LECTIVE ACTION ENCED TO THE DEFICIENCY)	SHOULD	BE	(X5) COMPLETION DATE	
2/8/16, Ind Care Confi "current in Resident ? Resident ? Restraints On 2/25/16 stated the physical re On 2/25/16 Assistant / inaccuraci Physical re Review of Instrument abilities) V Section P: is to recomback period any of the day or nigli indicated, considered be address determine factors and treating not	ils. 7's Care (licated "c ference R tervention 7's MDS (indicated 6 at 4:15 side rails estraint or 6 at 4:20 Administra es betwee estraint E and Resid the RAI (t - an ass ersion 3.0 Restraint d the freq d that the listed dev nt." Unde "When the d, thoroug sed by re- reversible d to idention-reversi at 8's clinic the facili	Conference Review dated urrent interventions", and eview dated 4/9/15, indican "SRX2 (Side Rails Times dated 2/1/16 under Physical no restraint". p.m., the MDS coordinator should have been coded a the MDS assessment. p.m., during an interview, attor stated there were en Resident 7's MDS, nabler, Care Conference flent Weekly Summaries. Resident Assessment essment of care needs and Manual indicated under its, "The intent of this section was restrained by resident was restrained by resident was restrained by the use of restraints is an assessment of problem straint use is necessary, to e causes and contributing fry alternative methods of ble issues."	the ated is 2). al	278						
retention of	f urine, h	tia without behaviors, istory of falls, osteoporosis	 _			<u>ec</u>		V [┷╃╀╌┾╁	$\prod_{\mathbf{r}}$
*ORM CM8-2567 (02-99) Previ	ous Versions	Obsolete Event ID:	Z1P811	Facil	LICEN	11	- 8	2016	Pade 9 df 2	

		WEDICAID SERVICES				. 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MŲI A. BUILD	TIPLE CONSTRUCTION		TE SURVEY MPLETED
		nroons	B. WING	•		C
		056288	D. WING			/26/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DOE	
HANFOR	ND NURSING & REHA	BILITATION CENTER		1007 WEST LACEY BLVD HANFORD, CA 93230		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(XS) COMPLETION DATE
F 278	Continued From pa and femur fracture.	-	F2	778		
	Resident 8 moved I	a.m., during an observation, himself in bed and used the to prepare for breakfast.	1			
		D p.m., during an interview, I need them [side rails] so I much as possible."		,		
	For The use of Res (Type of Restraint:	nt titled "Resident Information fraints," dated 1/26/16, under 1/4 Side rails up times 2 for I to muscles weakness porosis.)				
	Resident 8's Order 2/3/16, indicated no side rails.	Summary report, dated physician order for bilateral				
	3/25/15, and 6/17/1	Conference Reviews dated 5, indicated under Physical Side rails 2X (were used for)	,	·		
	Resident 8's Weekl Device/Restraints 3 devices/restraints w	ly Summary Report under 1/24/15 and 6/17/15 indicated were not used.				
	Resident 8's MDS's indicated no restrain	dated 3/28/15 and 12/9/15 nts were used.				
-	side rails should ha	p.m., the MDSC stated the ve been coded as a physical S assessments dated 3/28/15				
	On 2/25/16 at 4:20 DON stated there w	p.m., during an interview, the vere inaccuracies between				
ORM CMS-28	567 (02,99) Previous Verslans	Obsolete Event ID: Z1P8	11	AP CA DEPT. C LICENSING & CE	R - 8 2016	

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULT A. BUILDII	TPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		056268	B. WING		C 02/26/2016		
	PROVIDER OR SUPPLIER RD NURSING & REHA	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP GODE 1007 WEST LACEY BLVD HANFORD, CA 93230			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LO BE COMPLET		
F 278	Resident 8's MDS's Enabler, Care Cont Resident Weekly S Review of the RAI under Section P: Resection is to record look back period the by any of the listed day or night." Unde indicated, "When the considered, thorough be addressed by redetermine reversible factors and to ident treating non-reversional treating non-rever	and Physical Restraint erence Reviews, and ummaries. Version 3.0 Manual indicated estraints, "The intent of this the frequency over the 7 day at the resident was restrained devices at any time during the r Planning For Care it is use of restraints is in assessment of problems to straint use is necessary, to e causes and contributing ify alternative methods of ble issues." Inical record indicated she was cility on 3/26/13, with mer's dementia, hypertension, sphagia. 10's Order Summary Sheet sated the following physician 2 FOR BED MOBILITY R/T E WEAKNESS SECONDARY every day and night shift	F 27	78			
	WEAKNESS GENE dated 3/27/13, and On 2/23/16 at 1:50 Resident 10 laid in rails in place.	ER'S DISEASE MUSCLE ERALIZED." The order was started on 12/3/14. p.m., during an observation, her bed with full bilateral side n., during an interview, CNA	1				
ORM CMS-25	On 2/23/16 at 3 p.17 (Certified Nurse As: 567(02-99) Previous Versions	sistant) 1 stated he cared for	-	Facility ID: CA0400000 7 If continue	ation sheet Page 1] of 8 2016		

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		056288	B. WING_		C 02/26/2016	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 02/20/2010	
HANFOR	D NURSING & REHA	BILITATION CENTER	-	1007 WEST LACEY BLVD HANFORD, CA 93230		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIV (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETION	
F 278	Resident 10 on a re	egular basis. When asked 0 utilized her side rails for	F 278			
	Charge Nurse (CN) whether Resident 1	n., during an interview, 1 stated she did not know 0 utilized her side rails to turn. she would have to ask the t.				
	"MDS 3.0 Assessm	10's clinical record titled, ent dated 9/4/15, indicated physical restraint devices in				
	"MDS 3.0 Assessm	10's clinical record titled, ent dated 11/30/15, indicated physical restraint devices in				
,	MDSC stated she g resident MDS asses clinical record revier realizeI thought if out [of the restraint]	p.m., during an interview, the athered information for the asment from observation and w. She further stated, "I didn't they [the resident] couldn't get it wasn't a restraint! had the by [the MDS assessments] are				
	under Section P: Re section is to record look back period that by any of the listed of day or night." Under indicated, "When the considered, thorough	Version 3.0 Manual indicated estraints, "The intent of this the frequency over the 7 day at the resident was restrained devices at any time during the Planning For Care it a use of restraints is the assessment of problems to estraint use is necessary, to				
		e causes and contributing				
-ORM CMS-25	67 (02-99) Previous Versions	Obsolete Event ID: Z1PB11	Fac	APR = 8 CA DEPT. OF PUE		

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO	<u>. 0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	LTIPLE CONSTRUCTION		(00)	TE SURVEY MPLETED
		056288	B. WING			02	C / 26/2016
	PROVIDER OR SUPPLIER RD NURSING & REHA	BILITATION CENTER	•	STREET ADDRESS, 1007 WEST LACE HANFORD, CA		Ĭ	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX (EACH CC	DER'S PLAN OF CORREC DRRECTIVE ACTION SHO FERENCED TO THE APP DEFICIENCY)	OULD BE	(XS) COMPLETION DATE
F 278	factors and to ident treating non-revers 5. Random Reside indicated she was a period, with diagnost behavioral disturbation communication definitial assessment of Quarterly assessment. The DON have been coded a MDS assessment. Side rails up and coralls himself, therefore the property of the property of Quarterly of Q	cify alternative methods of ible issues." ent 19's clinical record readmitted to the facility on oses of dementia with nces, hypertension, cognitive ficit, and dysphagia. p.m., during a concurrent of review of Resident 10's MDS dated 11/23/15 and the ent dated 9/10/15, the DON cal Restraints" section of a dated 11/23/15 and 9/10/15 if rails were used as a physical is stated the bed rails should a physical restraint on the DON stated Resident 19 had ould not release those side ore was a restraint. Ician orders dated 11/13/15 ted "Side rails up x 2 for bed as weakness order dates	F	278			
F 281 SS=D	PROFESSIONAL S The services provide	IVICES PROVIDED MEET ITANDARDS led or arranged by the facility onal standards of quality.	F 2	281			
FORM CMS-25	67 (02-99) Pravious Versions	Obsolete Event ID: Z1PB11	•	Facility ID: CA04000001		PR = 8 2 OF PUBLIC ERTIFICATION	016

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

CENTER	AS FOR MEDICARE	& MEDICAID SERVICES			<u> </u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED .
	ı	056288	B. WING		C 02/26/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
		BILITATION CENTER ·	'	1007 WEST LACEY BLVD HANFORD, CA 93230	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO- DEFICIENCY)	D BE COMPLETION
F 281	Continued From pa	ge 13	F 281	F 281 How corrective actions will be accord	maliched
	This REQUIREMENT is not met as evidenced by: Based on observation, interview, clinical record			for those residents found to have been by the deficient practice.	"
	and administrative of failed to meet profe medication safety for residents (Resident 2 prepared medication Administrative of failed to meet a failed to medication administrative of failed to meet professional failed to me	document review, the facility assional standards of or one of five random (22) when licensed nurse (LN) and did not review the stration Record (MAR) to the medications for Resident		Resident 22's medication was immadministered to resident after omission LN 2 was provided immediate one on service on 2/25/2016 by DNS on madministration and safety of residents taccuracy of medications administration residents.	accrued. one in- edication to ensure
		potential to result in lack of ed medication for Resident 22.		How the facility will identify other a having the potential to be affected by the deficient practice and what corrective will be taken.	the same
	observation and into medications for Res oral medications for them in a plastic me counted nine oral (be entered Resident 25 seated at the bedsic room. LN 2 reviewe controlled medication cart, and retrieved of (Xanax- an antianxia) (unit of measure) fro controlled medication stated, "I didn't double walked to another L stated to an LN, "I n Alprazolam tablet]."	a.m., during a concurrent erview, LN 2 prepared sident 22. LN 2 prepared ten administration and placed edication cup. LN 2 stated she by mouth) pills in the cup. LN 2 2's room. Resident 22 was de. LN 2 was asked to exit the d the MAR, opened the ons cabinet of her medication one oral pill, Alprazolam ety medication) .25 milligrams on the bottom of the ons storage cabinet. LN 2 ble check [the MAR]." LN 2 N on the same wing, and leed to waste this [the LN 2 prepared a second dose tion, and administered ten		All residents receiving medications for have the potential to be effected. On pharmacy nurse consultant complemedication administration observation of with a zero percent medication error licensed nursing staff were in-serv 3/7/2016 by pharmacy nurse consumedication administration. What measure will be put into place systemic changes the facility will resure that the deficient practice directly? DNS or designee to complete a medication administration observation on all licensed nurses for the next three of licensed nursing staff to ensure accordinations given to residents an	3/7/2016 letted a on LN 2, rate. All riccd on litant on or what make to lices not random monthly quarters uracy of
	medications to Resi	dent 22.		professional standards of medication safe	IVED
Form oms-25	67 (02-99) Previous Versions	Obsolete Event ID: Z1PB:1	Fa	APR - 8	8 2016 BLIC HEALTH
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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COM	E SURVEY IPLETED
	:	056288	B. WING		<u></u>	I .	C 2 6/2016
NAME OF S	PROVIDER OR SUPPLIER			_	TREET ADDRESS, CITY, STATE, ZIP CODE	I UR.J	20/2010
NAMEOFF	-HOAIDEU OU SOLLTIEH						
HANFOR	D NURSING & REHA	BILITATION CENTER			007 WEST LACEY BLVD IANFORD, CA 93230		
				- ' '			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRÉCEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE .	(X5) COMPLETION DATE
	The facility policy are "Medication Administration." To accurate the reviewed by a Lindministration." 483.25(c) TREATM PREVENT/HEAL PRE	and procedure titled, stration" dated 9/20/12, rately administer medication to tion and biological orders shall censed Nurse prior to ENT/SVCS TO RESSURE SORES rehensive assessment of a must ensure that a resident ity without pressure sores ressure sores unless the condition demonstrates that ble; and a resident having gives necessary treatment and a healing, prevent infection and	F2		How the facility plans to moniperformance to make sure that solution sustained. The facility must develop a pensuring that correction is achieved sustained. This plan must be implemented and the corrective action evaluated effectiveness. The plan of correctintegrated into the quality assurance system of the plan of correctintegrated into the quality assurance system of the plan of correcting formedication administration observations. Quality Assurance Committee meeting if quarters. Negative findings will be address the quality assurance committee to deveimplement an action plan for compliance ded. Responsible Persons: DNS/Designee.	ons are plan for ed and mented, for its tion is stem. om the to the for three essed by elop and	
	by: Based on observatinterview, and clinic document review, the residents received the prevent the development one of five random 18) when she development which progress (destruction of full last subcutaneous layer treatment.	ion, staff and resident al record and administrative ne facility falled to ensure the services necessary to ment of a pressure ulcer for sampled residents (Resident oped an open area on her sed to a Stage III wound ayer of skin, extending into) and required daily medical in harm for Resident 18.			How corrective actions will be accommon for those residents found to have been a by the deficient practice. Resident 18's stage three pressure ulcer he of 1/20/2016. The IDT completed a revisedent 18's current plan of care relapressure ulcer prevention and managem 2/27/2016. A new pressure ulcer assessme completed on 2/27/2016 which identificated pressure ulcer development high, with a score of 21. Resident 18's call was immediately reviewed and revise 2/27/2016 by IDT to reflect current apprepreventive measures.	ealed as riew of ared to ent on ent was ed the re plan ed on	2/2/20
-ORM CMS-25	67 (02-99) Previous Versions	•		Pad	APR - 8 CA DEPT. OF PUB LICENSING & CERTIFIC	2016	

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

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO	<u>. 0938-0391</u> .
	TATEMENT OF DEFICIENCIES IND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '		CONSTRUCTION	COM	E SURVEY APLETED
		056288	B. WING	١	· · · · · · · · · · · · · · · · · · ·	1	C /26/2016
	PROVIDER OR SUPPLIER ID NURSING & REHA	BILITATION CENTER		100	REET ADDRESS, CITY, STATE, ZIP CODE 07 WEST LACEY BLVD ANFORD, CA 93230		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEPICIENCY)	DULD BE	(XS) COMPLETION DATE
F 314	Resident 18's clinic admitted to the faci diagnoses of deme abnormal curvature. Hesident 18's Nurs at 10:06 p.m., indic residents room by (Assistant) that residents room by (Assistant) that resident ass 1 inch in diameter (Back in the spinal attender. This writer inch in diameter. Nand received a new Resident 18's NN of indicated, "Treatmedicated, "Treatmedi	al record indicated she was allity on 11/13/14, with antia, and Kyphosis (an e of the spine). See Notes (NN) dated 7/18/15 ated, "This writer called into CNA (Certified Nurse dent has an opening on her ressed by this writer to have a opening in the middle of her area. Resident states it is assessed area, measured 1 otified MD [Medical Doctor] or order to cleanse area" Stated 8/3/15 at 4:53 p.m., nent orders renewed on age III to thoracic spine with ry, apply silvadene [a opically to wound bed. Apply uze and cover with foam daily x 14 days. One time a HOSIS ACQUIRED	F3	314	How the facility will identify oth having the potential to be affected deficient practice and what corre will be taken. All residents scoring "high" on Proceedings on their Pressure Ulcer Assessment have the potential to be a IDT completed a review of all residents on their Pressure Ulcer Assessments' wand revised by IDT on 2/28/201 appropriate pressure ulcer preventiare in place. Licensed nursing a serviced 2/27/16 on pressure ulcer promanagement. What measure will be put into playstemic changes the facility with ensure that the deficient practice recur? Upon admission, quarterly, and residents will be assessed for potent developing pressure ulcers by MDS or a licensed nurse. The IDT in conjute PMD will develop a plan of individualized to each resident unique to assure the residents plan of care appropriate interventions required identified with clinical conditions the development of new pressure ulcers will be reflected in their plan of Medical Records Director will corressure ulcer audit weekly and a assure the residents care plan is reflects interventions for presprevention and maintenance.	by the same ctive action essure Ulcer affected. The tents scoring sments. The ing high on was reviewed to to ensure on measures taif was in evention and ace or what ill make to be does not as needed tial risks for a coordinator unction with care that is ue diagnosis reflects the la Residents nat make the unavoidable of care. The omplete the sa needed to accurate and	
FORM CMS-25	transferring, and re 67(02-99) Previous Versions	quired two persons to assist Obsolete Event ID: Z1PB11	_	Facilit			Page 16 of 26
					CA DEPT. OF LICENSING & CER	- 8 2016 PUBLIC H	EALTH

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			· · · · · · · · · · · · · · · · · · ·	OMB NO	<u>). 0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 -		E CONSTRUCTION		TE SURVEY MPLETED
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	PROVIDER OR SUPPLIER ED NURSING & REHA	BILITATION CENTER		10	TREET ADDRESS, CITY, STATE, ZIP CODE 007 WEST LACEY BLVD (ANFORD, CA 93230		, 29/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (SACH CORRECTIVE ACTION SHO OF OSS-REFF ENCED TO THE APPR DEFICIENCY	ULD BE	(X5) COMPLETION DATE
F 314	and physical help for On 2/26/16 at 1:50 Director of Nursing Resident 18 development 18 development 19 is on turned red, and we progressed to Stag [recent] hospitalizated On 2/26/16 at 2:30 observation and into TV. Resident 18 stated turn her. Resident 18 stated the night shift. On 2/26/16 at 2:45 observation and into Stated She was going check her back, due 2 stated Resident 1 breakdown. The facility docume Management" revisionicy of this facility facility without press appropriate prevent insure that the Elder ulcers unless the eletthe development un The IDT [interdiscip and CNA's [Certified	quired extensive assistance or her hygiene and bathing. p.m., during an interview, the (DON) stated she was aware ped a pressure ulcer in July tated, "It's [the pressure ulcer usShe has KyphosisIt started to monitor it, but it e 3it was not because of her	FS	314	How the facility plans to m performance to make sure that sol sustained. The facility must develop ensuring that correction is ach sustained. This plan must be impand the corrective action evaluate effectiveness. The plan of corrintegrated into the quality assurance. Any findings identified in the median and to the Pressure Ulcer Audit will to the Quality Assurance Committed quarterly for three quarters. If confidentified by the Quality Assurance they will develop and implement an after compliance as needed. Responsible persons for monitoring: team, Medical Records Direct Administrator.	a plan for eved and olemented, ed for its rection is system. cal records be brought be meeting neems are Committee action plan DNS, IDT ctor and	
	67(02-99) Previous Versions			Facil	lity ID: CA040000 1 If continu	lation sheet	Page 17 of 26
		•			APR - CA DEPT. OF F LICENSING & CERT	8 2016 UBLIC HE	EALTH N - FRESNO

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				<u>OMB NO.</u>	. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COM	E SURVEY IPLETED
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	PROVIDER OR SUPPLIER RD NURSING & REHA	BILITATION CENTER		1	TREET ADDRESS, CITY, STATE, ZIP CODE 007 WEST LACEY BLVD MANFORD, CA 93230	1 021	20,2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DRFICIENCY)	LD BE	(XS) COMPLETION DATE
	turned and reposition Elder can't do so in should be based or factors"	own:c. Assure Elders are oned in bed or chair if the dependently. Frequency n individual Elder's risk		314	How corrective actions will be accorder those residents found to have been by the deficient practice.	n affected	
F 431 SS=E	483.60(b), (d), (e) £ LABEL/STORE DR The facility must en a licensed pharmac of records of receip controlled drugs in accurate reconciliat records are in order controlled drugs is reconciled. Drugs and biological labeled in accordant professional princip appropriate access instructions, and the applicable. In accordance with facility must store at locked compartmer controls, and permit have access to the The facility must propermanently affixed controlled drugs list Comprehensive Dro Control Act of 1976 abuse, except when package drug distri	nploy or obtain the services of cist who establishes a system at and disposition of all sufficient detail to enable an tion; and determines that drug and that an account of all maintained and periodically als used in the facility must be not extend the correctly accepted also, and include the ory and cautionary expiration date when the state and Federal laws, the all drugs and biologicals in the under proper temperature to only authorized personnel to	F4	131	No residents were found to be af deficient practice. All medications were by DNS from the affected refrigerator, vaccine and pneumococcal vacci immediately destroyed on 2/25/2016 by Pharmacist. Insulin pens were medication cart and utilized until expirit The refrigerator that temped above range was immediately taken out of new refrigerator was immediately in 2/25/2016 and remained un-used unverified appropriate temperature range met on 2/25/2016, normal operations reinstated. How the facility will identify other having the potential to be affected by deficient practice and what correcti will be taken. Two medication refrigerators had the potential to be affected, After a review of the templogs and current thermometers readi 2/25/2016 by DNS, it was determined appropriate range, 36 degrees to 46 degall other medication refrigerator was matemperature will continue to be checked. An audit will be completed by the records director daily to assure temperaturity within normal limits.	e removed influenza ine were v DNS and noved to ation date. acceptable service. A stalled on ntil DNS had been were then residents the same ive action ential to perature ings on that the rees, for intained, ecked at twice a medical	
FORM CMS-25	567 (02-99) Previous Versions	Obeciete Event ID: Z1PB11		Fac		- 8 20	HEALTH

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO.	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING	1' '		E SURVEY PLETED
		056288	B. WING				C 26/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, C	CITY, STATE, ZIP CODE	1 02/	20/2010
HANFOR	ID NURSING & REHA	BILITATION CENTER	•	1007 WEST LACEY HANFORD, CA 9			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFO TAG	X (EACH COF	ER'S PLAN OF CORRECTI RRECTIVE ACTION SHOUL RENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 431	Continued From pa		F4	systemic chan	e will be put into place ges the facility will he deficient practice	make to	
	by: Based on observat administrative docu to store refrigerated under appropriate t Fahrenheit), when t internal temperature (Fahrenheit). This placed residen	NT is not met as evidenced tion, staff interview, and iment review, the facility failed it medications and biologicals emperatures (36-46 degrees the medication refrigerator e measured 50 degrees F its at risk for receiving ons secondary to excessive e.		record director within normal to Refrigerator reviewed and re Clinical Service process for the of range tem Department as corrective action findings. All serviced on medication adm appropriate refr	will be completed by the to assure all refrige emperature range. The Mericon for the covised by the Regional I less on 2/25/2016 to receive the Mericon for the DNS for the DNS for the DNS will review licensed nursing staff 2/26/2015 or 2/27/2011 inistration and storage, rigerator temperature received out of range term	rators are Medication form was Director of effect the corning out aintenance immediate the audit were in- 2015 on including ange and	2/20/16
	-On-2/25/16 at 10:45 observation and interpretation and interpretation and interpretation and interpretation and the medical internal thermometric degrees." She sealed minutes. On 2/25/16 at 11 a DON rechecked the refrigerator and state A second thermometer and sealed thermometer. The refrigerator to rule of thermometer. The refrigerator and state and second thermometer. The refrigerator to rule of the momental sealed and	10:45 a.m., during a concurrent d interview in the medication the Director of Nursing (DON) dication refrigerator, retrieved the meter, and stated, "It says 50 sealed the refrigerator for 15. 11 a.m., during an observation, the d the internal thermometer of the I stated, "It looks like 48 degrees." nometer was placed in the ule out the first as a faulty "he refrigerator was sealed. 11:30 a.m., during a concurrent		How the fac performance to sustained. The ensuring that sustained. This and the correct effectiveness.	ultant will continue to cation refrigerators quar sility plans to more make sure that solutifacility must develop a correction is achieve plan must be implestive action evaluated. The plan of correction the quality assurance so	complete terly. sitor its tions are plan for yed and emented, for its ction is	
FORM CMS-25	were checked by th	erview, both thermometers e DON, who stated, "48-50 nometers]We can't use them Obsolets Event ID:ZIPB11	••	Facility ID: CA040000017	DE C	E	Page 19 of 26
	,					-82	016

CENTE	HS FUR MEDICARE	& MEDICAID SERVICES			OWR NO	<u> 0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' . '	TIPLE CONSTRUCTION	COM	E SURVEY IPLETED
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NAME OF	PRÓVIDER OR SUPPLIER		'	STREET ADDRESS, CITY, STATE, ZIP C		20/2010
	, , , , , , , , , , , , , , , , , , , ,	BILITATION CENTER		1007 WEST LACEY BLVD HANFORD, CA 93230		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFID TAG		ishould be	COMPLETION DATE
F 431	[the refrigerated me out." On 2/25/16 at 11:38 the DON listed the which consisted of	age 19 edications]It all has to come a.m., during an observation, contents of the refrigerator, influenza vaccine, a dose of cine, and several types of	F 4	Findings of the audit complete Records and Pharmacy Const brought to Quality Assurant quarterly for two quarters. Negati be addressed by the quality assurant Responsible persons for more Medical Records Director, Pharmand Administrator.	ultant will be oc Committee we findings will more committee.	
	"Medication Storage 9/25/12, indicated under Medications requiring temperatures ranging degrees F. Fahrent thermometer to allo Medications requiring refrigerated unless	nd procedure titled, e In The Facility" revised under Procedure, "9. ng 'refrigeration' are kept at ng from 36 degrees to 46 neit] in a-refrigerator-with a— w temperature monitoring. ng storage "in a cool place" are otherwise directed on the			•	
F 458 SS≃B		DROOMS MEASURE AT RESIDENT	F 4			
	per resident in multi	easure at least 80 square feet iple resident bedrooms, and at et in single resident rooms.		F 458 How corrective actions will for those residents found to he by the deficient practice.	ave been affected	
	by: Based on observat 2/23/16 through 2/2 provide the minimul resident rooms. Thi	NT is not met as evidenced ion during the survey period of 6/16, the facility failed to m square footage in 8 of 32 s placed the residents at needs including privacy,		There is sufficient room space health and safety were not affect. How the facility will identify having the potential to be affed deficient practice and what owill be taken.	ted. other residents cted by the same	
	Findings:	·		There is sufficient room space health and safety were not affect		
		0		F	CEI	作にして
Form CMS-25	667 (02-99) Previous Versions	Obsolete Event ID: Z1PB11	•	Facility ID: CA040000017	APR - 8 2	016

SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa During observation 2/23/16 to 2/26/16, easonable amount enough closet and resident. There was provision of nursing health and safety of	BILITATION CENTE TEMENT OF DEFICIENCY MUST BE PRECEDED BE SECONTIFYING INFORMATION OF THE PRECEDED BY THE PRECEDED BY THE PRECEDENCE OF THE PRECEDENC	R SIES SY FULL MATION) vey from a re was each r the nts. The lld not be	B. WING PREFD TAG	STREET ADDRESS, 1007 WEST LACEY HANFORD, CA S PROVID ((EACH CO) CROSS-REF	P3230 PER'S PLAN OF COAREC ARECTIVE ACTION SHO ERENCED TO THE APPR DEFICIENCY) The will be put into planges the facility with deficient practic deficient practic deficient room space and the were not affected.	CTION DULD BE ROPRIATE ace or what il make to be does not	
SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa During observation 2/23/16 to 2/26/16, reasonable amount enough closet and resident. There was provision of nursing health and safety of	throughout the sur the residents had a tof privacy and the storage space for a sufficient room fo care to the residents wou	Vey from a re was each r the nts. The ald not be	PREFD TAG	HANFORD, CA S PROVID (EACH CO CROSS-REF) What measure systemic charensure that is recur? There is suffile health and safe	Y BLVD 93230 ER'S PLAN OF CORRECT RECTIVE ACTION SHO ERENCED TO THE APPROPRIED TO THE APPROPRIED OF T	CTION DULD BE ROPRIATE ace or what il make to be does not	(X5) COMPLETION DATE
CEACH DEFICIENCY OR LEGULATORY OF LEGULATORY	throughout the sur the residents had a tof privacy and the storage space for e s sufficient room fo care to the resider the residents wou	vey from a re was each r the nts. The ild not be	PREFD TAG	((EACH CO. CROSS-REF	RRECTIVE ACTION SHO ERENCED TO THE APPE DEFICIENCY) e will be put into pla nges the facility will the deficient practic cient room space and ty were not affected.	DULD BE RÖPRIATE ace or what il make to be does not	COMPLETION DATE
During observation 2/23/16 to 2/26/16, reasonable amount enough closet and resident. There was provision of nursing nealth and safety of adversely affected.	throughout the sur the residents had a tof privacy and the storage space for e s sufficient room fo care to the resident f the residents wou	a re was each r the nts. The ild not be	F 4	systemic char ensure that the recur? There is suffinealth and safe	nges the facility with the deficient practic cient room space and many were not affected.	ll make to e does not	
valvei.		oi me		sustained. The	to make sure that so e facility must develop	olutions are p a plan for	
318.3 108 294.3 119 317.4 208 298.3 209 293.3 212 299.3	38 sq. ft. 37 sq. ft. 43 sq. ft. 31 sq. ft. 91 sq. ft. 61 sq. ft.	No. of 4 4 4 4 4 4 4 4		sustained. The and the corresponding of the corresp	The plan of cor o the quality assurance has requested a waive omit the waiver and the is will be monitored by sment and Assurance	nplemented, ted_far its rrection is resystem. er and will nen annually y the facility	
Recommend waive rooms.	r continue in effect	for 8 of 32					
3		#FES Date					
Request Waiver for Tooms.	above identified re	esident					
7(02-99) Previous Versions	Obsolete	Event ID: Z1PB11		Facility ID: CA040000017		APR - 8	2016
	eds. 06 318.6 08 294.6 19 317.4 08 298.6 09 293.6 12 299.6 13 296.6 17 312.6 Recommend waive points.	318.88 sq. ft. 08 294.37 sq. ft. 19 317.43 sq. ft. 08 298.81 sq. ft. 09 293.91 sq. ft. 12 299.61 sq. ft. 13 296.90 sq. ft. 17 312.95 sq. ft. Recommend waiver continue in effect coms. ASN degreest Waiver for above identified recoms.	19 317.43 sq. ft. 4 108 298.81 sq. ft. 4 109 293.91 sq. ft. 4 112 299.61 sq. ft. 4 113 296.90 sq. ft. 4 117 312.95 sq. ft. 4 118 ecommend waiver continue in effect for 8 of 32 coms. 111 16 12	19 317.43 sq. ft. 4 19 317.43 sq. ft. 4 19 317.43 sq. ft. 4 108 298.81 sq. ft. 4 109 293.91 sq. ft. 4 112 299.61 sq. ft. 4 113 296.90 sq. ft. 4 117 312.95 sq. ft. 4 118 commend waiver continue in effect for 8 of 32 coms. MSN_HF-ES Sq. ft.	eds. Square Footage No. of effectiveness, integrated into the facility is review and sult thereafter. The facility is review and sult the fac	Gom Square Footage No. of leds. O6 318.88 sq. ft. 4 O8 294.37 sq. ft. 4 19 317.43 sq. ft. 4 O9 298.81 sq. ft. 4 12 299.61 sq. ft. 4 13 296.90 sq. ft. 4 17 312.95 sq. ft. 4 Recommend waiver continue in effect for 8 of 32 coms. O8 298.81 sq. ft. 4 Common Marker Continue in effect for 8 of 32 coms. O9 293.91 sq. ft. 4 Common Marker Continue in effect for 8 of 32 coms. O9 293.91 sq. ft. 4 Common Marker Continue in effect for 8 of 32 coms. O9 293.91 sq. ft. 4 Common Marker Continue in effect for 8 of 32 coms. O9 293.91 sq. ft. 4 Common Marker Continue in effect for 8 of 32 coms. O9 293.91 sq. ft. 4 Common Marker Continue in effect for 8 of 32 coms. O9 293.91 sq. ft. 4 Common Marker Continue in effect for 8 of 32 coms. O9 293.91 sq. ft. 4 Common Marker Continue in effect for 8 of 32 coms. O9 293.91 sq. ft. 4 Common Marker Continue in effect for 8 of 32 coms. O9 293.91 sq. ft. 4 Common Marker Continue in effect for 8 of 32 coms. O9 293.91 sq. ft. 4 Common Marker Continue in effect for 8 of 32 coms. O9 293.91 sq. ft. 4 Common Marker Continue in effect for 8 of 32 coms. O9 293.91 sq. ft. 4 Common Marker Continue in effect for 8 of 32 coms. O9 293.91 sq. ft. 4 Common Marker Continue in effect for 8 of 32 coms. O9 293.91 sq. ft. 4 Common Marker Continue in effect for 8 of 32 common Marker Common Ma	effectiveness. The plan of correction is integrated into the quality assurance system. O6 318.88 sq. ft. 4 O8 294.37 sq. ft. 4 O8 298.81 sq. ft. 4 O9 293.91 sq. ft. 4 O9 293.91 sq. ft. 4 O9 293.91 sq. ft. 4 O13 296.90 sq. ft. 4 O14 312.95 sq. ft. 4 O15 299.61 sq. ft. 4 O16 299.61 sq. ft. 4 O17 312.95 sq. ft. 4 O18 299.61 sq. ft. 4 O19 299.61 sq. ft. 5 O19 299.61

NO. 1399 P. 2/2

PRINTED: 03/11/2016 FORM APPROVED

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			<u>OMB NO. 0938-0391</u>
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	JLTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED C
		056288	B. WING	<u></u>	02/26/2016
	Provider or Supplier RD NURSING & REHA	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1007 WEST LACEY BLVD HANFORD, CA 93230	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	KEACH CORRECTIVE ACTION SHO	OULD BE COMPLETION
F 458	Continued From pa	Mulapa	5141	458 V Mu/Thur	
F 514 SS=D	483.75(I)(1) RES RECORDS-COMPL LE	ETE/ACCURATE/ACCESSIB	F 5	514	
·	resident in accordant standards and pract accurately document systematically organ	1		F 514 How corrective actions will be acc	complished
I	information to identification resident's assessme services provided; the	y the resident; a record of the ints; the plan of care and le results of any ling conducted by the State;	. ,	for those residents found to have been by the deficient practice. Resident number 20's Medication Adm Records were immediately updated on by LVN two, to reflect the administrationary controlled substance.	ninistration 2/25/2016
	by: Based on observation Based on observation Based administrative do failed to maintain according samp and 21) when control	on, interview, clinical record ocument review, the facility curate clinical records for two led residents (Residents 20 led medications of documented in the		How the facility will identify other having the potential to be affected by deficient practice and what correct will be taken. All residents who have physician controlled medications under the care	orders for
-	Medication Administr Residents 20 and 21 These failures placed	ation Record (MAR) for I residents at risk for Indary to an inaccurate MAR		number 2 have the potential to be Licensed nurse two was in serviced 2/2 DNS on medication documentation an records. LVN two and all other licenswere in serviced 2/29/2016 by the medication documentation and medical	25/2016 by ad medical sed nurses DNS on
RM CMS-256	7(02-99) Previous Versions Ot	solete Even ID: 2)P311		- 3 2016	uation sheet Page 22 of 26

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			C	<u>MB NC</u>) <u>. 0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		056288	B. WING	·		1	/26/2016
	PROVIDER OR SUPPLIER RD NURSING & REHA	BILITATION CENTER		10	TREET ADDRESS, CITY, STATE, ZIP CODE 007 WEST LACEY BLVD ANFORD, CA 93230		JAGILOTO
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 458	Continued From pa	ge 21	F4	158			
F 514 SS=D	Facility Administrato 483.75(I)(1) RES RECORDS-COMPI LE	Date LETE/ACCURATE/ACCESSIB	F 5	514			
	resident in accordal standards and practaccurately document systematically-orgal. The clinical record information to identifications assessments assessments assessments assessments assessments assessments.	nust contain sufficient ify the resident; a record of the ents; the plan of care and he results of any ening conducted by the State;			F 514 How corrective actions will be accomposed for those residents found to have been a by the deficient practice. Resident number 20's Medication Administration accords were immediately updated on 21's by LVN two, to reflect the administration controlled substance.	stration	
	by: Based on observate and administrative of failed to maintain act of five random sample and 21) when controlled administered were a Medication Administration Administration and 2 These failures place adverse events section Residents 20 and 2 These failures place adverse events section Residents 20 and 2 These failures place adverse events section Residents 20 and 2 These failures place adverse events section Residents 20 and 2 These failures place adverse events section Residents 20 and 2 These failures place adverse events section Residents 20 and 2 These failures place adverse events section Residents 20 and 2 These failures place adverse events section Residents 20 and 2 These failures place adverse events section Residents 20 and 2 These failures place adverse events section Residents 20 and 2 These failures place adverse events section Residents 20 and 2 These failures place adverse events section Residents 20 and 2 These failures place adverse events section Residents 20 and 2 These failures place adverse events section Residents 20 and 2 These failures place adverse events section Residents 20 and 2 These failures place adverse events section Residents 20 and 2 These failures place adverse events section Residents 20 and 2 These failures place adverse events adverse events and 2 These failures place adverse events and 2 These failures place adverse events adverse events and 2 These failures place adverse events and 2 These failures place adverse events adverse events and 2 These failures place adverse events adverse events and 2 These failures events and 2 These failures events adverse e	not documented in the tration Record (MAR) for 1. ed residents at risk for ondary to an inaccurate MAR d 21.	·		How the facility will identify other rehaving the potential to be affected by the deficient practice and what corrective will be taken. All residents who have physician ordeontrolled medications under the care of number 2 have the potential to be a Licensed nurse two was in serviced 2/25/2 DNS on medication documentation and records. LVN two and all other licensed were in serviced 2/29/2016 by the D medication documentation and medical residual res	ers for of LVN ffected. 2016 by medical nurses VNS on cords.	272
FORM CMS-25	67 (02-99) Previous Versions	Obsolete Event ID: Z1PB11	•	Facil	APR CA DEPT. OF LICENSING & CEP	- 8 20	016 LEALTH

CENTE	<u>AS FOR MEDICARE</u>	& MEDICAID SERVICES			OMB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTIÓN	(X3) DATE SURVEY COMPLETED
		056288	B. WING		02/26/2016
	PROVIDER OR SUPPLIER ND NURSING & REHA	BILITATION CENTER	ı	STREET ADDRESS, CITY, STATE, ZIP CODE 1007 WEST LACEY BLVD HANFORD, CA 93230	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ILD BE COMPLETION
F 514	Continued From pa	ge 22	F 5	What measure will be put into pla systemic changes the facility will ensure that the deficient practic recur?	I make to
	Resident 20 was accurrent physician of medication order: "Norco Tablet 5-328 (Hydrocodone-Acet mouth every 8 hour 4-6 [pain level scale CHRONIC PAIN" On 2/25/16 at 10:30 observation and into (LN) 2 and the Dire Resident 20's Continuous medication to reviewed. The record medication to reviewed. The record a.m. Resident 20's document PRN [as 2/25/16 was blank, documentation of mLN 2 saw the blank sign the PRN sheet administration of the 20's MAR in the presurveyor. Resident 21 was accurrent physical following medication "Lorazepam [Ativan Tablet 1 MG Give o	aminophen) Give 1 tablet by s as need for moderate Pain el related to OTHER D'a.m., during a concurrent enview with Licensed Nursector of Nursing (DON), rolled Drug Record [a form to hat can be habit forming] was rd indicated one Norco tablet at by LN 2 on 2/25/16 at 8:30 MAR under the section to needed] medications for which indicated no needed] medications for which indicated no needed] medications for which indicated no needed medication administered. When MAR, she stated, "I forgot to "LN 2 then documented the environmented the environmented the environmented the environmented the environmented the morder: -an antianxiety medication] ne tablet by mouth every 12 r Anxiety M/B [manifested by]		•	ponsible for owing each curacy of irector will ion Record innually the pour, pass, medication is a plan for ieved and plemented, ed for its rection is esystem. The medical ministration Assurance ac quarters is Quality evelop and pliance as ing. DNS, strator.
FORM CMS-25	567 (02-99) Previous Versions		 -	Facility ID: CA04000017	ation sheet Page 23 of 26
			·	CA DEPT.	OF PUBLIC HEALTH SERTIFICATION - FRESNO

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DAYE SURVEY COMPLETED				
056288		B. WING			C 02/26/2016				
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, C		ZIP CODE		120,2010	
HANFORD NURSING & REHABILITATION CENTER				HANFORD, CA 93					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		RECTIVE AC		BE.	(X5) COMPLETI DATE	ON
F 514	observation and into DON, Resident 21' reviewed. It indicate signed out by LN 2 Resident 21's MAR documentation of P 2/24/16, was blank, space indicated the given. When LN 2 with should be documental administered, she sident 21' reviewed.	D a.m., during a concurrent erview with LN 2 and the s Controlled Drug Record was ed one Lorazepam tablet on 2/24/16 at 5:46 p.m. in the section for PRN medications, dated The DON stated a blank medication had not been was asked when medications	F 51	4	ı				
	Controlled Medicati under Procedures, medication is admir administering the mathe following inform	nd-precedure-titled, "HA7- ons" dated 2007, indicated "D. When a controlled nistered, the licensed nurse redication immediately enters ation on the accountability lication administration record							
	1. Date and time of 2. Amount administ 3. Signature of the r completed after the administered." 483.75(m)(2) TRAIT PROCEDURES/DR The facility must tra procedures when the	ered. hurse administering the dose, medication is actually N ALL STAFF-EMERGENCY ILLS in all employees in emergency hey begin to work in the facility;	F 51	В					
FORM CMS-25		he procedures with existing unannounced staff drills using Una		acility ID: CA040000017		If continuation	on sheet	_	**
					CA LICENSI	DEPT. OF NG & CER	PUBL	C HEAL TION - F	TH RESNO

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDERS UPPLIER CO.	CENTE	HS FOR MEDICARE	& MEDICAID SERVICES			OWR NO	. 0938-0391		
NAME OF PROVIDER OR SUPPLIER HANFORD NURSING & REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (CAS) ID (EACH DEFICIENCY MUST BE PRECEDED BY YULL RESULATORY OR USO IDENTIFYING INFORMATION) F 518 Continued From page 24 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and administrative document review, the facility failed to provide effective emergency procedures training to employees when one of eight employees [Licensed Nurse (LN) 3] failed to locate the key that provides access to the emergency utility. These failures put all residents in the facility at risk in the event of an emergency related to electricity. Findings: On 2/24/16 at 8:36 a.m., during a concurrent observation and interview in the maintenance hallway, LN 3 failed to locate a key which provided access to the emergency electrical shut-off. LN 3 stated that she was not trained on the key location or how to obtain the key. STREET ADDRESS, CITY, STATE, ZIP CODE 1007 WEST LACEY BLVD HAMPORD, CA 93230 TAGE THORSON, STATE, ZIP CODE 1007 WEST LACEY BLVD HAMPORD, CA 93230 PREFIX (EACH CORRECTION SHOULD BE (EACH CORRECTION S									
NAME OF PROVIDER OR SUPPLIER HANFORD NURSING & REHABILITATION CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 1007 WEST LACEY BLVD HANFORD, CA 93230 SUMMARY STATEMENT OF DEFICIENCIES [EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR USO DENTIFYING INFORMATION) F 518 Continued From page 24 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and administrative document review, the facility failed to provide effective emergency procedures training to employees when one of eight employees [Licensed Nurse (LN) 3] failed to locate the key that provides access to the emergency utility. These failures put all residents in the facility at risk in the event of an emergency related to electricity. Findings: On 2/24/16 at 8:36 a.m., during a concurrent observation and interview in the maintenance hallway, LN 3 failed to locate a key which provided access to the emergency electrical shut-off. LN 3 stated that she was not trained on the key location or how to obtain the key. STREET ADDRESS, CITY, STATE, ZIP CODE 1007 WEST LACEY BLVD HAMPORD, LA 93230 PROVIDER'S PLAN OF CORRECTION (CR) PREFIX TAGE PROVIDER'S PLAN OF CORRECTION (CR) PROVIDE ACCION (CR) PROVI	056288			B. WING					
HANFORD NURSING & REHABILITATION CENTER (CA) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 518 Continued From page 24 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and administrative document review, the facility failed to provide effective emergency procedures training to employees when one of eight emergency cluicensed Nurse (LN) 3] failed to locate the key that provides access to the emergency utility. These failures put all residents in the facility at risk in the event of an emergency related to electricity. Findings: On 2/24/16 at 8:36 a.m., during a concurrent observation and interview in the maintenance hallway, LN 3 failed to locate a key which provided access to the emergency electrical shut-off. LN 3 stated that she was not trained on the key location or how to obtain the key.	NAME OF		1 000200	12,0,00			26/2016		
HANFORD NURSING & REHABILITATION CENTER (X4) ID PRIEFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECIDED BY PULL REGULATORY OR USE DENTIFYING INFORMATION) F 518 Continued From page 24 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and administrative document review, the facility falled to provide effective emergency procedures training to employees when one of eight employees [Licensed Nurse (LN) 3] failed to locate the key that provides access to the emergency utility. These failures put all residents in the facility at risk in the event of an emergency related to electricity. Findings: On 2/24/16 at 8:36 a.m., during a concurrent observation and interview in the maintenance hallway, LN 3 failed to locate a key which provided access to the emergency electrical shut-off. LN 3 stated that she was not trained on the key location or how to obtain the key. HANFORD, CA 93230 PROVIDER'S PLAN OF CORRECTION (EACH CHORGE SPLAN OF CORRECTION (EACH	NAME OF	PHOVIDER OR SUPPLIER							
F 518 Continued From page 24 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and administrative document review, the facility failed to provide effective emergency procedures training to employees when one of eight employees (Lioensed Nurse (LN) 3) failed to locate the key that provides access to the emergency utility. Findings: On 2/24/16 at 8:36 a.m., during a concurrent observation and interview in the maintenance hallway. LN 3 failed to locate a key which provided access to the emergency electrical shut-off. LN 3 stated that she was not trained on the key location or how to obtain the key. Findings: On 2/24/16 at 8:36 a.m., during a concurrent observation and interview in the maintenance hallway. LN 3 failed to locate a key which provided access to the emergency electrical shut-off. LN 3 stated that she was not trained on the key location or how to obtain the key. Findings: On 2/24/16 at 8:36 a.m., during a concurrent observation and interview in the maintenance hallway. LN 3 failed to locate a key which provided access to the emergency electrical shut-off. LN 3 stated that she was not trained on the key location or how to obtain the key.	HANFO	RD NURSING & REHA	BILITATION CENTER						
F 518 Continued From page 24 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and administrative document review, the facility falled to provide effective emergency procedures training to employees when one of eight employees [Licensed Nurse (LN) 3] failed to locate the key that provides access to the emergency utility. These failures put all residents in the facility at risk in the event of an emergency related to electricity. Findings: On 2/24/16 at 8:36 a.m., during a concurrent observation and interview in the maintenance hallway, LN 3 failed to locate a key which provided access to the emergency electrical shut-off. LN 3 stated that she was not trained on the key location or how to obtain the key. Findings: On 2/24/16 at 8:36 a.m., during a concurrent observation and interview in the maintenance hallway, LN 3 failed to locate a key which provided access to the emergency electrical shut-off. LN 3 stated that she was not trained on the key location or how to obtain the key.	(X4) ID						(XS)		
This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and administrative document review, the facility failed to provide effective emergency procedures training to employees when one of eight employees [Licensed Nurse (LN) 3] failed to locate the key that provides access to the emergency utility. These failures put all residents in the facility at risk in the event of an emergency related to electricity. Findings: On 2/24/16 at 8:36 a.m., during a concurrent observation and interview in the maintenance hallway, LN 3 failed to locate a key which provided access to the emergency electrical shut-off. LN 3 stated that she was not trained on the key location or how to obtain the key. How corrective actions will be accomplished for those residents found to have been affected by the deficient practice. On 2/24/16 an Electrical Room key was added to all Charge Nurses keysets. All staff were inserviced on 2/24/16, 2/25/16, and 2/26/2016 on keysets by DNS and ESD. The in-service addressed the addition of the electrical room key	PRÉFIX				CROSS-REFERENCED TO THE APPR				
DON stated the Administrator (Admin), Maintenance Supervisor (MS), and she (DON) had a key to the utility. The DON did not know what the staff would do if they could not get reach her, the Admin, or the MS in an emergency. On 2/24/16 at 3:40 p.m., during a concurrent interview and record review, the Director of Staff Development (DSD) did not provide written evidence of demonstrating LN 3's ability to turn off the electrical shut-off. The DSD stated that she believes it states in the orientation packet of where the key is located. The facilities orientation quiz indicated the location of the emergency electrical shut-off, but had no questions about demonstration on how to access the electrical shut off switch. Xfow 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 had the potential to be affected by deficient practice in the event of an emergency related to electricity. All staff were in-serviced on 2/24/16, 2/25/16, and 2/26/2016 by DNS the in-service addressed concretely in-service		This REQUIREMENT by: Based on observat administrative docut to provide effective training to employee employees [License locate the key that performed in the event of a electricity. These failures put a risk in the event of a electricity. Eindings: On 2/24/16 at 8:36 observation and into hallway, LN 3 failed provided access to shut-off. LN 3 state the key location or had a key to the util what the staff would her, the Admin, or the Admin, or the Condition of the electrical shushe believes it state where the key is loc quiz indicated the locatorical shut-off, believered.	NT is not met as evidenced tion, staff interview, and ament review, the facility failed emergency procedures as when one of eight and Nurse (LN) 3] failed to provides access to the all residents in the facility at an emergency related to an emergency related to an emergency related to an emergency electrical and that she was not trained on now to obtain the key. In, during an interview, the ministrator (Admin), visor (MS), and she (DON) ity. The DON did not know it do if they could not get reach the MS in an emergency. In, during a concurrent of review, the Director of Staff of did not provide written strating LN 3's ability to turn at-off. The DSD stated that as in the orientation packet of stated. The facilities orientation packet of stated. The facilities orientation packet of stated. The emergency ut had no questions about		How corrective actions will be action those residents found to have be by the deficient practice. On 2/24/16 an Electrical Room key wall Charge Nurses keysets. All states serviced on 2/24/16, 2/25/16, and 2/keysets by DNS and ESD. The addressed the addition of the electricate to the charge nurse key set as demonstration on how to access the shut off switch. How the facility will identify other having the potential to be affected having the potential to be affected having the potential to be affected having the practice and what correct will be taken. All residents had the potential to be deficient practice in the event of an related to electricity. All staff were on 2/24/16, 2/25/16, and 2/26/2016 bin-service addressed emergency location of emergency should be taken.	vas added to off were in- 26/2016 on in-service al room key a well a ac electrical r residents by the same tive action affected by emergency in-serviced by DNS the procedures, and proper	2hir 2hio		

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO	. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LTIPLE CONSTRUCTION DING	COM	TE SURVEY APLETED
		056288	B. WING)		C /26/2016
NAME OF F	PROVIDER OR SUPPLIER		J	STREET ADDRESS, CITY, STATE, ZIP CO		20/2010
HANFOR	D NURSING & REHA	BILITATION CENTER		1007 WEST LACEY BLVD HANFORD, CA 93230		
· (X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEPICIENCIÉS Y MUST BE PRECÉDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		SHOULD BE	(XS) COMPLETION DATE
F 518	DSD stated that shexplanation of how access to the electrons. The facility policy at "Emergency Fire Prindicated, "Emerge SOUTH/WEST BAYMAINTENANCE SH	electrical shut-off. p.m., during an interview, the e did not find a written to obtain the key to gain rical shut-off.	F	What measure will be put into systemic changes the facility ensure that the deficient practice. DSD or designee will proviprocedure in-service to new hires, existing staff, and perform unannum drills which include the procedusconnect electrical services. Orientation Quiz was reviewed DNS on 2/29/2016 to include: which include the shut offs are located, how to shut where electrical room key is located. How the facility plans to performance to make sure that sustained. The facility must devensuring that correction is sustained. This plan must be and the corrective action evaluation of integrated into the quality assure. Negative findings on Orientation unannounced disaster drills will be corrected and findings will be broassurance committee meetings for	de emergency periodically to ounced disaster ss of how to The new hire and revised by nere emergency at them off and ed.	2/2all
FORM CMS-25	67,(02-99) Previous Versions			develop and implement on accompliance as needed. Responsible Persons: DNS, Adm DSD.	ninistrator, and	D16 HEALTH ON - FRESNC