

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055147	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/14/2025
NAME OF PROVIDER OR SUPPLIER  Madera Rehabilitation & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  517 South A Street Madera, CA 93638	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689  Level of Harm - Actual harm  Residents Affected - Few	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, interviews and record review, the facility failed to ensure residents' environment remained free of accident hazards as possible when: 1. In the memory care unit, facility staff were aware an exit door was secured by a slide barrel lock (a type of lock that requires the user to slide the barrel of the lock in order to unlock the device) and placed on the door in a position that was out of reach for most individuals. An environmental hazard risk assessment was not done for the lock on the door. Some staff were unaware of the placement of the slide-barrel lock and residents were not trained to unlock the device. These failures resulted in the possibility of 26 of 26 residents ((Residents 8, 16, 18, 20, 23, 24, 31, 43, 45, 51, 56, 58, 60, 64, 75, 76, 88, 99, 104, 117, 136, 149, 156, 168, 172 and 187) and staff being unable to exit the door in an emergency and could lead to entrapment. These failures could affect all 26 memory care residents, representing widespread scope and severity and substandard quality of care. 2. Facility staff was aware of the path of travel to the smoking area from the entrance of the facility crossed the parking area and did not safely and effectively address the hazard posed to residents who smoke and travel the path in order to reach the smoking area. These failures resulted in one of 15 sampled residents (Resident 81) traveling the path on 7/15/25 at time and was struck by a vehicle while in his wheelchair. Resident 81 sustained an unavoidable fracture (break in bone) to his left distal fibula (lower, outer portion of the two long bones in the lower leg) and medial malleolus (bony prominence located on the inner side of the ankle joint) fracture and was admitted to general acute care hospital (GACH) from 7/15/25 through 7/21/25, an open reduction internal fixation (ORIF-surgical opening the fracture site to realign the bone fragments and then using internal hardware like screws, plates, or rods to hold pieces together) to repair the fracture was performed on 7/18/25. These injuries resulted in Resident 81's decreased independence in mobility and to experience pain which led to increased dependence on staff to meet all his activities of daily living (ADL-routine tasks/activities such as bathing, dressing and toileting a person performs daily care for themselves) needs. During an observation on 08/05/25 at 1:06 p.m. a slide barrel lock was installed at the top right corner of an exit door located in the dining room located within the memory care unit leading out to a patio.</p> <p>During a concurrent observation and interview on 8/8/25 at 9:23 AM with the Director of Nurses (DON), DON observed the lock on the door and stated that she was not aware that this type of lock had been installed on the door. DON stated, "That lock can't be there"; DON stated that she thinks this is very unsafe and needs to be replaced. DON stated that it is a, "huge safety issue"; DON stated she never knew that the door had this type of lock installed. DON stated that in the event of an emergency the residents could not get out safely and the fire department could not get in easily. DON further stated that this could be considered a restraint. DON demonstrated that she was not able to reach the lock because the lock was installed high up on the door.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent observation and interview on 08/08/25 at 9:42 AM with Maintenance Director (MAINT DIR) the door leading from the dining room to an outside patio was equipped with a lock. According to MAINT DIR the lock's design was a slide barrel lock and stated the lock was installed several months before. The MAINT DIR stated the position of the lock on the door, near the very top right corner of the door, prevented most individuals, including staff and residents to reach the lock and could result in the possibility of residents and staff unable to exit the door in an emergency and could lead to entrapment. MAINT Dir stated that the slide barrel lock requires some fine motor skills and cognitive understanding to operate. Residents in the memory care unit, many of whom may have dementia or Alzheimer's, may not be able to unlock them in an emergency, posing a serious risk during fire or evacuation situations. Locks like these can trap residents or staff inside or outside the building, especially if staff are unaware the lock has been engaged. MAINT DIR stated that there had been no facility risk or hazard assessment done on this door and lock. MAINT DIR removed the lock from the door.</p> <p>During a review of the facility's policy and procedure titled, "Exits or Means of Egress"; revised date January 2024, indicated "primary and secondary exit doors will remain unlocked at all times";</p> <p>During a review of professional reference from the Life Safety Code (NFPA 101) Published by the National Fire Protection Association (NFPA) in which it requires, "doors must be readily operable from the egress side when a building is occupied. Locks and latches should not require special knowledge or effort to operate from the egress side"; and "that all occupancies, including health care facilities, have unobstructed and readily accessible means of egress to allow for safe evacuation during emergencies"; (NFPA 101: Life safety Code, Means of Egress Requirements (NFPA, latest edition).</p> <p>2. During a review of Resident 81's GACH document titled, "Physician History and Physical Note"; dated 7/16/25, the note indicated, "presented to the emergency department [ED] after reportedly being struck by a pickup truck while seated in his wheelchair in a parking lot"; ED Imaging and Findings: CT [computed tomography scan or CAT scan-medical imaging procedures that uses X-rays[type of electromagnetic radiation used to create images of the inside of the body particularly bones] to create detailed cross-sectional images of the body) Bilateral Lower Extremities (7/15/25 21:09): Left leg: Comminuted, displaced acute traumatic fracture of the distal fibular shaft. Comminuted medial malleolus fracture. Moderate soft tissue swelling. Right Leg: No acute fracture or dislocation"; Discharge Summary"; Hospital course: "successful ORIF on 7/18/2025";</p> <p>During a review of Resident 81's "admission Record"; (AR-a document containing resident profile information) dated 7/16/25, the AR indicated, Resident 81 was admitted to the facility on [DATE] with diagnoses that included cerebrovascular disease (group of conditions that affect the blood vessels in the brain) dysarthria (speech disorder characterized by difficulty in articulating words and producing clear speech) and anarthria (complete loss of the ability to produce speech) history of alcohol abuse, muscle weakness, unspecified dementia (a progressive state of decline in mental abilities) and diabetes mellitus (DM- disorder characterized by difficulty in blood sugar control and poor wound healing).</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Residents 81's Minimum Data Set (MDS- a resident assessment tool used to identify resident cognitive and physical function) assessment dated [DATE], indicated Resident 81's Brief Interview of Mental status assessment (BIMS &amp;ndash; assessment of cognitive status for memory and judgement) scored 14 of 15 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07 indicates severe impairment). The BIMS assessment indicated Resident 81 was cognitively intact.</p> <p>During a review of Resident 81's MDS Assessment, &amp;ldquo;Section GG-Functional Abilities,&amp;rdquo; dated 7/15/25, was reviewed. The MDS &amp;ldquo;Section GG&amp;rdquo; indicated, &amp;ldquo;&amp;hellip;R. Wheel 50 feet with two turns&amp;hellip; code 05 [Setup or clean-up assistance (helper sets up or cleans up; resident competes activity. Helper assist only prior to or following activity) &amp;hellip;S. Wheel 150 feet: Once seated in a wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space&amp;hellip;code 05&amp;hellip;&amp;rdquo;</p> <p>During a concurrent observation and interview on 8/5/25 at 3:15 p.m. in Resident 81's room, Resident 81 was sitting up at the edge of his bed appropriately dressed and observed All Cotton Elastic bandage (ACE- used to provide support and compression to injured or weak body parts) covering his left foot up to below the knee. Resident 81 stated he had an accident in the facility parking lot when he went out for a smoke and was coming back to the facility. Resident 81 stated he was struck by a vehicle backing out of the parking stall. Resident 81 stated he tried to get out of the way, but his wheelchair was hit on the side and went down on his right side with his wheelchair. Resident 81 stated the vehicle went forward and the driver got out of the vehicle and saw him on the ground with his wheelchair on top of him. Resident 81 stated the driver asked if he was injured and picked up the wheelchair off him and set the wheelchair on the ground. Resident 81 stated the driver then picked him up and placed him on the wheelchair and pushed the wheelchair inside to the nursing station. Resident 81 stated the driver informed the nursing staff what happened. Resident 81 stated he told the nurse he had pain in his feet and requested to be sent out to the hospital. Resident 81 stated he did not remember other residents were outside smoking or any staff member supervising smokers. Resident 81 stated the only way to the smoking area was to go through the parking area behind rows of parked cars. Resident 81 stated the facility decided on the smoking area location and thought it was safe. Resident 81 stated, &amp;ldquo;I just had to be careful passing behind parked cars to avoid getting hit.&amp;rdquo;</p> <p>During an interview on 8/7/25 at 2:10 p.m. with Registered Nurse (RN) 2, RN 2 stated she was Resident 81's nurse when Resident 81 was hit by a vehicle in the parking lot. RN 2 stated Resident 81 was alert and oriented and an independent smoker, Resident 81 was able to safely smoke on his own. RN 2 stated she last saw Resident 81 sitting up in his wheelchair requesting a cigarette. RN 2 stated she reminded Resident 81 it was not time to go out for smoke but Resident 81 insisted. RN 2 stated she was not sure if Resident 81 went out by himself to the smoking area and was not assisted by a staff member. RN 2 stated smokers had to go out the double door through the parking area to reach the smoking area. RN 2 stated she was not sure if it was safe for Resident 81 or any residents who smoked to go in the smoking area by themselves. RN 2 stated she did not remember any other accidents that occurred in the parking area before. RN 2 stated she remembered one of the CNA notified her of Resident 81 had an accident outside in the parking area. RN 2 stated she saw CDM/D wheeled Resident 81 to the nursing station and CDM/D stated he hit Resident 81 with his vehicle while he was backing out of parking area. RN 2 stated Resident 81 complained of pain in his feet and requested to be sent out to GACH. RN 2 attempted to assess Resident 81's feet but refused. RN 2 stated she offered pain medication which Resident 81 agreed to take.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 8/7/25 at 2:38 p.m. with Certified Nursing Assistant (CNA) 9, CNA 9 stated she was familiar with Resident 81's care. CNA 9 stated she last saw Resident 81 in his room sitting in his wheelchair and did not mention about wanting to go out to smoke. CNA 9 stated she walked outside to the parking lot and saw people in the parking lot standing around Resident 81 sitting in his wheelchair behind a car. CNA 9 stated she notified RN right away and stated, "I think he [Resident 81] was hit by a car." CNA 9 stated Resident 81 was wheeled back in his wheelchair back inside the facility and was complaining of pain. CNA 9 stated licensed nurses took care of Resident 81 and was sent out to the hospital.</p> <p>During a concurrent observation and interview on 8/7/25 at 3 p.m. with the Certified Dietary Manager/Driver (CDM/D) and DON outside in the parking lot where the incident occurred. The CDM/D showed the location where his vehicle was parked and the location of Resident 81 in his wheelchair when hit with his vehicle while he was backing out of the parking stall. The CDM/D stated his vehicle was parked in the second row on the 14th parking stall from the street near the kitchen back door exit. The CDM/D stated he did not remember seeing Resident 81 or any staff in the parking area when he walked toward his vehicle. The CDM/D stated he drives a truck and is higher than the regular vehicle and he did not see anyone around his vehicle when he was backing his vehicle out of the parking stall then he heard a "Steady honk", so he parked his vehicle and got out of the vehicle. The CDM/D stated he walked to the back of his vehicle and saw Resident 81 in his wheelchair tilted on its side behind his vehicle and the vehicle parked next to his in number 13 parking stall. The CDM/D stated Resident 81 was laying on his right side on the ground with the wheelchair and Resident 81's legs were straight out. The CDM/D stated he immediately moved the wheelchair and asked Resident 81 if he was alright. The CDM/D stated Resident 81 gave him permission to move and sit him in the wheelchair to bring him inside the facility due to the extreme heat (100 degrees Fahrenheit) condition at the time. The CDM/D stated he pushed Resident 81 inside the facility to the nursing station and notified the licensed nurse and the administrator. The CDM/D stated he remembered Resident 81 telling the licensed nurse he had pain in his feet and wanted to be sent out to the hospital. The CDM/D stated from the double door to the site of the incident was six parking stalls including the two handicapped spaces in the first row of parking spaces and directly opposite are eight parking spaces before his vehicle. The CDM/D stated from the smoking area to the site of the incident, Resident 81 had to pass the enclosed large trash bin area, four parking spaces and through the end of driveway where car turns to go to the next rows of parking stalls. The CDM/D stated there was no other safe pathway for residents except to go through the parking area behind parked cars going from the facility to the smoking area.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During a phone interview on 8/7/25 at 3:30 p.m. with Compassionate Care Driver (CCD), the CCD stated he was sitting inside his vehicle when the accident occurred. The CCD stated his car was parked across from where the DSM/D's vehicle was parked. The CCD stated he saw the CDM/D walking towards his vehicle and started his vehicle, he saw Resident 81 in his wheelchair wheeling himself from the smoking area and as Resident 81 approached behind the CDM/D vehicle and tried to move his wheelchair faster to avoid the vehicle. The CCD then saw the CDM/D vehicle backed out and was about to hit Resident 81 in his wheelchair &amp;I pressed my vehicle's horn steadily, but the vehicle already hit the wheelchair. &amp;The CCD stated Resident 81's wheelchair was struck and Resident 81 flipped to the side with his wheelchair. The CCD stated Resident 81 was not run over by the vehicle. The CCD stated he saw CDM/D moved his vehicle forward, got out of his vehicle and walked around behind his vehicle. The CCD stated he got out of his vehicle and helped the CDM/D with Resident 81. The CCD stated the driver straightened the wheelchair and picked up the resident and sat him on the wheelchair and pushed the wheelchair inside the facility and let the licensed nurse know of what happened. The CCD stated he did not remember seeing other residents or staff outside in the smoking area at the time of the accident.</p> <p>During an interview on 8/12/25 at 8:26 a.m. with the Director of Staff Development (DSD), the DSD stated she started working in the facility as DSD since 5/22/25. The DSD stated the smoking area was moved after the accident in the parking area. The DSD stated the smoking area was under the tree at the back of the parking area. The DSD stated residents who smoked had to go through the parking area behind parked cars to go to the smoking area. The DSD stated it was not safe for residents to go through the parking area behind parked cars without any staff assistance. The DSD stated Resident 81 was assessed as an independent smoker, he was alert and oriented and was able to smoke independently.</p> <p>During a concurrent observation and interview on 8/12/25 at 9:38 a.m. with Resident 120 in the smoking area, Resident 120 stated he had been in the facility for a year and had always smoked. Resident 120 stated he was an independent smoker and could go out to smoke anytime he wanted. Resident 120 stated the smoking area was moved after the accident in the parking area. Resident 120 stated there was no sidewalk to use from the double door to the smoking area. Resident 120 stated they had to go through the parking lot, and it was not safe. Resident 120 stated Resident 81 was slower to wheel himself and sometimes refused help from the staff. Resident 120 stated he was outside smoking before the accident and did remember seeing Resident 81 outside smoking with the group.</p> <p>During an interview on 8/12/25 at 10 a.m. with CNA 8, CNA 8 stated residents who smoke have schedule to follow and had to be assisted when they go outside. CNA 8 stated it was not safe for them to go through the parking lot to the smoking area. CNA 8 stated the parking lot was always busy and there was no sidewalk from the facility to the smoking area.</p> <p>During an interview on 8/12/25 at 1:45 p.m. with LVN 9, LVN 9 stated the smoking area was moved after Resident 81's accident in the parking lot. LVN 9 stated the residents are to be assisted to the smoking area by the activity staff and or any staff member then assisted back in the facility after they are done smoking. LVN 9 stated he did not think it was safe for residents to go out alone to smoke because they must go through the parking area behind parked cars. LVN 9 stated he always made sure residents who smoke were assisted when they go out to smoke because of the lack of safe pathway to the smoking area.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 8/12/25 at 4:20 p.m. with Activity Assistant (AA), AA stated she was working the day the incident happened in the parking lot. AA stated she was outside in the smoking area at 4 p.m. supervising smokers before the incident and Resident 81 was not outside with the group. The AA stated she helped smokers when they go outside to smoke because it is quite a distance from the double door to the smoking area. The AA stated residents had to go through the parking lot behind parked cars to get to the smoking area and there were always cars coming in and out. The AA stated, "There was a high risk of accident happening, there was no sidewalk for residents and staff to use."</p> <p>During a concurrent interview and record review on 8/12/25 at 4:45 p.m. with Assistant Director of Nursing (ADON), the ADON reviewed Resident 81's medical record titled "Smoking Assessment" dated 3/4/25, the ADON stated Resident 81 was assessed as independent smoker before the accident. The ADON stated she was working the day the incident happened and was on her way out when she saw Resident 81 sitting up in his wheelchair surrounded by staff by the nursing station. The ADON stated she assisted the licensed nurse and attempted to perform a head-to-toe assessment but Resident 81 refused. The ADON stated she notified the administrator of the incident and assisted sending Resident 81 out to hospital. The ADON stated the smoking assessment did not cover how residents go from the facility to the smoking area. The ADON stated there was no sidewalk or safe pathway from the facility to the smoking area. The ADON stated smokers had to be assisted when they go out to smoke because they had to go through the parking area to reach the smoking area. The ADON stated it was not safe for residents to be by themselves when they go out to smoke, there are a lot of cars all the time.</p> <p>During a concurrent observation and interview on 8/13/25 at 3:05 p.m. with MAINT DIR and DON outside in the parking lot, the MAINT DIR stated he was unable to measure the distance from the double door where residents exited the facility to go to the smoking area. The MAINT DIR stated in the first row of the parking area are four handicapped parking spaces and six regular parking spaces, 16 parking spaces on the opposite side. The MAINT DIR stated four parking spaces next to the trash bins area before the smoking area and an additional four rows of 16 parking spaces. The MAINT DIR stated the parking lot was always busy, cars were constantly going in and out, staff and visitors used the parking area and entered the facility through the double door. The MAINT DIR stated it was not a safe area for residents to be on their own, navigating behind parked cars and cars trying to find parking spaces and cars leaving the parking area. The MAINT DIR stated it was also a long distance from the double door to the smoking area, the MAINT DIR stated, "It was an accident waiting to happen."</p> <p>During an interview on 8/14/25 at 10:06 a.m. with the DON, the DON stated she had only been in the facility for eight weeks. The DON stated she was not in the facility when the incident happened and was notified by phone. The DON stated she was notified Resident 81 was run over by a vehicle in the parking lot. The DON stated, "The distance from the double door to the old smoking area was quite long and the parking lot is busy all the time." The DON stated the double door was where ambulance and transportation vans picked up and dropped off residents. The DON stated there should have been staff assisting residents in the parking lot when they go out to smoke because they had to go through the parking area behind several parked cars and it was not safe. The DON stated her expectation was for the facility to ensure there was a safe pathway/walkway for residents when they went out to the smoking area to smoke. The DON stated it was the responsibility of the facility to ensure resident's safety.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 8/14/25 at 11:05 a.m. with the Administrator (ADM), the ADM stated he was notified by phone by the ADON of the incident on the day it happened. The ADM stated he interviewed staff including the activities assistant who was with the smokers at 4 p.m. and Resident 81 was not with the group smoking. The ADM stated about the accident, &amp;ldquo;It was unfortunate, it could have happened to anybody, not just residents, it could have happened to staff or visitors.&amp;rdquo; The ADM stated it was a risk for anybody. The ADM stated the old smoking area was safe, it was an unfortunate event that occurred. The ADM stated the incident was not preventable, &amp;ldquo;There was nothing that could have been done to prevent the accident from happening.&amp;rdquo; The ADM stated they moved the smoking area to a new location after the incident and residents did not have to go through the parking lot.</p> <p>During a review of the facility&amp;rsquo;s policy and procedure (P&amp;P) titled &amp;ldquo;Smoking Policy-Residents, &amp;rdquo; dated 1/2024, the P&amp;P indicated, &amp;ldquo;&amp;hellip;Prior to, and upon admission, residents are informed of the facility smoking policy, including designated smoking areas, and the extent to which facility can accommodate their smoking or non-smoking preferences&amp;hellip; Smoking is only permitted in designated resident smoking areas&amp;hellip; Any resident with smoking privileges requiring monitoring shall have the supervision of a staff member, family member&amp;hellip; Residents who are currently allowed to smoke will be provided an area to smoke which maintains the quality of life and safety for smoking residents&amp;hellip;&amp;rdquo;</p> <p>During a review of the facility&amp;rsquo;s P&amp;P titled, &amp;ldquo;Safety and Supervision of Residents,&amp;rdquo; dated 1/24, the P&amp;P indicated, &amp;ldquo;&amp;hellip;2. Safety risks and environment hazards are identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting processes; QAPI [Quality Assurance and Performance Improvement-systematic, data-driven, and proactive approach to improving the quality of care and quality of life in healthcare settings] reviews of safety and incident/accident data; and a facility-wide commitment to safety at all levels of the organization. 3. When accident hazards are identified, the facility staff shall review the events in an attempt to identify the root-cause and possible associated hazards and develop strategies to mitigate or remove the hazards to the extent possible. 4. When safety risks can not be completely eliminated, such as the risk for falls and related injuries, the facility staff shall develop strategies to mitigate the risk for injuries that could result from these events. 5. The facility staff and QAPI committee shall review interventions to mitigate hazards or risk for injuries and modify as deemed necessary&amp;hellip;&amp;rdquo;</p> <p>During a review of facility&amp;rsquo;s policy and procedure (P&amp;P) titled, &amp;ldquo;Accidents and Incidents-Investigating and Reporting,&amp;rdquo; dated 7/19, the P&amp;P indicated, &amp;ldquo;&amp;hellip;The nurse supervisor/charge nurse and/or the department director or supervisor shall promptly initiate and document investigation of the accident or incident&amp;hellip; Incident/accident reports will be reviewed&amp;hellip; for trends related to accident or safety hazards in the facility and to analyze any individual vulnerabilities.&amp;rdquo;</p> <p>During a review of facility&amp;rsquo;s P&amp;P titled, &amp;ldquo;Unusual Occurrence Reporting,&amp;rdquo; dated 12/23, the P&amp;P indicated, &amp;ldquo;&amp;hellip; 1. Our facility will report the following events to appropriate agencies&amp;hellip; or other calamities that damage the facility or threaten the welfare, safety or health of residents&amp;hellip; &amp;ldquo;</p> <p>(continued on next page)</p>		

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