

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055199	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/02/2024
NAME OF PROVIDER OR SUPPLIER Horizon Health & Subacute Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3034 E Herndon Fresno, CA 93720	

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)
<p>F 0842</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44708</p> <p>Based on observation, interview, and record review, the facility failed to maintain complete, accurate, and readily accessible documentation of records for three of three sampled residents (Resident 1, 2, and 3) when Resident 1, 2, and 3 required turning and repositioning every two hours and the facility was unable to obtain documentation of turning and repositioning Resident 1, 2, and 3 every two hours.</p> <p>This failure was not the standard of practice according to the facility's policy and procedure titled, Charting and Documentation.</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record (AR), dated 2/2/24, the AR indicated, Resident 1 was admitted on [DATE] with a history of Respiratory Failure (a condition in which blood does not have enough oxygen or has too much carbon dioxide), Subarachnoid Hemorrhage (the accumulation of blood in the space between the arachnoid membrane and the [NAME] mater around the brain), Cerebral Aneurysm (a weak or thin spot on an artery in the brain that balloons or bulges out and fills with blood), Cerebral Edema (when fluid builds up around the brain, causing an increase in pressure known as intracranial pressure), Tracheostomy (a surgical procedure to create an opening through the neck into the trachea), Gastrostomy (A tube inserted through the wall of the abdomen directly into the stomach), and Pressure Ulcer (wound on the skin caused by prolong pressure) of sacral region (the bottom of the spine and lies between the fifth segment of the lumbar spine and the coccyx) stage 4.</p> <p>During a review of Resident 1's Minimum Data Set (MDS - an evaluation of a resident's cognitive and functional status), dated 11/13/23, the MDS indicated the Brief Interview for Mental Status (BIMS) score (an assessment of a resident's cognitive status for memory recall) was 0 (a score of 0 - 7 indicated severe impairment, 8 - 12 indicated moderate impairment, and 13 - 15 indicated minimal to no impairment).</p> <p>During a review of Resident 1's MDS for Functional Abilities And Goals (FAAG) dated 11/13/23, the FAAG indicated Resident 1 was dependent (relied on others) and required two or more assistants to complete activities of daily living (eating, toileting, bathing, transferring, etc.)</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 0842</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>During a review of Resident 1's Weekly Pressure Ulcer (WPU) report (a pressure injury tool used to assess pressure injuries), dated 1/26/24, the WPU indicated, Site: Coccyx. Type: Pressure. Length: 2.5 cm (centimeter - unit of measurement). Width: 2.3 cm. Depth: 1.2 cm. Stage: Unstageable (Fill thickness tissue loss in which the base of the ulcer (wound) is covered by slough [yellow, tan, gray, green or brown] and/or eschar [tan, brown or black] in the wound bed).</p> <p>During a concurrent observation and interview on 2/2/24 at 9:57 a.m. with Licensed Vocational Nurse (LVN) 1 in Resident 1's room, Resident 1 was in bed, non-verbal (not able to speak) and non-responsive (not able to react to stimulation). There was a quarter size stage 4 Pressure Ulcer PU on Resident 1's coccyx and pea size dry scabs (healing wounds) on Resident 1's left palm and 5th finger. LVN 1 stated Resident 1 had a stage 4 PU on his coccyx on admission and required dressing changes every day and turning and repositioning every two hours. LVN 1 stated it was unknown how the scabs on Resident 1 left hand appeared.</p> <p>During an interview on 2/2/24 at 11:05 a.m. with Medical Doctor (MD), MD stated he was a Wound Specialist (physician with specialized skills and knowledge in wound care) and has been following Resident 1 since admission. MD stated Resident 1 had a stage 4 PU to his coccyx on admission. MD stated he expected staff to turn and reposition Resident 1 every two hours to prevent Resident 1's PU from worsening and preventing new PU from occurring. MD stated the wounds on Resident 1's left hand was a result of a PU from lying on it for long periods of time.</p> <p>During an interview on 2/2/24 at 2:21 p.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated Resident 1 had a PU on his coccyx and required to be turned and repositioned every two hours. CNA 1 stated turning and repositioning immobile (unable to move) residents every two hours was required to provide comfort and prevent pressure injuries from occurring. CNA 1 stated documenting turning and repositioning every two hours was required to indicate residents were turned and repositioned as required.</p> <p>During an interview on 2/9/24 at 11:39 a.m. with CNA 2, CNA 2 stated Resident 1 had a PU on his coccyx and required to be turned and repositioned every two hours. CNA 2 stated Resident 1 required to be turned and repositioned every two hours because Resident 1 could not turn himself. CNA 2 stated turning and repositioning every two hours was required to improve circulation and comfort. CNA 2 stated it was important to document Resident 1 was turned and repositioned every two hours to show care was provided as required.</p> <p>During an interview on 2/9/24 at 11:46 a.m. with CNA 3, CNA 3 stated Resident 1 had a PU on his coccyx and required turning and repositioning every two hours. CNA 3 stated the turning and repositioning was documented in the ADL (activities of daily living) section in the Resident 1's electronic health record (EHR - the computer program the facility uses to document and store resident health information). CNA 3 stated the time required to turn and reposition a resident was indicated by a box that was checked by staff that the resident was turned and repositioned at that time. CNA 3 stated it was important to turn and reposition immobile residents every two hours to take pressure off the wound to heal. CNA 3 stated it was important to document accurately in the resident's EHR to keep track of the turning and repositioning of the resident and to ensure that the turning and repositioning was done at that time.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>During a review of Resident 1's Care Plan (CP), dated 6/9/23, the CP indicated, At risk for skin impairment and further decline of skin integrity r/t (related to) decreased mobility with high risk for friction, thin fragile skin, head of bed elevated most times, history of abnormal lab values. Interventions: Encourage and assist if needed with turning and repositioning (shifting weight to relieve pressure) on rising, before and after meals, and as needed.</p> <p>During a review of Resident 1's CP, dated 1/11/24, the CP indicated, Resident has redness to buttock r/t (related to) immobility. Interventions: Reposition resident frequently.</p> <p>During a review of Resident 1's CP, dated 1/15/24, the CP indicated, Resident has reoccurring shear to left buttock. Interventions: Reposition PT (patient) frequently.</p> <p>During a review of Resident 1's CP, dated 1/25/24, the CP indicated, Resident has scabs to left hand and palm. Interventions: Monitor scabs to left hand/palm for s/s (signs and symptoms) of worsening.</p> <p>During a review of Resident 1's turn and reposition report dated 1/1/24 - 1/31/24, the report indicated Resident 1 was turned and repositioned every shift (every 8 hours).</p> <p>During a review of Resident 2's Admission Record (AR), dated 3/5/24, the AR indicated, Resident 2 was admitted on [DATE] with a history of Alzheimer (a brain condition that causes a decline in memory, thinking, learning and organizing skills over time), Diabetes Mellitus (a chronic disease characterized by high levels of sugar in the blood), Parkinsonism (a brain condition that causes slowed movements, rigidity (stiffness) and tremors), End Stage Renal Disease (a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life), Dependence on renal dialysis (a procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly), Cerebrovascular Disease (a group of conditions that affect blood flow and the blood vessels in the brain), and Pressure Ulcer (wound on the skin caused by prolong pressure) of sacral region (the bottom of the spine and lies between the fifth segment of the lumbar spine and the coccyx) stage 4.</p> <p>During a review of Resident 2's Minimum Data Set (MDS - an evaluation of a resident's cognitive and functional status), dated 12/13/23, the MDS indicated the Brief Interview for Mental Status (BIMS) score (an assessment of a resident's cognitive status for memory recall) was 0 (a score of 0 - 7 indicated severe impairment, 8 - 12 indicated moderate impairment, and 13 - 15 indicated minimal to no impairment).</p> <p>During a review of Resident 2's MDS for Functional Abilities And Goals (FAAG) dated 12/13/23, the FAAG indicated Resident 2 was dependent (relied on others) and required two or more assistants to complete activities of daily living (eating, toileting, bathing, transferring, etc.)</p> <p>During a review of Resident 2's turn and reposition report dated 1/1/24 - 2/1/24, the report indicated Resident 2 was turned and repositioned every shift (every 8 hours).</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>During a review of Resident 3's Admission Record (AR), dated 3/5/24, the AR indicated, Resident 3 was admitted on [DATE] with a history of Nontraumatic Intracerebral Hemorrhage (bleeding into the substance of the brain in the absence of trauma or surgery), Chronic Respiratory Failure (when the respiratory system is unable to adequately exchange oxygen and carbon dioxide in the body, leading to decreased oxygen levels and increased carbon dioxide levels), Tracheostomy (an opening surgically created through the neck into the trachea (windpipe) to allow air to fill the lungs), Dependence on Respirator (reliance on a mechanical ventilator to compensate for decreased lung function), and Persistent Vegetative State (a chronic disorder in which an individual with severe brain damage appears to be awake but shows no evidence of awareness of their surroundings).</p> <p>During a review of Resident 3's Minimum Data Set (MDS - an evaluation of a resident's cognitive and functional status), dated 1/10/24, the MDS indicated the Brief Interview for Mental Status (BIMS) score (an assessment of a resident's cognitive status for memory recall) was 0 (a score of 0 - 7 indicated severe impairment, 8 - 12 indicated moderate impairment, and 13 - 15 indicated minimal to no impairment).</p> <p>During a review of Resident 3's MDS for Functional Abilities And Goals (FAAG) dated 1/10/24, the FAAG indicated Resident 3 was dependent (relied on others) and required two or more assistants to complete activities of daily living (eating, toileting, bathing, transferring, etc.)</p> <p>During a review of Resident 3's turn and reposition report dated 2/1/24 - 3/1/24, the report indicated Resident 3 was turned and repositioned every shift (every 8 hours).</p> <p>During an interview on 2/9/24 at 12:49 p.m. with Director of Nursing (DON), DON stated it was standard of practice to turn and reposition immobile residents every two hours to minimize and prevent PU. DON stated the facility was unable to obtain documentation of turning and repositioning every two hours. DON stated the facility was only able to obtain documentation of turning and repositioning every shift. DON stated the facility was required to obtain complete and accurate documentation to indicate care was provided as required.</p> <p>During an interview on 2/20/24 at 9:55 a.m. with Administrator (ADM), ADM stated the facility was only able to obtain documentation of turning and repositioning every shift. ADM stated staff turned and repositioned Resident 1 every two hours during each shift. ADM stated the facility was unable to obtain documentation that Resident 1 was turned and repositioned every two hours. ADM stated the facility did not maintain medical records that were complete, accurate, and readily accessible, for turning and repositioning every two hours.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Charting and Documentation, dated 7/1/20, the P&P indicated, POLICY. It is the policy of this facility that all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. POLICY INTERPRETATION AND IMPLEMENTATION . 2. The following information is to be documented in the resident medical record: a. Objective observations; b. Medications administered; c. Treatments or services performed; d. Changes in the resident's condition; e. Events, incidents or accidents involving the resident; and f. Progress toward or changes in the care plan goals and objectives. 3. Documentation in the medical record will be objective, complete and accurate as much as possible.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>During a professional reference review retrieved from https://www.hopkinsmedicine.org/health/conditions-and-diseases/bedsores titled, Bedsores (pressure injuries), dated 2024, the professional reference indicated, Bedsores can be prevented by inspecting the skin for areas of redness (the first sign of skin breakdown) every day with particular attention to bony areas. Other methods of preventing bedsores and preventing existing sores from getting worse include: Turning and repositioning every 2 hours. Sitting upright and straight in a wheelchair, changing position every 15 minutes. Providing soft padding in wheelchairs and beds to reduce pressure. Providing good skin care by keeping the skin clean and dry. Providing good nutrition because without enough calories, vitamins, minerals, fluids, and protein, bed sores can't heal, no matter how well you care for the sore Bedsores are ulcers that happen on areas of the skin that are under pressure from lying in bed, sitting in a wheelchair, and/or wearing a cast for a prolonged period. Bedsores can happen when a person is bedridden, unconscious, unable to sense pain, or immobile .</p>