STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055199	A. Building B. Wing	07/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Horizon Health & Subacute Center	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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 27137 Based on interview and record review, the facility failed to ensure one of three residents (Resident 1) was free from physical abuse when one Mental Health Worker (MHW) placed both of his hands on Resident 1's shoulders and shoved him backwards. This failure resulted in Resident 1 stumbling backwards and experiencing mental anguish, including intimidation, feeling threatened, frightened, and increased agitation. Findings: During a review of the document titled SOC341 - Report of Suspected Dependent Adult/Elder Abuse (submitted to the Department from the facility), dated 6/24/24, the SOC341 indicated that on that date between 5 PM and 5:15 PM, Resident 1 was observed in his bathroom yelling. [MHW] attempted to de-escalate the patient. Resident [1] then pushed [MHW. MHW] responded by pushing patient with two hands on each shoulder causing resident to stumble back. During a review of Resident 1's Admission Record (AR), dated 7/9/24, the AR indicated he was admitted to the facility with diagnoses that included Schizoaffective Disorder (a mental disease that affects the person's ability to understand what is real); Obsessive-Compulsive Disorder (is a long-lasting disorder in which a person experiences uncontrollable and recurring thoughts and engages in repetitive behaviors, or both; Restlessness and Agitation ; and Anxiety Disorder (usually involves a persistent feeling of anxiety or dread, which can interfere with daily life). During a review of Resident 1's Progress Notes (PN), dated 6/24/24, at 9:13 PM, the PN indicated, Approx. [5:15 PM to 5:30 PM] resident [1] was observed yelling in his bathroom. Staff attempted to de-escalate. Resident [1] yelling at staff to close bathroom door and staff denied. Resident [1] push staff, in return staff placed two hands on residents shoulders and returned a push causing resident [1] to stumble a few steps back in his bathroom. Staff member then walked out of room and returned to his office. During an interview on 7/9/24, at 11:40 AM, with the Administrator, the Administrator stated the MHW's employment with the facility was terminated. The Administrator stated, As a Mental Health Worker, I really don't think he was a good fit. He was triggering residents. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility document titled, Employee Warning/Discipline Memo (EWDM), addressed to MHW, dated 7/1/24, the EWDM indicated, On 6/24/2024, you were asked to assist a resident when he was in an agitated state. During your interaction with the resident you were observed by other staff who saw you engaging with the resident in a manner which is not consistent with the [de-escalation] training you received. In doing so, you placed yourself in a situation which increased the likelihood of assaultive behavior and physical injury. The resident became more agitated and pushed you as he was likely feeling threatened by your presence in a small space and no way to remove himself as you were blocking the exit of the restroom. When the resident became more agitated, you were observed to push the resident by placing hands on him and shoving him back into the restroom. Due to the nature and severity of this violation in our code of conduct we are moving forward with termination. The EWDM was signed by the Administrator and the MHW. During an interview on 7/9/24, at 12:10 PM, with the Program Director (PD), the PD stated she was the MHW's supervisor. The PD stated she looked into the incident between Resident 1 and the MHW occurring on 6/24/24, and stated, [MHW] violated our code of conduct, he stood in the doorway intimidating [Resident 1]. We don't want to intimidate patients, we want to de-escalate them. When the assault happened, [the MHW] was not able to conduct himself in a professional manner. During an interview on 7/9/24, at 3:15 PM, with Licensed Vocational Nurse (LVN) 1, LVN 1 stated, I saw this happen. LVN 1 stated Resident 1 has a history of behavioral issues. LVN 1 stated earlier in the day on 6/24/24, he was swinging his arms in the air with a closed fist, to try and silence the voices and staff were monitoring him closely, to protect himself and others. LVN 1 stated these behaviors were normal for Resident 1. LVN 1 stated after dinner on 6/24/24, Resident 1 went into his bedroom and began yelling, which was also normal behavior for him. LVN 1 stated she observed the MHW enter Resident 1's room in effort to de-escalate him. LVN 1 stated she was at the edge of the nurses' station and could see the interaction between Resident 1 and the MHW through Resident 1's open bedroom door. LVN 1 stated Resident 1 was in his bathroom and yelled at the MHW to close the bathroom door. LVN 1 stated Resident 1 told the MHW to close the door three times, then pushed the MHW on the shoulders. LVN 1 stated the MHW then pushed [Resident 1] back on his shoulders, using both hands, one on each shoulder. It was a good enough push to take a couple of steps back. My focus then was to get [MHW] away from [Resident 1]. It did end up escalating his behavior for 20-30 minutes after the fact. He came out and approached a staff person, wanting to fight them, which was out of the ordinary for him. LVN 1 stated she then notified the Director of Nursing, who instructed her to send the MHW home for putting hands on a resident. LVN 1 stated, Putting hands on a resident is absolutely abuse. In response to being pushed, it kind of looked like he wanted to retaliate against the resident. LVN 1 stated Certified Nursing Assistant (CNA 1) also was a witness to the event between Resident 1 and the MHW. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/11/24, at 3:50 PM, with CNA 1, CNA 1 stated he was a witness to event between Resident 1 and the MHW occurring on 6/24/24. CNA 1 stated, Resident 1 was in his room, yelling, which was not uncommon, and he usually de-escalates himself. CNA 1 stated, I was monitoring him for his safety. He went into his restroom and [the MHW] went into his him to try to talk him down. [Resident 1] got louder and louder, yelling at [the MHW] to ' get out.' [Resident 1] was standing at the inside of his restroom doorway, [MHW] was standing just outside the restroom doorway. [Resident 1] then pushed [MHW], and maybe five seconds later, [MHW] pushed [Resident 1] back, causing him to stumble backyards a couple of feet. [MHW] used both his hands, shoving [Resident 1] on his shoulders, and upper body area. [Resident 1] didn't fall, but he did stumble backwards. [MHW] then immediately left the room. It escalated so quickly. I made sure [Resident 1] was ok, [LVN 1] was there, and she assessed him. I asked [Resident 1] if he felt frightened, and he stated yes. His vital signs were ok. I was shocked that it escalated so quickly. My first thought was to make sure [Resident 1] was ok. I was taken aback by this incident. During a review of the facility's policy and procedure (P&P) titled, Fraud and Abuse Prevention and Reporting Policy, dated 11/24/27, the P&P indicated, in part, It is the policy of this facility that all employees and agents will provide residents an environment free from abuse and retaliation. Definitions: Abuse - the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 27137 Based on interview and record review, the facility failed to check the references of one of three employees (Mental Health Worker, or MHW) prior to employment. This failure resulted in the potential for one unqualified employee (MHW) to provide care to residents [Cross Reference with F600]. Findings: During a review of the document titled SOC341 - Report of Suspected Dependent Adult/Elder Abuse (submitted to the Department from the facility), dated 6/24/24, the SOC341 indicated that on that date between 5 PM and 5:15 PM, Resident 1 was observed in his bathroom yelling. [MHW] attempted to de-escalate the patient. Resident [1] then pushed [MHW. MHW] responded by pushing patient with two hands on each shoulder causing resident to stumble back. During an interview on 7/9/24, at 11:40 AM, with the Administrator, the Administrator stated the MHW's employment with the facility was terminated. The Administrator stated, As a Mental Health Worker, I really don't think he was a good fit. He was triggering residents. During a review of the facility document titled, Employee Warning/Discipline Memo (EWDM), addressed to MHW, dated 7/1/24, the EWDM indicated, On 6/24/2024, you were asked to assist a resident when he was in an agitated state. During your interaction with the resident you were observed by other staff who saw you engaging with the resident in a manner which is not consistent with the [de-escalation] training you received. In doing so, you placed yourself in a situation which increased the likelihood of assaultive behavior and physical injury. The resident became more agitated and pushed you as he was likely feeling threatened by your presence in a small space and no way to remove himself as you were blocking the exit of the restroom. When the resident became more agitated, you were observed to push the resident by placing hands on him and shoving him back into the restroom. Due to the nature and severity of this violation in our code of conduct we are moving forward with termination. The EWDM was signed by the Administrator and the MHW. During a concurrent record review and interview, on 7/9/24, at 12 PM, with the Director of Staff Development (DSD), MHW's employee file was reviewed. There were two documents titled Pre-Employment Reference Check (PERC), both dated 9/25/23. The two PERCs contained the names of former employers of MHW and their telephone numbers, but references were not completed. The DSD confirmed the findings. During a concurrent record review and interview, on 7/9/24, at 12:02 PM, with the Staffing Coordinator (SC), MHW's employee file was reviewed. The SC stated, There should be two references in there. The SC stated that normally, the candidate for employment fills it out and they get sent to the former employers, and I don't see where that was done. It is our policy to conduct references on new hires. During a review of the facility's policy and procedure (P&P), titled Background Checks, dated 12/23, the P&P indicated, in part: Policy - All background checks will be processed on potential candidates before being hired with the company and as necessary, through the course of employment as required by applicable governing agencies. Procedure - after interviewing the candidate, obtaining two references.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 27137 Based on interview and record review, the facility failed to report the findings of an investigation of an abuse allegation to the Department within five days. This failure had the potential for an allegation of abuse to not be thoroughly investigated and result in further abuse [Cross Reference with F600]. Findings: During a review of the document titled SOC341 - Report of Suspected Dependent Adult/Elder Abuse (submitted to the Department from the facility), dated 6/24/24, the SOC341 indicated that on that date between 5 PM and 5:15 PM, Resident 1 was observed in his bathroom yelling. [Mental Health Worker, or MHW] attempted to de-escalate the patient. Resident [1] then pushed [MHW. MHW] responded by pushing patient with two hands on each shoulder causing resident to stumble back. During an interview on 7/9/24, at 4:30 PM, with the Administrator, the Administrator stated, We don't have a 5-day follow up report. During a review of the facility's policy and procedure (P&P) titled, Reporting of Alleged Violations, dated 3/18, the P&P indicated, A completed copy of all investigation findings, documentation forms and written statements from witnesses, for all allegations of abuse, must be provided to the Administrator/designee; and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.