| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055199 | A. Building<br>B. Wing | 11/22/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Horizon Health & Subacute Center | 3034 E Herndon<br>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) |
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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>44708<br><br>Based on observation, interview, and record review, the facility failed to ensure one of four residents (Resident 1) was free from abuse, neglect, and exploitation when Licensed Vocational Nurse (LVN) 1 used profane language (language that is considered offensive, vulgar, or irreverent) toward Resident 1 and instructed staff not to assist Resident 1 after an unwitnessed fall (when an individual falls to the ground or a lower surface without anyone seeing it) on 11/17/24.<br><br>These failures had the potential for Resident 1 to experience agitation, intimidation, disrespect, and fear.<br><br>Findings:<br><br>During a review of Resident 1's Admission Record (AR), dated 11/22/24, the AR indicated, Resident 1 had a history of Schizophrenia (a chronic mental illness that affects a person's ability to think, feel, and behave normally) and Anxiety Disorder (a condition that causes excessive and persistent feelings of fear, dread, and uneasiness).<br><br>During a concurrent observation and interview on 11/22/24 at 3:10 p.m. with Resident 1, in Resident 1's room, Resident 1 stated, on 11/17/24 he was sitting on the bed in his room and slipped onto the floor. Resident 1 stated, he had arthritis (a condition that causes inflammation in the joints, which are the places where two bones meet) in his knees and could not walk. Resident 1 stated, staff came to help him get up from the floor, but LVN 1 was mean. Resident 1 stated, if you look at her (LVN 1) she will yell like a witch. Resident 1 stated, he did not want LVN 1 to provide care to him.<br><br>During an interview on 11/22/24 at 3:23 p.m. with Mental Health Worker (MHW), MHW stated, on 11/17/24 at 6:30 p.m., MHW was at the nursing station, when Resident 1's roommate came to the nursing station and informed staff that Resident 1 fell on to the floor. MHW stated she, Certified Nursing Assistant (CNA) 1, and LVN 1 went to Resident 1's room, and Resident 1 was on the floor with a pillow under his head. MHW stated, CNA 1 asked Resident 1 if he fell , and LVN 1 said to Resident 1, there's no way that you fucking fell , you always do this kind of shit. I'm sick and tired of your shit, always needing something. MHW stated, LVN 1 was using vulgar language and diminishing Resident 1. MHW stated, Resident 1 stated that he did fall. MHW stated, at that time, CNA 2 and CNA 3 came to assist Resident 1 and MHW left the room. MHW stated Resident 1's assigned LVN 2 was at the nursing station, and LVN 1 reported, the incident to LVN 2 that Resident 1 was on the floor but not to document the incident as a fall because Resident 1 did this all the time.<br><br>(continued on next page) |

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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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 11/22/24 at 3:40 p.m. with CNA 1, CNA 1 stated on 11/17/24 Resident 1 was found on the floor with a pillow under his head. CNA 1 stated, she and CNA 3 assisted Resident 1 back to bed. CNA 1 stated, she did not witness LVN 1 using foul language. CNA 1 stated, Resident 1 was using foul language. CNA 1 stated, Resident 1 said, we're racist because we don't help him. CNA 1 stated, Resident 1 was verbally abusive toward staff.<br><br>During an interview on 11/22/24 at 3:33 p.m. with CNA 2, CNA 2 stated, on 11/17/24 she went to Resident 1's room and found Resident 1 on the floor with a pillow under his head. CNA 2 stated, Resident 1 said he fell and LVN 1 said he did not fall, and Resident 1 called LVN 1 a bitch. CNA 2 stated, LVN 1 told Resident 1 not to say that. CNA 2 stated, LVN 1 was not using profanity in the room, but when LVN 1 left the room, LVN 1 said she, shouldn't be talked to like this, that this is bullshit.<br><br>During an interview on 11/27/24 at 10:34 a.m. with CNA 3, CNA 3 stated on 11/17/24 around 5:20 p.m. Resident 1 was in his room on the floor with a pillow under his head. CNA 3 stated, Resident 1, had manipulative behaviors (when a person uses controlling and harmful behaviors to avoid responsibility, conceal their true intentions, or cause doubt and confusion), he puts himself on the floor, and acts like he can't do anything. CNA 3 stated he, CNA 1, and LVN 1 were in Resident 1's room and LVN 1 stated, shit he did it again. CNA 3 stated, he and CNA 1 helped Resident 1 back to bed and LVN 1 said to Resident 1 you're doing it again; you're putting yourself on the floor. CNA 3 stated, Resident 1 replied by calling LVN 1, a bitch and fuck you. CNA 3 stated, when he and CNA 1 assisted Resident 1 onto the bed, Resident 1 started to slide off the bed. CNA 3 stated LVN 1 said, he can do the rest himself and instructed CNA 1 and CNA 3 not to continue assisting Resident 1. CNA 3 stated, Resident 1 did not like LVN 1 because LVN 1 was very direct. CNA 3 stated, it was not appropriate to use profane language in the workplace. CNA 3 stated, staff needed to be direct with Resident 1 but be professional. CNA 3 stated, it was necessary to treat all residents with kindness and compassion.<br><br>During an interview on 11/22/24 at 4:46 p.m. with LVN 1, LVN 1 stated, on 11/17/24 LVN 1 was informed Resident 1 was on the floor. LVN 1 stated, she went to Resident 1's room and saw Resident 1 on the floor with a pillow under his head. LVN 1 stated, Resident 1 had a history of putting himself on floor and a history of accusing staff of not helping him. LVN 1 stated, she told Resident 1, you're doing this again. LVN 1 stated, Resident 1 started cursing (using profane and vulgar language) and stated he fell . LVN 1 stated, she told Resident 1 he did not fall because there was a pillow under his head. LVN 1 stated, Resident 1 was angry and said, fuck you and told her to shut the fuck up and then told staff to get him the fuck up. LVN 1 stated, 2 CNAs assisted Resident 1 on to the bed. LVN 1 stated, after the CNAs put Resident 1 on the bed, LVN 1 stated she told Resident 1 he can do the rest himself and instructed the CNAs not to assist Resident 1 further because Resident 1 had manipulative behaviors. LVN 1 stated, the incident was reported to Resident 1's assigned nurse (LVN 2) that Resident 1 did not fall and was found on floor. LVN 1 stated, she informed LVN 2 that Resident 1 was laying there perfectly fine with a pillow under his head. LVN 1 denied using profane language during the incident.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 11/26/24 at 6:08 p.m. with LVN 2, LVN 2 stated on 11/17/24 LVN 2 was passing medication and she saw Resident 1 sitting on the edge of his bed. LVN 1 stated, Resident 1 looked like he was going to fall so LVN 1 asked CNA 4 to help reposition Resident 1. LVN 2 stated, at 7:00 p.m., LVN 1 approached her and informed her that Resident 1 put himself on the floor and to mark 1 on the behavior form for attention seeking. LVN 2 stated, she went to assess (evaluate a patient's condition and health status) Resident 1 and did not ask Resident 1 what happened. LVN 2 stated, she should have asked Resident 1 if he fell . LVN 2 stated, Resident 1 did not complain of pain or discomfort. LVN 2 stated, she instructed Resident 1 to ask for assistance when needed and Resident 1 did not reply. LVN 2 stated, it was not appropriate to use profane language in the workplace. LVN 2 stated it was required to redirect residents with behaviors in a professional, caring, and compassionate manner at all times.<br><br>During an interview on 11/22/24 at 3:47 p.m. with Program Director (PD), PD stated, no one especially staff was allowed to use profanity or speak in a derogatory (insulting or disrespectful) way in the workplace. PD stated, staff was expected to always behave professionally even when they are frustrated. PD stated, all residents regardless of behaviors must be treated with dignity, respect, and compassion.<br><br>During an interview on 12/4/24 at 11:44 a.m. with Director of Nursing (DON), DON stated, staff was expected to treat everyone with respect and dignity. DON stated, staff was expected to provide assistance as needed and not deprive residents of care.<br><br>During an interview on 12/4/24 at 11:50 a.m. with Administrator (ADM), ADM stated, staff was expected to treat residents with respect, dignity, and compassion. ADM stated, residents with behaviors should not be deprived of care. ADM stated, staff was expected to redirect residents with behaviors in a professional manner. ADM stated, Resident 1 had a history of lying on the floor, but any nurse was expected to assess the resident appropriately and follow fall protocol (a set of evidence-based procedures used in the event of a fall).<br><br>During a review of the facility's document titled, 5-day Summary (a report of findings done by the facility), dated 11/22/24 indicated, . [Resident 1] . Staff: [LVN 1] . After investigation and interviews we are substantiating the allegation of abuse against [LVN 1] .<br><br>During a review of the facility's policy and procedure (P&P) titled, Falls - Clinical Protocol, dated 2001, the P&P indicated, Assessment and Recognition .5. The staff will evaluate and document falls that occur while the individual is in the facility; for example, when and where they happen, any observations of the events, etc. 7. Falls should also be identified as witnessed or unwitnessed events.Monitoring and Follow-Up .1. The staff, with the physician's guidance, will follow up on any fall with associated injury until the resident is stable and delayed complications such as late fracture (broken bone) or subdural hematoma (bleeding in the brain) have been ruled out or resolved .<br><br>During a review of the facility's (P&P) titled, Standards of Conduct, undated, the P&P indicated, The Employer can only be successful by having an environment in which certain behaviors are upheld by its employees; The Employer's Mission statement speaks of professionalism of staff.All employees are expected to act in a mature, professional, kind and responsible way at all times .<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a review of the facility's (P&P) titled, Resident Right, dated 7/1/22, the P&P indicated, Policy. Employees shall treat all residents with kindness, respect, and dignity.Policy Interpretation and Implementation. 1. c. be free from abuse, neglect, misappropriation of property, and exploitation . |