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	03/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Horizon Health & Subacute Center	3034 E Herndon Fresno, CA 93720

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 41493 Based on observations, interviews, record reviews, and facility policy reviews, the facility failed to: 1) ensure staff monitored urinary output in accordance with the physician's order, and the facility policy; 2) immediately address Resident #1's complaint of severe pain; and 3) ensure the resident's stage four pressure ulcers were treated as ordered by the physician. On 02/26/2024 at 11:12 AM, Resident #1 notified Certified Nursing Assistant (CNA) #1 of their pain; however, staff did not intervene and address the resident's complaint of pain until 1:10 PM. Resident #1 experienced severe pain for greater than two hours, suffered bladder distension due to a malfunctioning catheter and had an infected pressure ulcer that was left uncovered. Once the malfunctioning catheter was removed, Resident #1 expelled a copious (large in quantity) amount of urine. The copious amount of urine expelled by the resident leaked onto the resident's uncovered, infected stage four pressure ulcers on their buttocks and sacrum. High volumes of urine removed at once could cause serious clinical complications for 1 (Resident #1) of 6 sampled residents reviewed for urinary catheter. It was determined the facility's non-compliance with one or more requirements of participation had caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was related to State Operations Manual, Appendix PP, 483.25 (Quality of Care) at a scope and severity of J. The IJ began on 02/26/2024 at 11:00 AM, when Resident #1 verbalized pain and was observed writhe in pain from bladder distention due to a lack of urinary output since. The last time staff indicated the resident had urinary output was during the 3:00 PM to 11:00 PM shift on 02/25/2024. The Administrator and Director of Nursing (DON) were notified of the IJ and provided with the IJ Template on 02/27/2024 at 9:00 AM. A Removal Plan was requested. The Removal Plan was accepted by the state survey agency on 03/01/2024 at 1:17 PM. The IJ was removed on 03/01/2024 at 5:00 PM, after the survey team performed onsite verification that the Removal Plan had been implemented. Noncompliance for F684 remained at the lower scope and severity of G. Furthermore, the facility failed to follow the physician's order for 1 (Resident #105) of 2 sampled residents reviewed for non-pressure related skin concerns. Specifically, the facility failed to ensure staff changed the resident's bilateral lower leg compression dressings as ordered by the physician. Findings included: (continued on next page)

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

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. A review of the facility policy titled, Wound Care, revised on 09/19/2022, revealed The purpose of this procedure is to provide guidelines for the care of wounds to promote healing and prevent infection. The policy specified, 7. Apply treatments as ordered by the physician. A review of the facility policy titled, Catheter Care - Urinary, revised on 07/01/2023, revealed The purpose of this procedure is to prevent catheter-associated urinary tract infections. Per the policy, 3. Observe the resident's urine level for noticeable increases or decreases. If the level stays the same, or increases rapidly, report it to the physician or supervisor. The policy revealed, Complications 1. Observed the resident for complications associated with urinary catheter. a. If the resident indicates that his or her bladder is full or that he or she needs to void (urinate), notify the physician or supervisor. b. Check the urine for unusual appearance. c. Notify the physician or supervisor in the event of bleeding, or if the catheter is accidentally removed, d. Report any complaints the resident may have of burning tenderness, or pain in the urethral area. e. Observe for other signs and symptoms of urinary tract infection or urinary retention. Report findings to the physician or supervisor immediately. A review of Resident #1's Admission Record revealed the facility admitted the resident on 04/11/2023, with diagnoses that included quadriplegia, hypertension, constipation, stage four pressure ulcer of the sacral regional and left buttock, muscle spasm, and neuromuscular dysfunction of the bladder. A review of Resident #1's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/18/2024, revealed the resident had a Brief Interview of Mental Status (BIMS) of 15, which indicated the resident was cognitively intact. The MDS revealed the resident was dependent on staff for toileting and personal hygiene. Per the MDS, the resident had an indwelling catheter and was always incontinent of bowel. The MDS revealed the resident had occasional pain and received a scheduled pain medication regimen, as needed pain medication, and non-medication interventions for pain. Per the MDS, the resident had a stage four pressure ulcer that was present on admission and other opened lesion(s) other than ulcers, rashes, or cuts. A review of Resident #1's care plan, revised on 03/02/2022, revealed the resident had an indwelling urinary catheter related to diagnoses of neuromuscular dysfunction of the bladder and quadriplegia. Interventions directed staff to monitor/record/report to the physician signs and symptoms of urinary tract infection to include pain, blood-tinged urine, and no urinary output, deepening of urine color. A review of Resident #1's care plan, revised on 02/05/2024, revealed the resident had actual skin impairment of a stage four pressure ulcer to their left buttocks. Interventions directed staff to provide treatment as ordered by the MD. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of Resident #1's Order Summary Report, with active orders as of 02/29/2024, revealed an order dated 04/11/2023, for indwelling catheter output every shift. If no output, assess the resident's bladder for distention, check for malfunction, and notify the MD as needed. The order dated 02/13/2024, directed staff to cleanse the resident's stage four pressure ulcer to the left buttocks with wound cleanser, pat dry, apply skin prep to the periwound (tissue that surrounded a wound), and apply a topical antiseptic solution with a soaked gauze sprinkled with Flagyl (an antibiotic) 500 milligrams crushed to wound bed, then cover with a foam dressing every day shift for 28 days. The order dated 02/21/2024, directed staff to cleanse the resident's stage four pressure ulcer to the right buttocks with a topical antiseptic solution, pat dry, apply medical honey to the wound bed, cover with an abdominal pad, and secure with paper tape every day shift. The order dated 02/21/2024, directed staff to cleanse the resident's stage four pressure ulcer to the sacrum with a topical antiseptic solution, pat dry, apply medical honey to the wound bed, cover with abdominal pad, and secure with paper tape every day shift. On 02/26/2024 at 11:00 AM, Resident #1 stated their catheter leaked and their bladder hurt. The surveyor noted the resident writhed (to move or proceed with twists and turns) in pain and hit their bed with their hands/fists. At 11:10 AM, the resident pressed their call light for assistance. At 11:12 AM, CNA #1 entered the resident's room to answer the resident's call light and stated she would notify Licensed Vocational Nurse (LVN) #2 of the resident's complaints. At 11:30 AM, the resident used a telephone to call the front desk of the facility to request their nurse. Resident #1 complained of bladder pain and was noted to writhe in bed. At 11:32 AM, a staff member (later identified as the unit clerk) approached the bedside of Resident #1 and stated their nurse (LVN #2) was at lunch and that another nurse had been made aware of the resident's complaint. At 11:39 AM, CNA #1 returned to Resident #1's bedside and asked the resident if they had been assisted yet. Resident #1 asked CNA #1 to reposition them in bed. As CNA #1 performed perineal care on Resident #1, the surveyor noted the resident had numerous uncovered pressured ulcers on their buttocks. The numerous uncovered pressure ulcers had bled/wept onto the disposable bed pad that was underneath the resident. The disposable bed pad was wet with moisture and CNA #1 stated she did not know if the disposable bed pad was wet from the resident's catheter that leaked or the resident's pressure ulcers. CNA #1 also reported that she was unaware of how long the resident's pressure ulcers had been uncovered. According to Resident #1, the wound care nurse (WCN) would perform wound care after the resident had a shower. At 11:50 AM, the surveyor noted there was no urine in Resident #1's catheter drainage bag. At 11:59 AM, LVN #2 entered the resident's room to administer the resident their medication(s) to include pain medication. According to LVN #2, she did not do anything with the resident's catheter. Per LVN #2, the resident's catheter and pressure ulcers were managed by the WCN. LVN #2 acknowledged Resident #1 had no urine in their catheter drainage bag and stated the WCN would complete the dressing change for the resident's pressure ulcers once the resident had a shower. At 12:03 PM, the resident acknowledged they were in pain. LVN #2 stated the facility was in the process of getting an urology consultation for the resident as staff did not want to keep having to change the resident's urinary catheter. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 02/26/2024 at 1:10 PM, the surveyor entered Resident #1's room just as the WCN removed the resident's catheter. LVN #2 stated since the resident was in so much pain, she decided to handle the resident's urinary catheter. Once the urinary catheter was removed from the resident, the resident began to urinate a copious amount of urine. The WCN stated she did not know how long it had been since the resident last had urine in their catheter drainage bag. The resident's mattress and two disposable bed pads were saturated, and the two disposable bed pads dripped of fluid as they were placed in a trash bag. The resident was noted to have an additional 300 cubic centimeters of dark yellow, blood-tinged urine that drained into the catheter drainage bag once a new catheter was inserted by LVN #2, who was under the direction of the WCN. Resident #1 stated they felt better now that their bladder had been emptied. As the resident was turned so the staff could remove the soiled bedding, Resident #1 began to have a bowel movement. While staff cleaned the resident of bowel, the WCN noticed the resident's lunch meal tray had arrived. In a hurried manner, the WCN placed a dressing on the resident's pressure ulcers to cover the areas and stated she would be back after lunch to place a fresh dressing on the resident's pressure ulcers. A review of Resident #1' catheter output document, revealed on 02/25/2024, staff documented the resident had 400 cc of output for the 3:00 PM to 11:00 PM shift. Per the document, there was no documentation of urinary output during the 11:00 PM to 7:00 AM shift that began on 02/25/2024 and ended on 02/26/2024 until the 3:00 PM to 11:00 shift on 02/26/2024. A review of facility Removal Plan, signed by the Administrator revealed in the early hours of 02/26/2024 at 2:44 AM, a CNA inadvertently removed the dressings from Resident #1's pressure ulcers. Per the Removal Plan, the CNA failed to inform the nurse of the need to replace the resident's pressure ulcer dressings. The Removal Plan revealed Resident #1's pressure ulcer dressings were replaced on 02/26/2024 at 1:24 PM. A review of Resident #1's Progress Notes, dated 02/26/2024 at 12:00 PM, revealed the resident complained of pressure in their bladder. The Progress Note indicated the resident's bladder was palpated (examine by touch) and noted to be slightly distended. Per the Progress Note, once the resident's indwelling urinary catheter was removed, the resident urinated on their bed. A review of Resident #1's Progress Notes, dated 02/26/2024 at 12:10 PM, revealed the resident's indwelling urinary catheter was changed and the resident had 300 cc of blood-tinged urine output. During an interview on 02/26/2024 at 1:47 PM with the DON and Regional Nurse Consultant, they stated the resident's pressure ulcers should be covered per the physician's order and they were unsure how long the pressure ulcers had not been covered. It was reported they would follow up with the night shift to figure out why the resident's pressure ulcers were not covered. During an interview on 02/27/2024 at 9:39 with the DON and WCN, the WCN stated she was not responsible for the care of the resident's catheter, but if she did see a problem, she would address it. The WCN stated she adjusted the resident's catheter and noticed it was clogged. Per the WCN, once the resident's catheter was adjusted, urine started to flow. According to the WCN, someone approached her and told her that Resident #1's bandages needed to be changed. The WCN states she was unsure how long the resident's pressure ulcers had been uncovered. The WCN stated from her observation of Resident #1, the resident only received pain relief once they were able to expel urine from their bladder. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 02/28/2024 at 3:30 PM, LVN #2 acknowledged it was around 11:10 AM on 02/26/2024 that CNA #1 notified her that Resident #1 was in pain. LVN #2 stated she then checked on a different resident and took a lunch break. LVN #2 stated once she returned from her lunch break, she went to Resident #1's room to address the resident's concerns. LVN #2 stated she did not know when the resident's pressure ulcer bandages were removed. LVN #2 acknowledged it would her responsibility to place a new pressure ulcer dressing in the event the WCN was unavailable. During a telephone interview on 02/29/2024 at 5:10 PM, the Medial Director (MD) stated staff informed him that Resident #1's indwelling urinary catheter was obstructed, and the resident had bladder distention. The MD stated he was not aware Resident #1 had no urine output for 12 hours. During an interview on 03/01/24 at 11:00 AM, the Administrator stated he expected the staff to acknowledge a resident's complaint of pain and address it immediately. The Administrator stated the nurse and CNA should monitor to ensure the resident had urinary output in order to determine what further needed to be done to treat the resident. The Administrator stated a resident's pressure ulcer should be covered and staff should replace the dressing as ordered by the physician. According to the Administrator, he would have wanted the concern with Resident #1 to be addressed with a greater sense of urgency. On 03/01/2024 at 1:17 PM, a Removal Plan was submitted by the facility and accepted by the state survey agency. It read as follows: Removal Plan F684 Failure to provide care to indwelling catheter and to measure output in accordance with professional standard and facility policy and procedure: 1. Resident #1's catheter was checked by nursing staff who were unable to get urine to flow. The catheter was changed by nursing staff on 02/26/2024, completed by 1:24 PM. Root cause analysis determined the catheter was non-functioning. 2. On February 26th, 2024, Resident #1 was scheduled for hourly checks to ensure the proper functioning and care of the catheter. Licensed nurses will verify the catheter's proper function every hour, with documentation to be recorded in the electronic medication administration record (EMAR) system. 3. Urology consult was in process with the insurance company. Authorization was given by the facility to proceed with scheduling without insurance authorization. A urology office was found on 02/27/2024 that will see private pay (by the facility) and their scheduling department is arranging the date. 4. Resident #1's primary care physician was made aware of concerns and came to review the resident on 02/27/2024. The physician left a report detailing his visit. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	5. On 02/27/2024, the Assistant Director of Nursing (ADON) conducted an audit of all residents with urinary catheters to confirm the presence of orders, care plans, and documentation of urinary intake and/or output. The purpose was to ensure compliance and identify any potential issues. The audit revealed no other issues or discrepancies. 6. On 02/27/2024, the Director of Nursing (DON) in-serviced the AM [ante meridiem, translated as before midday] and PM [post meridiem, translated as the time after noon] licensed nurses and CNAs [certified nursing assistants] regarding Urinary Catheter Care. Topics covered under Catheter Care, Urinary: Preparation, General Guidelines, Catheter Evaluation, Perineal Care, Infection Control, Input/Output, Maintaining Unobstructed Urine Flow, Changing Catheters, Complications, Cleaning and Disinfecting Drainage Bags, Equipment and Supplies, Proper Procedures, Documentation. The ADON or designee will in-service the remaining employees before start of the staff's next scheduled shift. Additionally, all in-service material will be placed at each station available for staff review prior to starting their shift. 7. Because the issue of taking a break without checking on a resident was isolated to the resident's assigned licensed nurse, on 02/28/2024 the DON educated the licensed nurse, who took the lunch break before checking with the resident, that it is her responsibility to make sure any concerns shared with the nurse are addressed or delegated prior to taking their break. The MDS [minimum data set] nurse mentioned was determined to be a unit clerk. 8. On 02/28/2024, the ADON in-serviced all PM and NOC [nocturnal, night shift] licensed nurses and CNAs regarding not leaving for breaks with unresolved resident care needs and/or without proper delegation to another licensed nurse. On 02/29/2024, the DON in-serviced all AM licensed nurses and CNAs on the same topics. The ADON or designee will in-service the remaining employees, including the unit clerk, before the start of their next scheduled shift. Additionally, all in-service material will be placed at each station available for staff review prior to starting their shift. 9. Certified Nursing Assistants (CNAs) and licensed nurses are required to check the proper function of catheters during each shift. Over the next 90 days, until 05/31/2024, the Director of Nursing (DON) or assigned representative will conduct weekly audits of all residents with urinary catheters. These audits will verify the presence of necessary documentation, including care orders, removal/change procedures, care plans, and documentation of urinary intake and/or output. 10. An impromptu meeting of the Quality Assurance Committee was held on 02/28/2024, which included the Administrator, Medical Director, DON, RN [registered nurse] ADON [assistant director of nursing], Activity Director, Director of Staff Development, Minimum Data Set Nurse, and Wound Licensed Vocational Nurse to review the above findings and corrective actions. Topics discussed were those identified above: failure to provide care to indwelling catheter, failure to immediately address severe pain, and failure to provide care to a diagnosed pressure ulcer. Also discussed were the root causes identified, the training given, the audits to be completed, and the reports to be given to the Quality Assurance Committee. Any issues found during the performance of the items above will be shared with the Quality Assurance Committee for review and action as necessary. Failed to immediately address severe pain of Resident #1, after notifying the CNA and nursing staff, for over 2 hours. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. Upon the return from her break at 12:00 PM, Resident #1's licensed nurse administered the resident's scheduled hydrocodone [a medication used to treat moderate to severe pain]. On 02/26/2024 when the catheter was adjusted and ultimately removed, the resident's bladder emptied, and the discomfort was relieved. It was determined that the root cause of the resident's pain was the non-functioning catheter. 2. The DON educated Resident #1's assigned licensed nurse that it is her responsibility to make sure that any concerns shared with her are addressed or delegated prior to taking her break on 02/28/2024. 3. On 02/27/2024, the resident was interviewed and felt comfortable with the current measures for pain management. 4. Licensed nurses will assess pain every shift and as needed and document in the EMAR system. 5. On 02/27/2024, all other residents with recorded pain were audited by the DON for any un-addressed pain, including residents with catheters. No other issues were found. 6. On 02/27/2024, The DON in-serviced licensed nurses and CNAs regarding Pain Assessment and Management, including how to recognize and report pain. Topics on Pain Assessment and Management covered: General Guidelines, Equipment and Supplies, Recognizing Pain, Assessing Pain, Identifying the Causes of Pain, Defining Goals and Appropriate Interventions, Implementing Pain Management Strategies, Monitoring and Modifying Approaches, Promptly Addressing Resident's Complaints of Pain, Documentation, Reporting. The ADON or designee will in-service remaining employees before the start of their next scheduled shift. Additionally, all in-service material will be placed at each station available for staff review prior to starting their shift. 7. For the next 90 days, until 05/31/2024, on a weekly basis, the DON or designee will audit resident pain scores to ensure proper pain management, including resident interviews to ensure timely responses. 8. An impromptu meeting of the Quality Assurance Committee was held on 02/28/2024, which included the Administrator, Medical Director, DON, RN ADON, Activity Director, Director of Staff Development, Minimum Data Set Nurse, and Wound Licensed Vocational Nurse to review the above findings and corrective actions. Topics discussed were those identified above: failure to provide care to indwelling catheter, failure to immediately address severe pain, and failure to provide care to a diagnosed pressure ulcer. Also discussed were the root causes identified, the training given, the audits to be completed, and the reports to be given to the Quality Assurance Committee. Any issues found during the performance of the items above will be shared with the Quality Assurance Committee for review and action as necessary. Failed to provide care to diagnosed pressure ulcer and follow physician's orders on wound care for Resident #1. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. The root cause analysis revealed the following: According to the physician's orders, dressings on each wound were to be changed during every AM shift and as needed. In the early hours of February 26, 2024, at 2:44 am, while receiving peri-care administered by the NOC CNA, the dressings were inadvertently removed. The CNA did not inform the floor nurse about the need to replace the dressings. Around 8 am, during peri-care performed by the AM CNA, the absence of dressings was observed, prompting immediate notification of the treatment nurse. Assuming the resident's shower was imminent, the treatment nurse planned to reapply the dressings afterward. However, the treatment nurse was mistaken, and it was scheduled for a later time. 2. On 02/26/2024, following the catheter change completed by 1:24 PM, new dressings were placed on the pressure ulcers by the treatment nurse. A shower was given to the resident at 2:00 PM, and new dressings were placed immediately afterward and again the next morning on 02/27/2024. 3. Resident #1's has an order in place, dated 02/21/2024, for daily treatment and dressing changes for pressure ulcers and/or PRN due to soiling or dislodged. Floor staff nurses to date and initial all dressings and report any issues to a nurse supervisor when performing daily dressing changes. 4. On 02/27/2024, all other residents with pressure ulcers were audited by Assistant Directors of Nursing and Unit Supervisors to ensure that orders were in place, being followed, and dressings were in place accordingly. No other issues were found. 5. On 02/27/2024, the DON in-serviced AM and PM licensed nurses and CNAs regarding wound care. Wound Care topics covered: Preparation, Equipment and Supplies, Proper Procedures, Infection Control, Dating with Time and Initials, Timely Changing of Dressings (including promptly responding when dislodged dressings are reported), Appropriate Coordination of Dressing Changes with Regards to Showers, Monitoring for Signs and Symptoms of Infection, Medication use when appropriate, Documentation, Reporting. The ADON or designee will in-service remaining employees before the start of their next shift. Additionally, all in-service material will be placed at each station available for staff review prior to starting their shift. 6. On 02/28/2024, all PM and NOC shift CNAs were in-serviced by the ADON, and on 02/29/2024 all CNAs were in-serviced by the DON regarding the requirement to notify nursing in the event of detached dressings and/or uncovered pressure ulcers/wounds. The ADON or designee will in-service the remaining employees before the start of their next scheduled shift.) 7. For the next 90 days, ending on 05/31/2024, on a weekly basis, the Director of Nursing or designee will audit all pressure ulcers to ensure that orders are in place, being followed, and dressings are in place according to physician's orders, including the dressing having the appropriate date and initials. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	8. An impromptu meeting of the Quality Assurance Committee was held on 02/28/2024, which included the Administrator, Medical Director, DON, RN ADON, Activity Director, Director of Staff Development, Minimum Data Set Nurse, and Wound Licensed Vocational Nurse to review the above findings and corrective actions. Topics discussed were those identified above: failure to provide care to indwelling catheter, failure to immediately address severe pain, and failure to provide care to a diagnosed pressure ulcer. Also discussed were the root causes identified, the training given, the audits to be completed, and the reports to be given to the Quality Assurance Committee. Any issues found during the performance of the items above will be shared with the Quality Assurance Committee for review and action as necessary. All corrections were completed on 02/29/2024. The immediacy of the IJ was removed on 02/29/2024. Onsite Verification: The IJ was removed on 03/01/2024 at 5:00PM, after the survey team verified the implementation of the Removal Plan as follows: Failure to provide care to indwelling catheter and to measure output in accordance with professional standard and facility policy and procedure: 1. Verified through interview and review of the quality assurance and performance improvement (QAPI) minutes with the Administrator on 03/01/2024. An impromptu QAPI meeting was held with the facility MD, DON, Administrator, and ADON on 02/28/2024. In this meeting, the resident was discussed, and a root cause was determined to be the resident's non-functioning catheter. 2. Verified through audit review and interview with LVNs on 03/01/2024. Verified through record review on 03/01/2024. 3. Verified through resident record review and interview with DON on 03/01/2024 at 3:30 PM. He stated the urology consultation was being sought in the community. The facility called the hospital where the resident was sent and asked the nurse to include a urology consultation at the hospital. Review of progress notes revealed the hospital staff documented the request. 4. Verified through resident record review and interview on 02/29/2024 at 5:15 PM with the physician. The physician's note was included in the chart and revealed the resident's condition of suprapubic abdominal distention and urinary obstruction. 5. Verified through interview and audit record review on 03/01/2024 with the ADON. No other issues were found during the audits. Audits reviewed residents with catheters for pain, input and output and proper placement. 6. Verified through interviews on 03/01/2024 with dayshift and nightshift CNAs, LVNs, ad RNs. No concerns were identified. 7. Verified through interview with LVN #2 on 03/01/2024 at 2:24 PM. Verified through in-service document review on 03/01/2024. (continued on next page)

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	03/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Horizon Health & Subacute Center	3034 E Herndon Fresno, CA 93720

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	8. Verified through interviews on 03/01/2024 with the DON. He stated output and input would be monitored, any pain, discoloration, odor, signs and symptoms of infection, and catheter functioning. Audit will be conducted weekly, residents who have catheter will be interviewed and functionality checked. Verified through record review on 03/01/2024. Failed to immediately address severe pain of Resident #1, after notifying the CNA and nursing staff, for over two hours. 1. Verified through interview and review of the QAP) minutes with the Administrator on 03/01/2024. An impromptu QAPI meeting was held with the facility MD, DON, Administrator, and ADON on 02/28/2024. In this meeting, the resident was discussed, and a root cause was determined to be the resident's non-functioning catheter. 2. Verified through interview with LVN #2 on 03/01/2024 at 2:24 PM. Training provided to LVN #2 verified through in-service review on 03/01/2024 at 2:18 PM. 3. Validated through interview and observation with the resident on 02/26/2024 and 02/27/2024 after the issues were addressed. The resident reported their pain was controlled, and they were not in pain. 4. Verified through interviews on 03/01/2024 with dayshift and nightshift CNAs, LVNs, ad RNs. No concerns were identified. 5. Verified through interview on 03/01/2024 with the DON. He stated pain audits would be completed for any resident who has a pain level of five or greater, and the staff would meet with the residents weekly to cover pain and pain management. Per the DON, the staff would review resident charts for documented pain levels. Any residents who reported a pain level of five or greater would be reviewed that week. Verified through audit review on 03/01/2024. All residents who had pain scores greater than one for multiple days through February 2024 reviewed and interviewed regarding pain control. No issues found. Failed to provide care to diagnosed pressure ulcers and follow physician's orders on wound care for Resident #1. 1. Verified through interview and review of the QAPI minutes with the Administrator on 03/01/2024. An impromptu QAPI meeting was held with the facility MD, DON, Administrator, and ADON on 02/28/2024. In this meeting, the resident was discussed, and a root cause was determined to be a miscommunication between the resident, CNA, and the wound treatment nurse. 2. Verified through record review on 03/01/2024. Documentation of wound care present in medication administration record/treatment administration record. 3. Verified through interviews with licensed nursing staff on 03/01/2024. 4. Verified through interviews on 03/01/2024 with both ADONs and unit managers. No other issues arose from the audits. (continued on next page)

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	055199	A. Building B. Wing	03/01/2024

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	5. Verified through interviews on 03/01/2024 with dayshift and nightshift CNAs, LVNs, ad RNs. No concerns were identified. 6. Verified through interview on 03/01/2024 with the DON. He stated pressure ulcer audits would be reviewed weekly and staff would check for injuries and that dressings were intact and accurate per the physician's order. 42192 2. A review of Resident #105's Admission Record, revealed the facility admitted the resident on 04/20/2023 with diagnoses that included type 2 diabetes mellitus, congestive heart failure, morbid obesity, localized edema. Per the Admission Record, the resident received a diagnosis of non-pressure chronic ulcer of the left lower leg on 04/28/2023. A review of Resident #105's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/27/2024, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. A review of Resident #105's care plan, revised on 08/30/2023, revealed the resident had a venous/stasis ulcer of the left and right lower leg. Interventions directed staff to administer treatment as ordered by the physician. A review of Resident #105's Order Summary Report with active orders as of 02/29/2024, revealed an order dated 0[TRUNCATED]

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 28196 41493 2. A review of Resident #304's Admission Record, revealed the facility admitted the resident on 02/23/2024, with diagnoses that included acute respiratory failure with hypoxia, asthma, and morbid obesity. A review of Resident #304's care plan, initiated on 02/23/2024, revealed the resident was at risk for hypoxemia related to diagnoses of acute respiratory failure with hypoxia and morbid obesity. Interventions directed staff to apply the resident's CPAP device at the prescribed time and setting as indicated by the physician's order. A review of Resident #304's Order Summary Report, revealed an order dated 02/24/2024 for staff apply the resident's CPAP/auto-adjusting positive airway pressure (APAP) device at bedtime and remove in the morning upon awakening. The order did not specify the PEEP setting for the CPAP/APAP. During an interview on 02/29/2024 at 7:18 AM, Licensed Vocational Nurse #7 acknowledged staff did not verify Resident #304's physician order to ensure the order was complete. During an interview on 02/29/2024 at 9:42 AM, the Respiratory Therapist stated the nursing staff was responsible for ensuring the physician's order was complete. During an interview on 02/29/2024 at 2:01 PM, the Director of Nursing (DON) stated the CPAP/APAP PEEP settings were not touched by the nurses as the residents were admitted from home or the hospital with already established settings. Per the DON, the physician's order should be complete with the CPAP/APAP PEEP settings so that the nurses could verify the settings to ensure the resident wore the CPAP/APAP as ordered by the physician. During an interview on 03/01/2024 at 11:10 AM, the Administrator stated the nurses should verify the physician ordered PEEP setting for a CPAP/APAP machine before the CPAP was placed on a resident.