| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055626 | A. Building<br>B. Wing | 11/29/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Healthcare Centre of Fresno | 1665 M Street<br>Fresno, CA 93721 |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38961<br><br>Based on observation, interview, and record review the facility failed to ensure residents received adequate supervision and assistance to prevent accidents for one of five sampled residents (Resident 1) when Resident 1 fell out of bed during provision of care by Certified Nurse Assistant (CNA) without assistance from another staff member in accordance with the Comprehensive Assessment and needs of the resident.<br><br>This failure resulted in Resident 1 having an avoidable fall, sustaining injuries of a Fractured Occipital Condyle (break at the base where skull meets spine), laceration (cut) to her nose, bruising, swelling to her left eye and experienced pain.<br><br>Findings:<br><br>During a review of Resident 1's Admission Record (AR), dated 11/29/23, the AR indicated, Resident 1 was admitted on [DATE] with diagnoses that included, Dementia (loss of cognitive functioning, thinking remembering, and reasoning), Muscle Weakness, Difficulty in Walking and Other Specified Disorders of Bone Density and Structure (disease of the bone).<br><br>During a review of Resident 1's Minimum Data Set (MDS) assessment (assessment of functional and cognitive abilities), dated 11/09/23, the MDS Section C indicated, Resident 1 had a BIMS (Brief Interview for Mental Status - a test given by medical professionals to determine cognitive understanding on a scale of 1-15 with 15 being the highest score) of 4 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15-cognitively intact).<br><br>During a review of Resident 1's MDS assessment, dated 11/09/23, the MDS Section GG (Functional Abilities and Goals) indicated, Resident 1 was dependent (requiring assistance from staff) to roll from left and right, for a Tub/shower Transfer, completion of Oral Hygiene, upper and lower body dressing, personal hygiene and eating.<br><br>During a concurrent observation and interview on 11/29/23 at 9:45 a.m. in Resident 1's room, Resident 1 was lying in bed awake. Resident 1 had an [brand name] Collar (device used to prevent movement of head and neck) around her neck. Resident 1 stated she was having difficulty speaking due to the presence of the device. Resident 1 stated she was having pain.<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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| NAME OF PROVIDER OR SUPPLIER Healthcare Centre of Fresno | | STREET ADDRESS, CITY, STATE, ZIP CODE 1665 M Street Fresno, CA 93721 | |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During an interview on 11/29/23 at 11:20 a.m. with Certified Nursing Assistant (CNA) 2, CNA 2 stated Resident 1 required extensive assistance by two staff members at all times. CNA 2 stated prior to Resident 1's fall on 11/6/23 Resident 1 was able to feed herself and brush her teeth.<br><br>During a concurrent interview and record review on 11/29/23 at 12:10 p.m. with the Assistant Director of Nursing (ADON), Resident 1's Care Plan (CP) dated 6/22/23 was reviewed. The CP indicated, .provide assistance and care to resident with two staff members . The ADON stated CNA 1 was changing Resident 1's brief on 11/6/23 when Resident 1 was rolled out of bed and onto the floor. The ADON stated Resident 1 sustained injuries from the fall. The ADON stated he spoke with CNA 1 after the fall and CNA 1 was aware Resident 1 required the assistance of two staff members to assist when care was being provided.<br><br>During a record review on 11/29/23 of untitled undated document, signed by CNA 1, document indicated, at 5:44 a.m., .when doing my last round, I knocked on resident door and asked to come into complete my last round, as I was changing resident I pulled the draw (half) sheet toward me so I can turn resident on side to change her brief, but she continued to roll and fell off bed .<br><br>During an observation on 11/29/2023 at 12:50 p.m. outside of Resident 1's room with the ADON. In the doorway of the room, there was a picture of two hand shaking. The ADON stated the meaning of this picture was to alert staff that resident was two-person care. ADON stated there should be two persons providing care for Resident 1. ADON stated the picture of two hands shaking was outside of Resident 1's room since the care plan was implemented on 6/22/2023.<br><br>During a concurrent observation and interview on 11/29/23 at 12:55 p.m. with CNA 2, outside of Resident 1's room, CNA 2 stated there was a picture of a handshake by Resident 1's name outside the doorway of her room. CNA 2 stated, the picture of the handshake had been there for a long time. CNA 2 stated the picture indicated Resident 1 required two persons to assist with Resident 1's care in order to meet any of her needs.<br><br>During an interview on 11/29/23 at 1:00 p.m. with CNA 4, CNA 4 stated she was aware Resident 1 required the assistance of two staff members when providing care. CNA 4 stated the picture of the handshake was there for staff to provide two-person care at all times. CNA 4 stated when staff provided care without following the two-person assistance, it placed Resident 1 at risk for falls and injuries.<br><br>During an interview on 11/29/23 at 1:10 p.m. with CNA 3, CNA 3 stated Resident 1 was unable to feed herself or brush her teeth due to the supportive device around her neck. CNA 3 stated Resident1's care and needs had changed because of the injuries from the fall.<br><br>During an interview on 11/29/23 at 1:30 p.m. with Licensed Vocational Nurse (LVN 2), LVN 2 stated Resident 1 required the assistance of two staff when care was provided. LVN 2 stated Resident 1 was at risk for falls, injuries, or death when care was not provided according to the care plan interventions in place. LVN 2 stated prior to the fall, Resident 1 was able to feed herself, and was currently unable to feed herself because of the injuries. LVN 2 stated Resident 1 fell off her bed and sustained injuries that were life threatening.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During an interview on 11/29/23 at 1:45 p.m. with the Director of Nursing (DON), the DON stated Resident 1 needed assistance and care for brief changes, showers, repositioning. The DON stated, CNA 1 did not follow protocol for a two person assist when care was provided. DON stated, the outcome resulted in Resident 1 falling out of bed and sustaining major injuries. DON stated, the fall and injuries could have been prevented. DON stated the intervention in the care plan were put in place to keep Resident 1 from harm. DON stated CNA 1 did not follow the care plan.<br><br>During an interview on 11/29/23 at 2:10 p.m. with Administrator (ADM), ADM stated, Resident 1's fall was avoidable. The facility Administrator (ADM) stated CNA 1 did not follow the facility policy and care plan that were in place for Resident 1. The ADM stated during the investigation, CNA 1 admitted she provided care to Resident 1 by herself. The ADM stated CNA 1 admitted it was wrong to provide care for Resident 1 without assistance from a second staff member.<br><br>During a telephone interview on 11/30/23 at 12:15 p.m. with LVN 3, LVN 3 stated he was assigned to Resident 1 during his shift on 11/06/23. LVN 3 stated he noticed the door to Resident 1's room was closed and thought staff were providing care to the resident. LVN 3 stated CNA 1 came out of Resident 1's room and alerted him that Resident 1 had fallen out of bed. LVN 3 stated when he immediately went into the room CNA 1 was alone in the room with Resident 1. LVN 3 stated he saw Resident 1 lying on the floor next to her bed face down. LVN 3 stated there was blood on the floor around Resided 1's face and she was moaning in pain. LVN 3 stated he then assisted Resident 1 back into bed and performed an assessment. LVN 3 stated Resident 1 was bleeding from her nose and there was a laceration across her nose and swelling to her left eye. LVN 3 stated Resident 1 was moaning in pain during the physical assessment. LVN 3 stated prior to the fall Resident 1 was able to feed herself and brush her teeth. LVN 3 stated Resident 1 was now unable to feed herself and needed feeding assistance. LVN 3 stated Resident 1 was now unable to brush her teeth and had limited movement of her head and neck. LVN 3 stated Resident 1's fall could have been prevented if CNA 1 had provided care assisted by with another staff person.<br><br>During a review of Resident 1's general acute hospital record, titled, AFTER VISIT SUMMARY, dated 11/6/2023, the AFTER VISIT SUMMARY indicated Resident 1 received an x-ray of the cervical spine (neck region of your spinal column or backbone) due to a fall. The X-Ray indicated Resident 1 was found to have an occipital condyle fracture.<br><br>During a review of the facility's policy and procedure (P&P) titled, Fall Management Program undated, the P&P indicated, .To provide residents a safe environment that minimizes complications associated with fall . the facility will implement a Fall Management Program that supports providing an environment free from fall hazards .staff will develop a care plan according to the identified risk factors and root causes .<br><br>During a review of the facility's P&P titled, Resident Safety, undated, the P&P indicated, .To provide a safe and hazard free environment .Residents will be evaluated to identify circumstances that pose a risk for the safety and wellbeing of the Resident .After a risk evaluation is completed .a Resident-centered care plan will be developed to mitigate safety risk factors .<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During a review of the facility's P&P titled, Comprehensive Person-Centered Care Planning undated, the P&P indicated, .It is the policy of this facility to provide person-centered, comprehensive and interdisciplinary care that reflects best practice standards for meeting health, safety, psychosocial, behavioral, and environmental needs of residents in order to obtain or maintain their highest physical, mental and psychosocial well-being . |