STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055626	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Healthcare Centre of Fresno	1665 M Street 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 (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48713 Based on observation, interview, and record review the facility failed to ensure residents received adequate supervision to prevent accidents for one of three sampled residents (Resident 1), when facility had knowledge of Resident 1's preference to sit outside, had a history of falls, and required assistance with personal care. Facility staff did not provide supervision while Resident 1 was outside and were unaware Resident 1 left the facility's premises on 10/1/24 unsupervised. These failures resulted in Resident wandering unsafely in the streets around the facility and suffering an avoidable auto versus pedestrian accident. Resident 1 sustained injuries which included injury to the right femur shaft fracture (break in the thigh bone between the hip and knee), closed inferior pubic rami fractures (break in one of the bones in part of the pelvis), traumatic pneumothorax (air leaks from the lung and fills the space between the lung and chest wall), closed fracture of multiple ribs, right phalanx fracture (a break in one or more of the small bones in right finger), L1 vertebra compression fracture (injury that occurs when too much pressure is applied to the spine), closed fracture of transverse process of lumbar vertebra (injury caused by high amount of force on a bone in the lower back). As a result, Resident 1 was hospitalized in the trauma unit with injuries that caused pain, suffering and mobility deficits. During an interview on 10/3/24 at 10:00 a.m. with the administrator (ADM), the ADM stated that on 10/1/24 at approximately 8:00 a.m., he was alerted by a facility staff member that a man, resembling Resident 1, was being transported by emergency medical services (EMS) two to three blocks away from the facility. The ADM stated when he arrived at the incident site, law enforcement was at the scene. The facility staff checked the facility to account for all residents and concluded Resident 1 was missing. The ADM stated Resident 1 was his own representative and made decisions for himself and had no prior history of leaving the facility premises. The ADM stated Resident 1 was considered an independent resident and did not require constant monitoring while being outside for daily exercises around the facility perimeter or sitting in the courtyard. (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1's Admission Record (AR- a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), the AR indicated, Resident 1 was admitted to the facility on [DATE] with diagnosis for Hypertensive heart and kidney disease (condition that damages the heart and kidneys), peripheral vascular disease (circulation disorder), end stage renal disease (terminal illness when kidneys can no longer function), Chronic Kidney Disease (CKD- kidneys are damaged and don't filter blood properly), Alcohol abuse, hyperlipidemia, Anxiety disorder (feeling of worry, unease and nervous), Polyneuropathy (nerve damage), muscle weakness, dysphagia (difficulty swallowing), need for assistance in personal care, other abnormalities of gait and mobility, cognitive communication deficit, heart failure, cardiomegaly (heart is larger than normal), constipation, pain, acquired absence of the left leg, history of falling, edema (swelling caused by too much fluid). During a review of Resident 1's Minimum Data Set [MDS a resident assessment tool used to identify cognitive (mental processes) and physical functional level assessment] dated 8/29/24, the MDS indicated, Resident 1's Brief Interview for Mental Status (BIMS screening tool used to assess resident cognitive level) score was 13 out of 15 (0 - 7 indicated severe cognitive impairment [memory loss, poor decision making skills] 8 12 moderate cognitive impairment, (13 -15) cognitively intact) which indicated Resident 1 was cognitively intact. During a review of Resident 1's ADL care plan, dated 3/21/23, the care plan indicated, . The resident has an activities of daily living (ADL) self-care performance and resident is at risk for declining in ADL self-performance . interventions . toilet use . the resident requires supervision/touching assistance by 1 staff for toileting. Transfer the resident requires supervision/touching assistance (requiring person to observe transfers) by 1 staff for to move between surfaces . During a review of Resident 1's Falls care plan, dated 3/22/23, the care plan indicated, . The resident at risk for falls related to gait (manner of walking)/balance problems . interventions anticipate and meet the residents' needs, be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance . During an interview on 10/3/24 at 10:15 a.m. with the Receptionist, the receptionist stated the process for a leave of absence (LOA) included signing out the resident at the nurse's station on the floor they were located. The receptionist stated it was her responsibility to ask any resident who was exiting the facility through the lobby doors, where they were going. The receptionist stated it was also her responsibility to identify elopement (when a patient incapable of protecting themselves departs unsupervised and undetected) risk residents when they are near the exit doors in the lobby. The receptionist stated on the morning of 10/1/24, she was told Resident 1 had left the facility premises before her start of shift at 8:00 a.m. The receptionist stated there was no facility staff positioned to monitor the exit doors in the lobby before she arrived. The receptionist stated she was not responsible for monitoring residents when they were outside but was responsible for alerting staff when residents exited the facility. The receptionist stated it was important to monitor all residents and know where they are at all times to ensure their safety. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 10/3/24 at 10:35 a.m. with Resident 2, Resident 2 stated he had been in the facility for two and half years. Resident 2 stated he understood the facility process to sign himself out but would exit the facility and return without any issues of signing out. Resident 2 stated he knew Resident 1 and would often see him sitting outside. Resident 2 stated there were no employees seen outside when he would sit outside with Resident 1. During a review of Resident 2's Admission Record (AR), the AR indicated Resident 2 was admitted to the facility on [DATE] with diagnosis for polyneuropathy, type 2 diabetes mellitus (body doesn't regulate insulin and causes high blood sugar), osteoarthritis (cartilage and bone break down over time), seizures (uncontrolled activities in the brain that cause changes in behavior, movement and awareness), major depressive disorder (mental illness that causes low mood and loss of interest in activity), alcohol abuse, lack of coordination, abnormalities of gait and mobility, muscle weakness, heart failure (heart is unable to pump enough blood and oxygen in the body), opioid (medication used to reduce moderate to severe pain) abuse. During a review of Resident 2's MDS dated [DATE], the MDS indicated, Resident 2's BIMS score was 14 out of 15 which indicated Resident 2 was cognitively intact. During a record review of Resident 1's Physician Order dated 10/18/23, the Physician Order indicated, May go out on pass. During a record review of Resident 1's Physician Order dated 10/1/24, the Physician Order indicated, May go out on pass independently. During a concurrent interview and record review on 10/3/24 at 10:46 a.m. with LVN 1, Resident 1's Physician Order dated 10/18/23 and Leave of Absence Binder dated 2024 were reviewed. The Physician Order indicated, May go out on pass. LVN 1 stated the order indicated Resident 1 could have left the faciity on his own as long as he signed out in the LOA binder. The LOA binder indicated Resident 1 had not signed himself out of the facility on 10/1/24. LVN 1 stated she was the nurse in charge of Resident 1's care on 10/1/24. LVN 1 stated she knocked on Resident 1's bathroom door at approximately 7:15 a.m. as he was not in bed, and Resident 1 had verbally responded from the bathroom indicating he was there. LVN 1 stated she left the room and returned at approximately 7:45 a.m. to check Resident 1's blood pressure, but noted he was not in his room. LVN 1 stated she knew Resident 1 had a daily routine to wheel himself to the elevator of the third floor, wheel himself outside and sit in the facility front courtyard or wheel himself around the facility perimeter for exercise. LVN 1 stated she was not alarmed by Resident 1's absence from his room as the certified nursing assistant (CNA) caring for Resident 1 would have gone downstairs to alert Resident 1 that breakfast was being served or Resident 1 would have gone up to the third floor on his own by breakfast time served at around 7:55 a.m. to 8:00 a.m. LVN 1 stated usually Resident 1 would have been monitored by the facility receptionist while he was outside because there was no staff assigned to monitor residents while they are outside or surrounding the perimeter of the facility. LVN 1 stated, generally there were a lot of residents who sat outside at a time, and it would have been beneficial to assign a staff member to monitor them. LVN 1 stated it was important to monitor Resident 1 and all other residents for their safety. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 10/3/24 at 11:16 a.m. with CNA 1, CNA 1 stated the facility process was for all residents to sign out in the LOA binder prior to leaving the facility premises. CNA 1 stated when Resident 1 left the facility to sit in the courtyard or exercise around the facility premises, Resident 1 was not required to sign out because he was still on the facility premises. CNA 1 stated when Resident 1 was outside there was no one specifically assigned to monitor. CNA 1 stated when Resident 1 was sitting outside it was the CNA assigned to Resident 1's responsibility to monitor resident every hour. CNA 1 stated it would have been beneficial to have staff assigned to monitor residents who were sitting outside for their safety. During an interview on 10/3/24 at 11:50 a.m. with the social services director (SSD), the SSD stated it was all staff responsibility to monitor residents while they were sitting outside of the facility. The SSD stated when the residents were sitting outside the facility, staff kind of kept an eye on them. The SSD stated it was all facility staff's responsibility to monitor the residents who were outside. The SSD stated she was not aware of who would monitor residents in the early morning before the receptionist arrived at 8:00 am. During a concurrent interview and record review on 10/3/24 at 1:15 p.m. with the assistant director of nurses (ADON), Resident 1's Physician Order dated 10/1/24 and Physician Order dated 10/18/23 were reviewed. The physician order dated 10/1/24 indicated, . May go out on pass independently. The physician order dated 10/18/23 indicated, May go out on pass. The ADON stated Resident 1 was permitted to leave the facility independently without supervision but had not followed the LOA process in place when he was outside for his exercises. The ADON stated Resident 1 was independent and his own representative and did not require constant monitoring when he was outside. The ADON stated the two physician orders were the same and Resident 1 could have signed himself independently. The ADON stated the reason for the change in the orders specifically on 10/1/24 was because the facility was working on changing the orders not because they meant different things. During an interview on 10/3/24 at 1:24 p.m. with the administrator (ADM), the ADM stated Resident 1 was non-compliant with the facility policies. The ADM stated that during his investigation, the LOA binder located at the nurse's station on the third floor was reviewed. The ADM stated it was determined, Resident 1 had not signed himself out of the facility on 10/1/24. The ADM stated independent residents including Resident 1, were not monitored as they would go outside complete their daily routines and go back into the facility. The ADM stated that prior to the receptionist arrival, residents who were sitting outside were monitored by staff that were in and out of the facility, but no one was specifically assigned to monitor the residents. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a phone interview on 10/3/24 at 2:47 p.m. with CNA 2, CNA 2 stated she was assigned to Resident 1 on 10/1/24 the day of incident. CNA 2 stated that on the day of the incident she had arrived late to her shift at around 7:40 a.m. and did not receive report as night shift CNA had ended her shift prior to CNA 2's arrival. CNA 2 stated she went to Resident 1's room and noted Resident 1 was not in his room. CNA 2 stated she was not alarmed with Resident 1's absence as Resident 1 was assumed to be downstairs in the courtyard or facility premises as per his routine. CNA 2 stated she was assisting other residents on the third floor when she was notified that something had happened to Resident 1. CNA 1 stated the facility process was for all residents leaving the facility premises to sign out at the nurse's station and alert staff. CNA 2 stated Resident 1 required set up help with dressing & toileting and required 1 person supervision assistance for transfers. CNA 2 stated when Resident 1 was outside it was assumed all staff was monitoring all residents and stated she would monitor Resident 1 every 30 minutes to an hour. CNA 2 stated it was important to monitor all residents when they were outside for safety and to know where they were at all times. During a review of electronic mail (Email) correspondence from the facility ADM titled Out on Pass Clarification dated 10/3/24, the email was regarding Resident 1's Physician Order dated 10/18/23, the Physician Order indicated, May go out on pass. The email was also regarding Resident 1's Physician Order dated 10/1/24, the Physician Order indicated, May go out on pass independently. The email indicated .I talked to director of nursing (DON) about the difference between out on pass and out on pass independently. The difference between the two is that both residents are able to go out on pass but one will require assistance to go out, while the Independent is able to go without the need of assistance . Review of the email from the ADM indicated Resident 1 required assistance when leaving the facility. During a concurrent observation and interview on 10/4/24 at 9:50 a.m. with Resident 1 at the acute care hospital room, Resident 1 was observed lying in bed eating breakfast, Resident 1 was observed smiling and talking. Resident 1 was observed with abrasion (rub or wearing off of the skin) to the right side of face, bilateral (both) bruising to upper extremities and bandage wrapped around his right thigh extending below the knee. Resident 1 stated he did not recall what had occurred during the accident and could not recall where he was located at the time of the interview. Resident 1 stated he recalled being at the facility for a few days not years. Resident 1 stated he recalled riding his bike and then suddenly being transported by EMS. Resident 1 was not able to state the year, location or situation but could recall his name. Resident 1 stated he had lost his legs in the acute hospital when they were cut by a laser. Resident 1 repeatedly asked if it was ok for him to stay in the acute hospital because he could not walk. Resident 1 appeared confused. During a record review of emergency medical services (EMS) report, dated 10/1/24, the EMS report stated, . EMS arrived on scene patient laying supine (lying on back) in middle of road, Glasgow Coma Scale (GCS-13 a clinical scale used to measure a person's level of consciousness after a brain injury. Score levels 3-8 are sever traumatic brain injury [TBI], 9-12 moderate TBI, and 13-25 mild TBI) patient was involved in a vehicle versus pedestrian accident where he was struck by a vehicle, traveling approximately 25 miles per hour per driver of vehicle while crossing the road in his wheelchair. It's estimated that the patient was approximately six feet from his wheelchair patient presents with altered mental status, combativeness. Physical exam revealed a hematoma (blood collection under the skin) to the right side of forehead, abrasions to upper back, possible deformity to the right femur, and appeared to have vomited at least once . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1's Intensive Care Unit Progress Note dated 10/4/24, the progress note indicated, . patient who presented to the emergency department after pedestrian versus auto. Patient was in middle of street in wheelchair when he got hit by car going 25 miles per hour. Was ejected off of wheelchair, positive head trauma, loss of consciousness. GCS 13 . injuries right femur shaft fracture, closed inferior pubic rami fractures, traumatic pneumothorax, closed fracture of multiple ribs, right phalanx fracture), L1 vertebra compression fracture, closed fracture of transverse process of lumbar vertebra Procedures right femur open reduction and internal fixation (ORIF- surgical procedure that realigns and stabilizes the bone), right foot nail avulsion (removal of a toenail or fingernail due to injury) and nailbed repair . During a review of the facility's policy and procedure (P&P) titled, Out on Pass, dated 1/11/2016, the P&P indicated, . it is the policy of the facility to meet residents' physical and psychosocial needs when going out on pass. The facility will make reasonable efforts to ensure the resident safety and uphold resident rights . the attending physician will write/give an order for a resident to go out on pass on the physician order sheet. The attending physician should include whether the resident should be accompanied by a responsible person while out on pass or may leave the facility unaccompanied . in the absence of a specific order that indicates the resident may go out on pass unaccompanied, the resident must be accompanied by a responsible person. If the resident is receiving skilled service, the resident may go out on pass for a therapeutic purpose (preventing, diagnosing, monitoring, treating for a disease or injury) only . During a review of the facility's policy and procedure titled, Elopement Risk Reduction Approaches, dated 11/2012, the P&P indicated, . ensure that residents are able to move about freely, are monitored and remain safe . During a review of the facility's P&P titled, Resident Safety, dated 4/15/21, the P&P indicated, . to provide a safe and hazard free environment . the interdisciplinary team (IDT- team that consists of various staff that are involved with resident's care) will establish a person-centered observation or monitoring systems for the resident to address the identified risk factors identified. To observe the safety and wellbeing of the residents, a resident check will be made at least every two hours around the clock by nursing service personnel. The person-centered care plan may require more frequent safety checks .