

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055649	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2024
NAME OF PROVIDER OR SUPPLIER Tulare Healthcare & Wellness Center, LP		STREET ADDRESS, CITY, STATE, ZIP CODE 680 East Merritt Avenue Tulare, CA 93274	

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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34401</p> <p>Based on interview and record review, the facility failed to notify one of two sampled residents (Resident 1) Responsible Party (RP) after a fall resulting with a black left eye and a cut to left lower lip. This failure resulted Resident 1's RP not being notified of the fall incident.</p> <p>Findings:</p> <p>During a concurrent interview and record review on 5/9/24 at 1:16 p.m. with Assistant Director of Nurses (ADON), Resident 1's medical records was reviewed. ADON stated Resident 1 was admitted to the facility on [DATE], under respite care (temporary care). ADON stated Resident 1 had a fall incident on 5/6/24 and sustained a black eye and a cut to left lower lip.</p> <p>During an interview on 5/9/24 at 3:05 p.m. with Licensed Vocational Nurse (LVN), LVN stated on 5/6/24, Resident 1 was in the front lobby when she had fallen off her wheelchair when she attempted to stand. LVN stated Resident 1 sustained a cut to her left lower lip and left black eye. LVN stated she notified the hospice (type of care that focuses on the relief of terminally ill patient) agency but did not notify Resident 1's RP.</p> <p>During a concurrent interview and record review on 5/15/24 at 11:15 a.m. with Director or Nurses (DON) and Administrator, Resident 1's Consent to Treatment form was reviewed. The form indicated Resident 1's son was her RP and had given the facility the consent to treat.</p> <p>During an interview on 5/15/24 at 12:31 p.m. with DON, DON stated it was the facility practice to notify the RP for any change in condition, including a fall incident.</p> <p>During a review of the facility policy and procedure (P&P) titled, Fall Management Program, dated 3/13/21, the P&P indicated, E. The licensed nurse will notify the Resident's attending physician and Resident's responsible party of all incident.</p>

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
---	-------	-----------