

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 05/15/2024
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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>34401</p> <p>Based on interview and record review, the facility failed to notify one of three sampled residents (Resident 1) Physician when Resident 1 had a significant change in condition requiring hospitalization . This failure resulted in a delay of care.</p> <p>Findings:</p> <p>During an interview on 5/15/24 at 10 a.m. with Resident 1's Responsible Party (RP), RP stated Resident 1 was transferred to the acute hospital on 5/11/24.</p> <p>During a review of Resident 1's medical record, there was no documented evidence Resident 1's Physician was notified of Resident 1's significant change of condition and transfer to the acute hospital.</p> <p>During an interview on 5/15/24 at 1:37 p.m. with the Administrator, Administrator stated Resident 1 was transferred to the acute hospital on 5/11/24. Administrator was unable to find documented evidence Resident 1's Physician was notified of Resident 1's significant change in condition. Administrator stated she was not aware what type of change of condition Resident 1 had that required transfer to the acute hospital.</p> <p>During an interview on 5/15/24 at 1:47 p.m. with Director of Nurses (DON), DON stated it was the facility practice and expected nursing staff to notify Physician when residents have a significant change of condition.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Alert Charting Documentation, dated 1/2012, the P&P indicated, I. Alert charting is required for but not limited to the following: C. Change in Medical condition;.III. The Licensed Nurse must note the change in condition that justifies alert charting when assessing the resident and thereafter: B. Notify the physician and responsible party;</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
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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>34401</p> <p>Based on interview and record review, the facility failed to assess one of three sampled residents (Resident 1) when Resident 1 had a significant change in condition. This failure has the potential for unmet care needs.</p> <p>Findings:</p> <p>During an interview on 5/15/24 at 10 a.m. with Resident 1's Responsible Party (RP), RP stated Resident 1 was transferred to the acute hospital on 5/11/24.</p> <p>During a review of Resident 1's medical records, there was no documented evidence an assessment was completed when Resident 1 had a significant change in condition and was transferred to the acute hospital.</p> <p>During an interview on 5/15/24 at 1:37 p.m. with the Administrator, Administrator stated Resident 1 was transferred to the acute hospital on 5/11/24. Administrator stated the nurse on-duty failed to assess and document when Resident 1 had a change of condition. Administrator stated because there was no documentation made by the nurse on-duty, Administrator was not aware what type of change of condition Resident 1 had that required transfer to the acute.</p> <p>During an interview on 5/15/24 at 1:47 p.m. with Director of Nurses (DON), DON stated it was the facility practice and expected nursing staff to complete assessment and complete Change of Condition form when residents have a change in condition. DON stated there was no assessment and documentation made by the nurse on-duty as to why Resident 1 required transfer to the acute hospital. DON stated, The nurse failed to assess and document.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Alert Charting Documentation, dated 1/2012, the P&P indicated, I. Alert charting is required for but not limited to the following: C. Change in Medical condition;.III. The Licensed Nurse must note the change in condition that justifies alert charting when assessing the resident and thereafter: A Document the findings in the nursing notes;</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>34401</p> <p>Based on interview and record review, the facility failed to ensure wound care was provided for one of three sampled residents (Resident 1) according to physician's order. This failure has the potential to result in worsening of Resident 1's wounds.</p> <p>Findings:</p> <p>During a review of Resident 1's Order Summary Report (OSR) , dated 4/6/24 thru 5/11/24, the OSR indicated Resident 1 had the following treatments: Stage 2 pressure ulcer (lesion caused by unrelieved pressure that results in damage to the underlying tissue) to coccyx (tail bone area) was to be cleanse with a wound cleanser, apply calmoseptine (wound ointment) topically, and leave open to air every shift (day and night). Surgical sutures and scarring to abdomen, cleanse with wound cleanser, pat dry, leave open to air every shift. Dehisced (reopen) surgical wound to abdomen, cleanse with wound cleanser, apply medi honey (wound gel), cover with dressing every shift.</p> <p>During a review of Resident 1's Treatment Administration Record (TAR), dated 4/6/24 thru 5/11/24, the TAR for the stage 2 pressure ulcer wound and surgical sutures and scarring to the abdomen had no signature on 4/8 day shift, 4/10 day shift, 4/13 day and night shift, 4/16 day shift, and 4/18 day shift. Resident 1's dehisced surgical wound to abdomen had no signature on 4/29 night shift, 4/30 day shift, 5/1 day shift, 5/4 night shift, 5/5 day shift, and 5/10 night shift.</p> <p>During an interview on 5/15/24 at 2:28 p.m. with Licensed Vocational Nurse (LVN), she stated it was the facility practice to document in the residents TAR after completing the ordered treatment. LVN stated by documenting in the TAR, it shows proof that the treatment was completed. LVN stated, Not documented, not done.</p> <p>During a concurrent interview and record review on 5/15/24 at 3:05 p.m. with Director of Nurses (DON), Resident 1's TAR dated 4/6/24 thru 5/11/24 was reviewed. DON confirmed treatment was not provided for Resident 1 on 4/10 day shift, 4/13 day and night shift, 4/16 day shift, 4/18 day shift, 4/29 night shift, 4/30 day shift, 5/1 day shift, 5/4 night shift, 5/5 day shift, and 5/10 night shift. DON stated they [nurse] should document as soon as they are done.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Medication-Administration dated 1/2012, the P&P indicated, I. Medication will be administered directed by a Licensed Nurse and upon the order of a physician or licensed independent practitioner. IX. Documentation A. The time and dose of the drug or treatment administered to the patient will be recorded in the patient's individual medication record by the person who administers the drug or treatment.</p>		