Printed: 10/31/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055649	A. Building B. Wing	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tulare Healthcare & Wellness Center, LP	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)
F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prepare residents for a safe transfer or discharge from the nursing home. 34401 Based on interview and record review, the facility failed to ensure a safe discharge was provided for one of two sampled resident (Resident 1) when Resident 1 was discharged home with Resident 2's prescribed medications. This had the potential for Resident 1 to take the wrong medication and potential for adverse effects. Findings: During an interview on 7/31/24 at 10:40 a.m. with Resident 1, Resident 1 stated she was discharged home on 7/23/24 with her roommates (Resident 2's) prescribed medication. Resident 1 stated, What if I didn't look and I didn't know and I took them (Resident 2's prescribed medication). During an interview on 7/31/24 at 12:09 p.m. with Registered Nurse (RN), RN stated upon Resident 1's discharge on 7/23/24, Licensed Vocational Nurse (LVN) handed Resident 1 a bag filled with medications. RN stated she did not double check or triple check to ensure all medications inside the bag were prescribed for Resident 1. RN stated Resident 1 was discharged home with Resident 2's prescribed medication. RN stated, Yes, I should have double and triple check all the medication prior to giving to her (Resident 1). During an interview on 7/31/24 at 12:17 p.m. with Director of Nurses (DON), DON stated Resident 1 was sent home with Resident 2's medication on 7/23/24. DON stated Resident 2's medication was returned to the facility a few days later by Resident 1's family member. DON stated it was the facility practice to perform a triple check on all prescribed medications before handing it over to the resident. During a review of the facility's policy and procedure (P&P) titled, Discharge and Transfer of Residents, dated 2/2018, the P&P indicated, X. Disposition of Resident's Drugs Upon Discharge A. Drugs which have been dispensed for individual resident use and are labeled in conformance with State and Federal law for outpatient use will furnished to a resident by the Licensed Nurse upon discharge according to the orders of the resident's Attending Physician.

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