

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  056288	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/24/2025
NAME OF PROVIDER OR SUPPLIER  Hanford Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  1007 West Lacey Blvd Hanford, CA 93230	

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 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47888</b></p> <p>Based on interview and record review, the facility failed to send a copy of the resident's transfer or discharge notification to the state long term care Ombudsman (resident advocacy agency) office for one of 23 sampled residents (Resident 87) when Resident 87 was transferred to the General Acute Care Hospital (GACH).</p> <p>This failure resulted for the long-term care Ombudsman not being aware of Resident 87's transfer and discharge circumstances should appeals be filed by the residents or their representative.</p> <p>Findings:</p> <p>During a review of Resident 87's Face Sheet (a summary of important information regarding a patient which include patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 1/24/25, the face sheet indicated, Resident 87 was admitted to the facility on [DATE] with a diagnosis of muscle weakness (loss of muscle strength), end stage renal disease (the final stage of kidney disease where the kidneys can no longer function adequately) and chronic obstructive pulmonary disease (a condition caused by damage to the lungs).</p> <p>During a concurrent interview and record review on 1/24/25 at 10:04 a.m., with the Director of Nursing (DON), Resident 87's Electronic Medical Record (EMR) dated 12/4/24 to 1/24/25 was reviewed. The EMR indicated Resident 87 was transferred out of the facility on 1/1/25 to a GACH for shortness of breath. The DON stated the Ombudsman was not notified by phone or in writing.</p> <p>During a concurrent interview and record review on 1/24/25 at 1:58 p.m., with the Social Services Director (SSD), Resident 87's Notice of Proposed Transfer/Discharge (NOPT), dated 1/1/25 was reviewed. The NOPT indicated, .Ombudsman Services . D. Ombudsman Notified of Transfer/Discharge Via: Fax [bubble empty], Phone [bubble empty], Email [bubble empty], Other [bubble empty] . The SSD stated the Ombudsman was not notified of Resident 87's transfer to GACH. The SSD stated the expectation was to notify the Ombudsman. The SSD stated it was important to notify the Ombudsman because the Ombudsman was the patient advocate. The SSD stated the policy and procedure (P&amp;P) Transfer or Discharge was not followed.</p> <p>(continued on next page)</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 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's P&amp;P titled, Transfer or Discharge, Facility Initiated, dated October 2022, indicated, . once admitted to the facility, residents have the right to remain in the facility. Facility initiated transfers and discharges, when necessary, must meet specific criteria and require resident/representative notification . documentation as specified in this policy . 1. Each resident will be permitted to remain in the facility cannot be transferred or discharged unless: a. The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in this facility . the health of individuals in the facility would otherwise be endangered . Transfer and Discharge includes movement of a resident . to a non-certified bed outside the facility . Notice of Transfer or Discharge (Emergent or Therapeutic Leave) . when residents are sent emergently to an acute care setting, these scenarios are considered facility-initiated transfers . Notice of Discharge after Transfer . if the facility does not permit a residence return to the facility based on inability to meet the residents needs the facility will notify the resident and/or his or her representative in writing of the discharge . The facility will send a copy of the discharge notice to a representative of the Office of the State Long Term Care Ombudsman . Notice of the Office of the State Long Term Care Ombudsman will occur at the same time the notice of discharge is provided to the resident and resident representative .</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p>48424</p> <p>Based on interview and record review the facility failed to provide written information to of the facility's bed hold policy for one of six sampled residents (Resident 16) when Resident 16 was not provided written information regarding the facility's bed hold policy upon his transfer to the hospital</p> <p>This failure violated the right of Resident 16 to be informed in writing of the facility's bed hold policy.</p> <p>Findings:</p> <p>During an interview on 1/24/25 at 9:21 a.m. with Licensed Vocational Nurse (LVN) 5, LVN 5 stated Resident 16 had not been notified in writing of the facility's bed hold policy. LVN 5 stated nurses only called him to notify him of the bed hold, no written policy was given to Resident 16. LVN 5 stated it was important to provide the bed hold policy so he could read it on his own time and ask questions.</p> <p>During an interview on 1/24/24 at 2:19 p.m. with the Business Office Manager, The BOM stated Resident 16 only received the bed hold policy in writing during his admission. The BOM stated since Resident 16 was a long-term resident business office staff did not feel the need to notify him of the bed hold policy when he got transferred to the hospital. The BOM stated notifying residents of the bed hold policy in writing upon transfer to the hospital was important because it ensured the residents were aware of the facility's policy and the possibility of paying out of pocket.</p> <p>During an interview on 1/24/25 at 4:36 p.m. with the Director of Nursing (DON), The DON stated notifications regarding bed holds were only made over the phone. The DON stated written notification of the bed hold policy was not given to Resident 16.</p> <p>During a review of the facility's Policy and procedure (P&amp;P) titled, Bed-Holds and Returns, dated 10/22 indicated, . all residents/ representatives or provided written information regarding the facility and state bed-hold policies, which address holding or reserving a resident's bed during periods of absence (hospitalization or therapeutic leave). Residents, regardless of payer source, are provided written notice about these policies at least twice: a. notice 1: well in advance of any transfer (e.g., in the admission packet); and b. notice 2: at the time of transfer (or if the transfer was an emergency, within 24 hours) .</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 51059</p> <p>Based on observations, interviews, and record reviews, the facility failed to develop and implement a comprehensive, person-centered care plan for five out of fourteen sampled residents (Resident 51, Resident 75, Resident 84, Resident 342, and Resident 343) when:</p> <ol style="list-style-type: none"> <li>Resident 51's care plan was not developed and implemented to address the use of an assistive device transfer pole (an adjustable pole that is installed from ceiling to floor and used to assist in transfers).  This failure had the potential to result in Resident 51 not receiving appropriate, consistent, and individualized care to ensure safe transfer needs are met to prevent injury.</li> <li>Resident 75's care plan was not developed and implemented to address toenail assessment and condition.  This failure resulted in Resident 75 not receiving appropriate, consistent, and individualized toenail treatment and monitoring which could lead to ingrown toenails, infection, or injury.</li> <li>Resident 342's care plan was not developed and implemented to address oxygen therapy services or noncompliance with oxygen therapy services.  This failure resulted in Resident 342 not receiving appropriate, consistent, and individualized care and monitoring interventions which led to the incorrect administration of oxygen therapy.</li> <li>Resident 343's care plan was not developed and implemented to address noncompliance with low bed position.  This failure resulted in Resident 343 not receiving appropriate, consistent, and individualized care interventions to ensure his safety which could lead to injury.</li> <li>Resident 84's care plan was not developed and implemented to address oxygen therapy (a colorless, odorless, tasteless gas that is essential for the body to function properly and survive) services.  This failure resulted in Resident 84 not receiving appropriate, consistent, and individualized care and monitoring interventions which led to the incorrect administration of oxygen therapy.</li> </ol> <p>Findings:</p> <ol style="list-style-type: none"> <li>During a review of Resident 51's Admission Record (AR- document containing resident personal information), dated 3/12/21, the AR indicated, Resident 51 was admitted in the facility on 3/12/21, with diagnoses which included, muscle weakness, and other abnormalities of gait and mobility (an abnormal walking condition).</li> </ol> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 51's Minimum Data Set (MDS- a resident assessment tool) assessment, dated 1/13/25, the MDS assessment indicated Resident 51's Brief Interview for Mental Status (BIMS- an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) assessment score was 12 out of 15 which indicated Resident 51 had moderate cognitive deficit.</p> <p>During a review of Resident 51's Occupational Therapy Treatment Encounter Note, dated 1/6/25, the Occupational Therapy Treatment Encounter Note indicated, Resident 51 was a fall risk and required a transfer pole to ensure safe bedside transfers.</p> <p>During a concurrent interview and record review on 1/23/25 at 3:08 p.m. with Licensed Vocational Nurse (LVN) 4, Resident 51's care plan was reviewed. LVN 4 stated Resident 51 required a transfer pole at bedside for safe transfers. LVN 4 stated Resident 51 did not have a care plan for the transfer pole. LVN 4 stated the transfer pole should be care planned to indicate Resident 51's transfer needs and ensure the transfer pole was used as instructed by Occupational Therapy. LVN 4 stated it was important to have an individualized care plan on the transfer pole to ensure Resident 51's progress was monitored.</p> <p>During an interview on 1/24/25 at 3:03 p.m. with the Director of Nursing (DON), the DON stated a transfer pole was an assistive device, and she expected all assistive devices to be care planned. The DON stated care plans provides resident specific instructions on how to provide care and monitor progress. The DON stated without a transfer pole care plan Resident 51 was at risk for injury from improper transfers and goals could not be measured. The DON stated it was expected all residents to have an individualized person-centered care plan to reflect the resident's condition, needs, and orders.</p> <p>During a review of the facility's Policy and Procedure (P&amp;P) titled, Transfer Pole, undated, the P&amp;P indicated, Therapist will work with the patient teaching them how to use the pole safely and correctly (E.g. wear non-skid shoes or socks, where to push up from and where to hold the pole) .therapist works with .staff in training them how to best assist the patient for positioning and transfers. Include the following in the training: where to position the chair for transfer, how to apply and use gait belt, how much assistance should be provided and to check the pole prior to transfer to ensure it is stable and has not become loose.</p> <p>During a review of the facility's P&amp;P titled, Assistive Devices and Equipment, dated 1/ 2020, the P&amp;P indicated, Recommendations for the use of devices and equipment are based on the comprehensive assessment and documented in the resident care plan.</p> <p>2. During an interview on 1/21/25 at 9:41 a.m. with Resident 75, Resident 75 stated his toenails were long, falling off and painful. Resident 75 stated he told multiple CNAs about the pain and discomfort his toenails caused him. Resident 75 stated no CNA, LVN, or provider had assessed his toenails.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 75's AR, dated 9/26/24, the AR indicated, Resident 75 was admitted in the facility on 9/26/24, with diagnoses which included, Alzheimer's Disease (a brain disorder that causes memory loss and thinking difficulties, and eventually the inability to perform simple tasks), Type 2 Diabetes ( a medical condition in which the sugar level is high in the blood stream), Type 2 Diabetes Mellitus with Diabetic Neuropathy (a complication of type 2 diabetes that occurs when high blood sugar damages nerves throughout the body), and abnormalities of gait and mobility (an abnormal walking condition).</p> <p>During a review of Resident 75's MDS assessment, dated 12/31/24, the MDS assessment indicated Resident 75's BIMS assessment score was 12 out of 15 which indicated Resident 75 had moderate cognitive deficit.</p> <p>During a concurrent observation and interview on 1/22/25 at 11:21 a.m. with LVN 4 in Resident 75's room, Resident 75 was lying in bed, and had long, yellow, hard thick, curled toenails (all ten toenails). Resident 75's fourth toenail on his right foot, next to his pinky toe, was separated and lifted upward from the toe with blackness underneath the toenail at the base. LVN 4 stated Resident 75 was able to make his needs known and communicate with no deficits. LVN 4 stated CNAs were expected to report Resident 75's toenail pain, discomfort and toenail condition to the licensed nurse. LVN 4 stated Resident 75's toenail condition should have been identified in the daily head-to- toe assessment and documented in the medical record.</p> <p>During a concurrent interview and record review on 1/23/25 at 11:41 a.m. with LVN 4, Resident 75's Order Summary, dated 9/26/24 was reviewed. The Order Summary indicted, .Podiatry for hypertrophy toenails [a nail disorder that causes fingernails or toenails to grow abnormally thick, curl and discolor] or other foot problems as needed . LVN 4 stated Resident 75 was at risk for toenail and foot problems. LVN 4 stated Resident 75's toenails should have been identified as a concern by CNAs. LVN 4 stated nail and toenail conditions were included in the licensed nurse daily head- to-toe assessment and should have been identified. LVN 4 stated she could not locate a head-to-toe assessment, progress note, care plan or podiatry consult for Resident 75's toenails.</p> <p>During an interview on 1/24/25 at 3:03 p.m. with the DON, the DON stated she expected the licensed nurse to identify Resident 75's toenail as a concern during daily head-to-toe assessments, documented, and care planned for monitoring. The DON stated care plans provides resident specific instructions on how to provide care and monitor progress. The DON stated it was expected for the license nurses to initiate an individualized person-centered care plan to reflect the residents' condition and needs.</p> <p>During a review of the facility's job description titled, Certified Nursing Assistant, dated 2/2024, the job description indicated, Report all changes in the resident's condition to the Nurse Supervisor/Charge Nurse as soon as practical .Record all entries on flow sheets, notes, charts, ect. in a descriptive manner .Report all complaints and grievances made by the resident .Assist residents with daily functions ( .bath functions, dressing and undressing .) .Report injuries of an unknown source, including skin .</p> <p>During a review of the facility's P&amp;P titled, Head-to Toe Assessment, dated 12/ 2023, the P&amp;P indicated, Nurses are required to perform a thorough head-to-toe assessment on all residents under their care .a head-to-toe assessment will be conducted for each resident at least once per shift .</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facility's P&amp;P titled, Fingernails/Toenails, Care of, dated 2/2018, the P&amp;P indicated, Review the resident's care plan to assess for any special needs of the resident.</p> <p>3. During a concurrent observation and interview on 1/21/25 at 10:58 a.m. with Resident 342, Resident 342 was lying in bed, the oxygen concentrator (medical device that helps residents/patients' breath) was at the head of the bed turned off, and the nasal cannula oxygen tubing was tucked underneath her pillow. Resident 342 stated she only used her oxygen at night since she was admitted .</p> <p>During a review of Resident 342's AR, dated 1/14/25, the AR indicated, Resident 342 was admitted in the facility on 1/14/25, with diagnoses which included .Chronic Obstructive Pulmonary Disease (COPD- a progressive lung disease that makes it difficult to breathe) .</p> <p>During a review of Resident 342's MDS assessment, dated 1/21/25, the MDS assessment indicated Resident 342's BIMS assessment score was 14 out of 15 which indicated Resident 342 had no cognitive deficit.</p> <p>During a review of Resident 342's Physician Orders dated 1/15/25, the Physician Orders indicated, . Oxygen 2 LPM (liters per minute- a unit of measurement for the flow rate of oxygen) Via Nasal Cannula Continuously . and Oxygen humidifier bottle and tubing to be changed on Thursday NOC [night] shift .</p> <p>During a concurrent observation and interview on 1/21/25 at 11:15 a.m. with LVN 3 in Resident 342's room, LVN 3 stated Resident 342 did not receive oxygen from the oxygen concentrator because the oxygen concentrator was turned off and the nasal cannula oxygen tubing was tucked underneath Resident 342's pillow.</p> <p>During a concurrent interview and record review on 1/23/25 at 9:30 a.m. with LVN 4, Resident 342's Physician Orders, dated 1/15/25 was reviewed. The Physician Orders indicated, Resident 342 had an order for .Oxygen 2 LPM Via Nasal Cannula Continuously . and Oxygen humidifier bottle and tubing to be changed on Thursday NOC Shift . LVN 4 stated licensed nurses were responsible for administering oxygen therapy orders as prescribed by the physician. LVN 4 stated the oxygen concentrator should have been turned on and the nasal cannula placed on Resident 342. LVN 4 stated Resident 342 was non-compliant with oxygen therapy services and only wore her oxygen at night. LVN 4 could not locate a care plan for oxygen therapy services. LVN 4 stated Resident 342 should have a care plan to reflect the use of oxygen therapy services and non-compliance with oxygen therapy.</p> <p>During an interview on 1/23/25 at 10:17 a.m. with Respiratory Therapist (RT) 1, RT 1 stated Resident 342 had an order for continuous oxygen therapy at 2 LPM via nasal cannula. RT 1 stated continuous oxygen therapy meant oxygen must always be administered. RT 1 stated non-compliance with oxygen therapy should be documented and care planned by the licensed nurse. RT 1 stated it was important to document and care plan oxygen therapy and non-compliance with oxygen therapy to ensure oxygen was administered as ordered and monitoring instructions were followed.</p> <p>During an interview on 1/24/25 at 3:03 p.m. with the DON, the DON stated she expected all licensed nurses to follow physician orders and administer oxygen therapy as ordered and initiate a care plan. The DON stated Resident 342 used of oxygen should have been care plan to reflect Resident 342 condition, needs, physician orders, and non-compliance. The DON stated care plans provided resident specific instructions on how to provide care and monitor progress.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. During a concurrent observation and interview on 1/22/25 at 8:51 a.m. with CNA 2 in Resident 343's room, Resident 343 was lying in bed and the bed in the highest position. CNA 2 stated Resident 343 preferred his bed in the highest position and would not let staff lower the bed. CNA 2 stated Resident 343 had a history of seizures and was at risk for injury if he fell from the bed.</p> <p>During a review of Resident 343's AR, dated 1/23/25, the AR indicated, Resident 343 was admitted in the facility on 1/14/25, with diagnoses which included .Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (a condition that occurs when the left side of the brain is damaged, resulting in weakness or paralysis on the right side of the body), generalized idiopathic epilepsy and epileptic syndromes, intractable, without status epilepticus (a type of epilepsy [a chronic brain disorder that causes seizures, which are episodes of abnormal electrical activity in the brain] that causes generalized seizures throughout the brain), other abnormalities of gait and mobility, and muscle weakness .</p> <p>During a review of Resident 343's MDS, dated [DATE], the MDS assessment indicated Resident 343 BIMS assessment score was 14 out of 15 which indicated Resident 343 had no cognitive deficit.</p> <p>During a review of Resident 343's Care Plan, dated 9/18/19, the Care Plan indicated, Resident 343 was at risk for falls. The Care Plan indicated, low bed position.</p> <p>During an observation on 1/23/25 at 9:10 a.m. in Resident 343's room, Resident 343 was lying in bed, and the bed raised in the highest position.</p> <p>During an interview on 1/23/25 at 9:15 a.m. with Resident 343, Resident 343 stated he preferred his bed raised to the highest position. Resident 343 stated when the bed was in the low position it made transfers difficult.</p> <p>During a concurrent observation and interview on 1/23/25 at 4:26 p.m. with LVN 2 in Resident 343's room, Resident 343 was lying in bed, and the bed raised to the highest position. LVN 2 stated Resident 343 was non-compliant with keeping his bed in the lowest position and preferred his bed in the highest position. LVN 2 stated Resident 343 was able to make his needs known and had the right to refuse care or treatment. LVN 2 stated non-compliance should be care planned to ensure ongoing education and reinforcement to prevent injury. LVN 2 stated Resident 343 was at risk for injury if he fell from the bed.</p> <p>During an interview on 1/24/25 at 3:03 p.m. with the DON, the DON stated Resident 343 had the right to make his own decisions and refuse to have his bed in the low position. The DON stated she expected Resident 343's non-compliance to be care planned. The DON stated Resident 343 was at risk for injury if he fell or had a seizure with the bed in the highest position. The DON stated care plans provided resident specific instructions on how to provide care and monitor progress. The DON stated the expectation was for license nurses to initiate an individualized person-centered care plan to reflect resident's condition, needs, physician orders, and non-compliance.</p> <p>During a review of the facility job description document titled, LPN LVN, dated 11/ 2018, the document indicated, .Prepare and administer medications as ordered by physician .Review the resident's chart for specific treatments, medications, orders . etc .Review care plans daily to ensure appropriate care is being rendered .Ensure nursing notes reflect the care plan is being followed when administering nursing care or treatment .</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facility's P&amp;P titled, Care Plans, Comprehensive Person-Centered, dated 3/2022, the P&amp;P indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident . The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment .Assessments of residents are ongoing, and care plans are revised as information about the residents and the resident's condition change . The comprehensive, person-centered care plan: a. includes measurable objective and timeframes; b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being: (3) which professional services are responsible for each element of care .The resident has the right to refuse to participate in the development of his/her care plan and medical and nursing treatments. Such refusals are documented in the resident's clinical record in accordance with established policies .</p> <p>51271</p> <p>5. During an observation on 1/21/25 at 10:15 a.m. Resident 84 was observed lying in bed with their nasal cannula (device that delivers additional oxygen through your nose) on the floor.</p> <p>During the review of Resident 84's Admission Record (AR- a document that provides resident contact details, a brief medical history, level of functioning, preferences, and wishes) dated 1/3/25, the AR indicated Resident 84 was admitted on [DATE] with the diagnoses of: Acute (condition developed suddenly) and chronic (condition developed slowly overtime) respiratory failure ( lungs cannot get enough oxygen into the blood) and pneumonia (infection had caused inflammation and fluid buildup in the lungs, making it difficult to breath).</p> <p>During a review of Resident 84's Minimum Data Set (MDS- resident assessment tool which indicated physical and cognitive abilities), dated 1/9/25, the MDS indicated a Brief Interview for Metal Status (BIMS- an assessment of cognitive function) score of ten (0-7 severe cognitive impairment, 8-12 moderate cognitive impairment, 13-15 no cognitive impairment), which indicated Resident 84 had moderate cognitive impairment.</p> <p>During a concurrent observation and interview on 1/21/25 at 10:15 a.m. with CNA 3 in Resident 84's room, Resident 84's nasal cannula was on the floor under a chair. CNA 3 stated Resident 84 used of oxygen was as needed.</p> <p>During a concurrent interview and record review on 1/23/25 at 11:03 a.m. with LVN 2, Resident 84's physician orders, dated 1/23/25, was reviewed. LVN 2 stated Resident 84's oxygen physician order was continuous. LVN 2 stated Resident 84 did not have care plan for oxygen used. LVN 2 stated a care plan should have been initiated to ensure oxygen therapy physician's order was followed and to determine effectiveness.</p> <p>During an interview on 1/24/25 at 3:05 p.m. with the DON, the DON stated it was her expectation license nurse should follow physician order. The DON stated the license nurses should have initiated a care plan for Resident 84's oxygen used but did not. The DON stated care plans were important to ensure residents needs are met.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facilities policy and procedure (P&amp;P) titled, Care plans, Comprehensive Person-Centered dated 3/2022, indicated, .the interdisciplinary team, in conjunction with the resident and his/her family or legal representative, developed and implemented a comprehensive, person-centered care plan for each resident .The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment .The comprehensive, person-centered care plan: a. includes measurable objective and timeframes; b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being: (3) which professional services are responsible for each element of care .</p> <p>During a review of the facilities Registered Nurse (RN) Job Description, dated 2/2024, the document indicated .The RN monitored medication pass and treatment schedules to ensure medication is administered as ordered and treatment is provided as scheduled .Participate in the development of a written plan of care (preliminary and comprehensive) for each resident that identifies the problems/needs of the resident, indicates the care to be given, goals to be accomplished, and which professional service is responsible for each element of care .Ensure that all personnel involved in providing care to the resident are aware of the residents care plan .</p> <p>During a review of the facilities Licensed Vocational Nurse (LVN) Job Description, dated 11/2018, the document indicated .Prepare and administer medications as ordered by physician .Review the resident's chart for specific treatments, medications, orders, diet, etc .Review care plans daily to ensure appropriate care is being rendered .Ensure nursing notes reflect the care plan is being followed when administering nursing care or treatment .</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48739</p> <p>Based on observation, interview and record review, the facility failed to timely revise and implement a person-centered comprehensive care plan for two of ten sampled residents (Resident 31 and 67) when:</p> <ol style="list-style-type: none"> <li>1. Resident 31's CP was not revise for his non-compliance with the use oxygen (O2).</li> </ol> <p>This failure put Resident 31 at risk of not receiving the appropriate oxygen administration and not having his oxygen needs met.</p> <ol style="list-style-type: none"> <li>2. Resident 67's CP was not reviewed and revised to reflect the need to use prescription glasses.</li> </ol> <p>This failure resulted Resident 67's ability to maintain adequate vision and had the potential to increase risk for falls and limit functional independence.</p> <p>These failures resulted for Resident 31 not receiving oxygen as prescribed by the physician and Resident 67 decreased ability to maintain adequate vision which had the potential risk for falls and limit functional independence.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. During an observation on 1/21/25 at 9:43 a.m. in Resident 31's room, Resident 31 was sleeping in bed. Resident 31 oxygen (O2) concentrator (a medical device that supplies oxygen to people who have difficulty breathing) was turned on but the nasal cannula was not connected to Resident 31.</li> </ol> <p>During a review of Resident 31'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), dated 1/23/25, the AR indicated Resident 31 was admitted to the facility on [DATE] with diagnoses of metabolic encephalopathy (a condition where brain function is disturbed due to different diseases or toxins [poisons] in the blood), pulmonary edema (a buildup of fluid in the lungs), shortness of breath, Type 2 Diabetes Mellitus (when the blood sugar levels in the body are too high), dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), heart failure (a condition when the heart muscle doesn't pump enough blood to meet the body's needs which can cause fatigue and shortness of breath), and major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities).</p> <p>During a review of Resident 31's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 12/31/24, the MDS section C indicated Resident 31 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15 ) score of 10 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 31 was moderately impaired.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 31's Clinical Physician Orders, dated 1/24/25, the Clinical Physician Orders indicated, . Oxygen at 2 LPM (Liters per minute - a unit of measurement) continuously via nasal cannula . every shift for SHORTNESS OF BREATH . start date . 9/25/24 .</p> <p>During a review of Resident 31's Care Plan, Dated 1/23/25, the Care Plan indicated, . (Resident 31) has shortness of breath . Date Initiated: 10/14/24 . Oxygen as ordered by MD (Medical Doctor) . Date Initiated: 10/14/24 .</p> <p>During a review of Resident 31's Medication Administration Record (MAR), dated 1/1/25-1/31/25, the MAR indicated, . Oxygen at 2 LPM continuously via nasal cannula every shift for SHORTNESS OF BREATH . Start Date . 09/25/24 0600 .</p> <p>During a concurrent observation and interview on 1/22/25 at 11:21 a.m. in Resident 31's room, Resident 31 was lying in bed not wearing his oxygen nasal cannula. Resident 31's O2 tubing was wrapped around the back of his wheelchair.</p> <p>During a concurrent observation and interview on 1/22/25 at 11:24 a.m. in Resident 31's room with Licensed Vocational Nurse (LVN) 7, Resident 31 was lying in bed not wearing his O2 nasal cannula and his oxygen machine turned off. LVN 7 stated Resident 31 had orders for continuous O2, but Resident 31 was non-compliant and would take off his oxygen nasal cannula.</p> <p>During a concurrent interview and record review on 1/24/25 at 1:50 p.m. with LVN 1, Resident 31's Care Plan, undated was reviewed. Resident 31 did not have a Care Plan for O2 non-compliance. LVN 1 stated Resident 31 was non-compliant with the use of O2. LVN 1 stated Resident 31's CP should have been revised to reflect current condition and interventions needed to meet Resident 31's needs.</p> <p>During an interview on 1/24/25 at 3:09 p.m. with the Director of Nursing (DON), the DON stated the expectation was for the license nurse to initiate or revise Resident 31's CP for the use of O2. The DON stated the CP should reflect Resident 31's non-compliant with O2 use and interventions to manage the non-compliance.</p> <p>During a review of the facility policy and procedure (P&amp;P) titled, Oxygen Administration, dated 10/2010, the P&amp;P indicated, . verify that there is a physician's order for this procedure . review the resident's care plan to assess for any special needs of the resident . adjust the oxygen delivery device so that it is comfortable for the resident . observe the resident upon setup and periodically thereafter to be sure oxygen is being tolerated . if the resident refused the procedure, the reason(s) why and the intervention taken . notify the supervisor if the resident refuses the procedure .</p> <p>During a review of the facility's P&amp;P titled, Care Plans, Comprehensive Person-Centered, dated 3/2022 indicated, . a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident . assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change . the interdisciplinary team reviews and updates the care plan . at least quarterly . the resident has the right to refuse to participate in the development of his/her care plan and medical and nursing treatments. Such refusals are documented in the resident's clinical record .</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facility job description titled, LPN LVN, undated, indicated, . review care plans daily to ensure that appropriate care is being rendered . inform the Nurse Supervisor of any changes that need to be made on the care plan . review resident care plans for appropriate resident goals, problems, approaches, and revisions based on nursing needs . ensure that your assigned certified nursing assistants (CNAs) are aware of the resident care plans .</p> <p>2. During a concurrent observation and interview on 1/21/25 at 3:25 p.m. Resident 67 was lying in bed. Resident 67's pair of glasses was placed on dresser located near the head of the bed out of the Resident 67's reach. Resident 67 was looking for her glasses and stated she did not know where her glasses was placed.</p> <p>During a record review of Resident 67's AR dated 1/24/25, the AR indicated, Resident 67 was admitted to the facility on [DATE] with diagnoses muscle weakness, dementia (the loss of thinking, remembering and reasoning that interferes with daily life and activities) and diabetes mellitus (a disease that occurs when your blood sugar level is too high which can cause damage to the heart, blood vessels, eyes, kidneys and nerves).</p> <p>During a review of Resident 67's Minimum Data Set (MDS-a federally mandated resident assessment tool), dated 12/11/24, the MDS section C indicated, Resident 67 had a Brief Interview for Mental Status (BIMS-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 06, which indicated Resident 67 had severe cognitive impairment.</p> <p>During an interview on 1/21/25 at 3:32 p.m. with CNA 4 in Resident 67's room, CNA 4 stated, she has been employed at the facility for one month and did not know if Resident 67 needs to wear glasses.</p> <p>During a concurrent interview and record review on 1/23/25 at 2:41p.m., with the Minimum Data Set (MDSC) Nurse in her office, Advanced Eyecare, A Professional Optometric Group vision report dated 11/1/24, MDS section B-Hearing, Speech, and Vision B1200. Corrective Lens dated 12/11/24, and Care Plan dated 1/14/25 was reviewed. The Advanced Eyecare, A Professional Optometric Group vision report indicated, Resident 67 was prescribed new glasses. The MDS section B1200. Corrective Lenses indicated, 0. No the resident does not use corrective lenses (contacts, glasses or magnifying glass) . The MDS stated, she would like to verify Resident 67's new glasses prescription with the Social Services Director. The MDS Coordinator stated, she recorded 0. No on MDS section B1200. Corrective Lens, dated 12/11/24. The MDSC stated, stated Resident 67 did not have a CP for the use of prescription glasses.</p> <p>During a concurrent interview and record review on 1/23/25 at 3:52 p.m., with MDSC, Resident 67's Vision Report titled Advanced Eyecare, A professional Optometric Group dated 11/1/24 was reviewed. The Vision Report indicated, the provider diagnosed Resident 67's eyes with cataracts (clouding of the natural lens inside your eye causing blurry or hazy vision), pinguecula (yellowish bump on the white of the eye) and diabetic retinopathy (a type of nerve damage that can occur in the eye due to high blood sugar levels) and recommended new reading glasses to improve vision and quality of life. The MDSC stated, the resident's need for glasses should have been care planned to ensure Resident 67 wears glasses to improved vision and decrease the risk for falls.</p> <p>During an interview with the DON on 1/24/25 at 9:16 a.m., the DON stated</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>CP are reviewed and should reflect Resident 67's need for assistive/adaptive devices such as glasses. The DON stated nursing staff should have been aware Resident 67 needs to wear glasses, without the glasses Resident 67 would have a difficult time performing activities of daily living such as reading, watching TV, eating and participating in facility activities.</p> <p>During a review of Resident 67's CP, revised on date 12/4/24, the Care Plan indicated, Resident 67 is at high fall risk with a goal to minimize the risk for falls by keeping personal items within reach.</p> <p>During a review of Resident 67's Order Summary Report dated 1/24/25, the Order Summary indicated an active order dated 6/3/24 for eye-health and vision consult with follow up treatment as indicated.</p> <p>During a review of Job Description: MDSC Nurse, dated 7/2018, the general purpose indicated a primary function of the MDS nurse is to assess resident care needs, direct and supervisor staff to meet the resident's needs, coordinate with other members of the Inter-Disciplinary Team (IDT) develop and implement a plan of care that meets the individual needs of each resident .</p> <p>During a review of the facility's policy and procedure titled, Care Plans, Comprehensive Person-Centered, dated 2001, indicated, 1. The interdisciplinary team (IDT) .develops and implements a comprehensive, person-centered care plan for each resident .7. The comprehensive, person-centered care plan: b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being .11. Assessments of residents are ongoing and care plans are revised as information about the resident's and the residents' conditions change .</p> <p>During a review of Journal of the American Medical Directors Association Volume 24, Issue 1, dated January 2023, Pages 105-122, Risk Factors for Vision Lost among Nursing Home Residents: A Cross-Sectional Analysis indicated correcting vision impairments can improve resident function and independence.</p> <p>51223</p>		

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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>51059</p> <p>Based on observation, interview, and record review, the facility failed to ensure services provided met professional standards of practice for one of six sampled residents (Resident 342) when Resident 342's Oxygen (O2) therapy (a colorless, odorless, tasteless gas essential to living organisms) was not administered per the physician order and the O2 tubing (a thin, flexible tube with two prongs that fit into the nostrils and deliver oxygen) was not labeled when it was put into use allowing for tracking when it needs to be replaced to prevent bacterial contamination.</p> <p>This failure resulted in Resident 342 not receiving her oxygen therapy on 1/21/25 which could led to shortness of breath, fatigue, and the potential to developed respiratory infection from the use of contaminated O2 tubing.</p> <p>Findings:</p> <p>During a concurrent observation and interview on 1/21/25 at 10:58 a.m. in Resident 342's room, Resident 342 was lying in bed, the O2 concentrator (medical device that helps residents/patients' breath) was turned off, and the nasal cannula O2 tubing was tucked underneath Resident 342's pillow. The O2 tubing did not have label which indicate when the O2 tubing was first used.</p> <p>Resident 342 stated she only used her O2 at night since she was admitted .</p> <p>During a review of Resident 342's Admission Record (AR- document containing resident personal information), dated 1/14/25, the AR indicated, Resident 342 was admitted in the facility on 1/14/25, with diagnoses which included .Chronic Obstructive Pulmonary Disease (COPD- a progressive lung disease that makes it difficult to breathe) .</p> <p>During a review of Resident 342's Minimum Data Set (MDS- a resident assessment tool) assessment, dated 1/21/25, the MDS assessment indicated Resident 342's Brief Interview for Mental Status (BIMS-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) assessment score was 14 out of 15 which indicated R 342 had no cognitive deficit.</p> <p>During a review of Resident 342's Physician Orders (PO) dated 1/15/25, the PO indicated, .Oxygen 2 LPM (liters per minute-a unit of measurement for the flow rate of oxygen) Via Nasal Cannula Continuously . and . Oxygen humidifier bottle and tubing to be changed on Thursday NOC shift .</p> <p>During a concurrent observation and interview on 1/21/25 at 11:15 a.m. with Licensed Vocational Nurse (LVN) 3 in Resident 342's room, Resident 342 was lying in bed, the O2 concentrator was turned off and the nasal cannula was tucked underneath Resident 342's pillow. LVN 3 stated the O2 concentrator was turned off and Resident 342 nasal cannula was tucked underneath the pillow. LVN 3 stated Resident 342 did not received O2 therapy as ordered by the physician.</p> <p>LVN 3 stated the O2 tubing should have been labeled with a date when it was first use to track when it needs to be disposed.</p> <p>(continued on next page)</p>		

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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>During a concurrent interview and record review on 1/22/25 at 9:03 a.m. with the Infection Preventionist (IP), Resident 342's PO, dated 1/15/25 was reviewed. The PO indicated, .Oxygen 2 LPM Via Nasal Cannula Continuously . The IP stated Resident 342 should have received oxygen 2 LPM via nasal cannula continuously. The IP stated all physician orders should be followed. The IP stated Resident 342 could experience respiratory distress if she did not receive her oxygen therapy as ordered.</p> <p>During an interview on 1/22/25 at 2:31 p.m. with Resident 342, Resident 342 stated she did not receive her oxygen therapy on 1/21/25 and was not instructed to wear the nasal cannula to receive oxygen. Resident 342 stated she felt tired and it was hard to breathe today .</p> <p>During an interview on 1/23/25 at 9:01 a.m. with Resident 342, Resident 342 stated she felt tired, fatigued, and short of breath.</p> <p>During a concurrent interview and record review on 1/23/25 at 9:30 a.m. with LVN 4, Resident 342's PO, dated 1/15/25 was reviewed. The PO indicated, Resident 342 had an order for .Oxygen 2 LPM Via Nasal Cannula Continuously . and Oxygen humidifier bottle and tubing to be changed on Thursday NOC [night] Shift . LVN 4 stated licensed nurses were responsible for administering oxygen therapy orders as prescribed by the physician.</p> <p>During an interview on 1/23/25 at 10:17 a.m. with Respiratory Therapist (RT) 1, RT 1 stated Resident 342 had an order for continuous oxygen therapy at 2 LPM via [by way] of nasal cannula. RT 1 stated the licensed nurses should have administer oxygen as ordered by the physician. RT 1 stated Resident 342 had increased work of breathing and felt tired today which could have been the result of not wearing oxygen as ordered by the physician.</p> <p>During an interview on 1/24/25 at 11:22 a.m. with RT 2, RT 2 stated licensed nurses should have labeled the O2 tubing with a date to be replace every Thursday as ordered by the physician to prevent bacterial contamination.</p> <p>During an interview on 1/24/25 at 3:03 p.m. with the Director of Nursing (DON), the DON stated it was the responsibility of licensed nurses to ensure oxygen was administered as ordered by the physician for every resident. The DON stated Resident 342 could experienced shortness of breath and fatigue without the use of O2. The DON stated the O2 tubing should have been labeled with a date when it was first use to know when it needs to be replace to prevent the growth of bacteria in the )2 tubing.</p> <p>During a review of the facility job description document titled, LPN LVN, dated 11/ 2018, the document indicated, .Prepare and administer medications as ordered by physician .Review the resident's chart for specific treatments, medications, orders . etc .Review care plans daily to ensure appropriate care is being rendered .Ensure nursing notes reflect the care plan is being followed when administering nursing care or treatment .</p> <p>During a review of the facility's P&amp;P titled, Oxygen Administration, dated 10/2010, the P&amp;P indicated, Review the physician's orders .for oxygen administration .the following information should be recorded .date . name and title of the individual who performed the procedure .</p> <p>(continued on next page)</p>		

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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>During a review of the facility's lesson plan document titled, IC-O2 Supply Safe Handling &amp; Storage, dated 1/21/25, the document indicated, At the conclusion of this course, the student will be able to .understand the proper techniques to ensure patient safety and comfort while maintaining oxygen equipment according to facility protocols . The document indicated, when and how to replace oxygen tubing. The document was signed by all staff.</p> <p>During a professional reference review retrieved from <a href="https://pubmed.ncbi.nlm.nih.gov/19377391/">https://pubmed.ncbi.nlm.nih.gov/19377391/</a> titled, The use of medical orders in acute care oxygen therapy, dated 2009, the professional reference review indicated, . Oxygen is considered to be a drug requiring a medical prescription and is subject to any law that covers its use and prescription . authorized by a physician following legal written instruction to a qualified nurse .</p>		

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<p>F 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate foot care.</p> <p>51059</p> <p>Based on observation, interview, and record review, the facility failed to ensure one of six sampled Residents (Resident 75) received toenail care consistent with professional standards of practice when Resident 75's toenails were long, yellow, hard thick, curled, and separated from the nail bed.</p> <p>This failure resulted in Resident 75's toenails to become long, curled, and painful which had the potential to lead to ingrown toenails, infection, or injury.</p> <p>Findings:</p> <p>During an interview on 1/21/25 at 9:41 a.m. with Resident 75, Resident 75 stated his toenails were long, falling off and painful. Resident 75 stated he told multiple Certified Nursing Assistants (CNA) about the pain and discomfort his toenails caused him. Resident 75 stated no CNA, Licensed Vocational Nurse (LVN), or provider had assessed his toenails.</p> <p>During a review of Resident 75's Admission Record (AR- document containing resident personal information), dated 9/26/24, the AR indicated, Resident 75 was admitted in the facility on 9/26/24, with diagnoses which included, Alzheimer's Disease (a brain disorder that causes memory loss and thinking difficulties, and eventually the inability to perform simple tasks), Type 2 Diabetes ( a medical condition in which the sugar level is high in the blood stream), Type 2 Diabetes Mellitus with Diabetic Neuropathy (a complication of type 2 diabetes that occurs when high blood sugar damages nerves throughout the body), and abnormalities of gait and mobility (an abnormal walking condition).</p> <p>During a review of Resident 75's Minimum Data Set (MDS- a resident assessment tool) assessment, dated 12/31/24, the MDS assessment indicated Resident 75's Brief Interview for Mental Status (BIMS- an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) assessment score was 12 out of 15 which indicated Resident 75 had moderate cognitive deficit.</p> <p>During an interview on 1/22/25 at 8:51 a.m. with CNA 2, CNA 2 stated CNAs were expected to report resident complaints, pain, and discomfort to the licensed nurse for assessment. CNA 2 stated CNAs were expected to report and mark skin concerns, which included toenail concerns, on a shower sheet (a form CNA's use to document a resident's shower and any changes in resident condition) for licensed nurse review.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Hanford Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  1007 West Lacey Blvd Hanford, CA 93230	
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<p>F 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent observation and interview on 1/22/25 at 11:21 a.m. with LVN 4 in Resident 75's room, Resident 75 was observed lying in bed, observed to have long, yellow, hard thick, curled toenails (all ten toenails). Resident 75's fourth toenail on his right foot, next to his pinky toe, was separated and lifted upward from the toe with blackness underneath the toenail at the base. LVN 4 stated Resident 75 was able to make his needs known and communicate with no deficits. LVN 4 stated CNAs should have reported Resident 75's toenail pain and discomfort to the licensed nurse. LVN 4 stated CNAs should have identified Resident 75's toenails as a skin concern and reported to the licensed nurse for further assessment. LVN 4 stated Resident 75's toenail condition should have been identified by the licensed nurse during daily head- to- toe assessments and charted in the medical record. LVN 4 stated toenail concerns should have been reported to the Social Services Director (SSD) for referral to podiatry (foot doctor).</p> <p>During an interview on 1/23/25 at 11:12 a.m. with the Infection Preventionist (IP), the IP stated CNA's performed routine shower sheet forms on each resident and marked areas of concern for the licensed nurse to review. The IP stated CNAs should have identified Resident 75's toenails as an area of concern and reported to the licensed nurse for assessment. The IP stated Resident 75's toenails should have been identified as an area of concern during daily licensed nurse head-to-toe assessments, documented, care planned and reported to the SSD. The IP stated the SSD was responsible to refer residents to podiatry for toenail care and treatment. The IP stated toenails that were long, yellow, hard thick, curled, separated and lifted upward from the toe with blackness underneath the toenail at the base were at risk for infection, pain, and injury.</p> <p>During an interview on 1/23/25 at 11:26 a.m. with LVN 2, LVN 2 stated head- to- toe assessments were to be completed every shift, on each resident, by the licensed nurse. LVN 2 stated, all resident complaints of pain, including at the location of the toenail, should be reported, and assessed. LVN 2 stated Resident 75's toenails should have been identified as a concern, documented, care planned and reported to the SSD for podiatry services. LVN 2 stated it was important to document accurate assessments and care plans to ensure residents received treatment and monitoring of their condition.</p> <p>During a concurrent interview and record review on 1/23/25 at 11:41 a.m. with LVN 4, Resident 75's Order Summary, dated 9/26/24 was reviewed. The Order Summary indicted, .Podiatry for hypertrophy toenails [a nail disorder that causes fingernails or toenails to grow abnormally thick, curl and discolor] or other foot problems as needed . LVN 4 stated Resident 75's podiatry order was placed .as needed . which indicated a consult could be made if toenail or foot problems were identified, needed, or requested. LVN 4 stated Resident 75 was at risk for toenail and foot problems. LVN 4 stated Resident 75's toenails should have been identified as a problem by CNA's and marked on the shower sheet form for licensed nurse review. LVN 4 stated Resident 75's toenails should have been identified as a problem during the licensed nurse daily head-to-toe assessment. LVN 4 stated Resident 75's toenails should have been reported to the SSD for a podiatry consult. LVN 4 stated she could not locate a head-to-toe assessment, progress note, care plan or podiatry consult that reflected Resident 75's toenail condition. LVN 4 stated it was important to accurately document resident condition to ensure proper treatment and monitoring interventions were in place.</p> <p>During an interview on 1/23/25 at 12:00 p.m. with the SSD, the SSD stated podiatry had not been consulted or seen Resident 75 since his admission.</p> <p>(continued on next page)</p>		

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<p>F 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent observation and interview on 1/24/25 at 10:05 a.m. with LVN 5, LVN 5 stated Resident 75's toenails appeared long, yellow, hard thick, curled (all ten toenails) and his fourth toenail on his right foot, next to his pinky toe, was separated and lifted upward from the toe with blackness underneath the toenail at the base. LVN 5 stated Resident 75's toenails were an issue. LVN 5 stated Resident 75 had a diagnosis of diabetes (a medical condition in which the sugar level is high in the blood stream) and placed him at risk for toenail and foot problems. LVN 5 stated facility policy did not allow staff to perform toenail care on a resident with the diagnosis of diabetes. LVN 5 stated facility policy required residents with the diagnosis of diabetes and a toenail concern to be referred to podiatry. LVN 5 stated Resident 75's toenails should have been reported to the SSD for a podiatry consult.</p> <p>During a concurrent interview and record review on 1/24/25 at 3:03 p.m. with the Director of Nursing (DON), a photograph taken of Resident 75's toenails, was reviewed. The DON stated Resident 75's toenails were an issue. The DON stated it was facility policy for CNAs to identify a change in resident condition and report concerns to the licensed nurse. The DON stated she expected the licensed nurse to identify Resident 75's toenails as a problem during daily head-to-toe assessments. The DON stated a head-to-toe assessment included toenails. The DON stated Resident 75's toenails should have been reported to the SSD for a podiatry consult. The DON stated it was facility policy for residents with the diagnosis of diabetes to receive toenail care from the podiatrist. The DON stated she expected all staff to follow facility policy. The DON stated she expected Resident 75's toenail condition to be documented, and care planned for monitoring. The DON stated if toenail issues were not identified or documented it could lead to ingrown toenails, infection, pain, and difficulty completing activities of daily living.</p> <p>During a review on Resident 75's Shower Sheets dated 1/2/25, 1/9/25, 1/16/25, 1/20/25, the Shower Sheets indicated, Resident 75 had no skin, nail, or toenail issues by the CNA. The Shower Sheets were signed and cleared for accuracy by licensed nursing staff.</p> <p>During a review of Resident 75's Care Plan dated 11/20/24, the Care Plan indicated, .resident at risk for skin breakdown . The Care Plan did not include podiatry services, nail, or toenail issues.</p> <p>During a review of the facility's job description titled, LPN LVN, dated 11/2018, the job description indicated, Chart nurses' notes in an informative and descriptive manner that reflects the care provided to the resident, as well as the resident's response to the care . Review resident care plans for appropriate .problems .</p> <p>During a review of the facility's job description titled, Certified Nursing Assistant, dated 2/2024, the job description indicated, Report all changes in the resident's condition to the Nurse Supervisor/Charge Nurse as soon as practical .Record all entries on flow sheets, notes, charts, ect. in a descriptive manner .Report all complaints and grievances made by the resident .Assist residents with daily functions ( .bath functions, dressing and undressing .) .Report injuries of an unknown source, including skin .</p> <p>During a review of the facility's Policy and Procedure (P&amp;P) titled, Head-to Toe Assessment, dated December 2023, the P&amp;P indicated, Nurses are required to perform a thorough head-to-toe assessment on all residents under their care .a head-to-toe assessment will be conducted for each resident at least once per shift .</p> <p>(continued on next page)</p>		

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<p>F 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facility's P&amp;P titled, Care Plans, Comprehensive Person-Centered, dated March 2022, the P&amp;P indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident . The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment .Assessments of residents are ongoing, and care plans are revised as information about the residents and the resident's condition change.</p> <p>During a review of the facility's P&amp;P titled, Fingernails/Toenails, Care of, dated February 2018, the P&amp;P indicated, .report .if there is evidence of ingrown nails, infections, pain, or if the nails are .hard .or thick .the following information should be recorded in the resident's medical record .the condition of the resident's nails and nail bed, including .ingrown nails .pain .</p> <p>During a review of the facility's P&amp;P titled, Foot Care, dated 10/2022, the P&amp;P indicated, .residents receive appropriate care and treatment in order to maintain mobility and foot health .overall foot care includes the care and treatment of medical conditions to prevent foot complications from these conditions .(diabetes) . residents are provided with foot care and treatment in accordance with professional standards of practice . residents with foot disorders or medical conditions associated with foot complications are referred to qualified professionals .foot disorders include .nail disorders .</p> <p>During a review of the facility's P&amp;P titled, Podiatry Services, dated 2/2023, the P&amp;P indicated, .residents requiring foot care who have complicated disease process will be referred to qualified professionals such as a podiatrist .foot disorders which may require treatment include .nail disorders .employees should refer any identified need for foot care to the social worker or designer.</p> <p>During a review of the Nursing Times article titles, Foot Assessment and Care for Older People dated 12/9/14, the article indicated, .Foot care is a crucial part of nursing care, particularly for older patients, who may be unable to care for their own feet .Toenail disorders including hardened or ingrown nails .Toenails can thicken and become hard and brittle with age, which makes it difficult to cut them .Nails that become too long or thickened can damage the skin on adjacent toes .Ingrown toenails occur when a nail grows into the skin, and can cause pain, swelling, redness and infection .When older people can no longer manage their own foot care, an initial assessment is required to identify what help they need .Podiatrists assess all new nursing home residents .After an individual has been assessed, care may be provided by Podiatrists .Referrals should be made to podiatrists .if patients have .Medical complications that put feet at risk, such as diabetes toenails that are excessively thickened and caused pain, prevent mobility, or are a risk to surrounding skin . Patients with diabetes who have an increased risk must have an expert assessment carried out by health professionals with specialist experience in the management of the foot in diabetes .Nurses should know who to refer and should ensure a timely referral is made and response given .</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>41166</p> <p>Based on observations, interviews and record records, the facility failed to provide pharmaceutical services for all controlled medications (medications that have the potential for abuse or addiction) and non-control medications when periodic reconciliation (a process which validates that the controlled medication inventory amount on hand is what is expected) was not completed for all residents with standing and as needed orders for controlled medications.</p> <p>This failure resulted in inadequate record keeping ensuring accurate inventory of controlled medications, prompt identification or potential for diversion of controlled medications.</p> <p>Findings:</p> <p>During a concurrent observation and interview on 1/22/25 at 11:16 a.m., with the Assistant Director of Nursing (ADON) in the Director of Nursing (DON) office, the controlled medication log sheets stored in a locked cabinet was reviewed. The controlled medication log sheets did not have periodic reconciliation. The ADON stated she was unsure if there was a process for doing periodic reconciliation for controlled medications.</p> <p>During an interview on 1/22/25 at 11:45 a.m. with the DON, the DON stated periodic reconciliation was not something the DON and/or ADON are currently conducting. The DON stated it was important to have periodic reconciliation to prevent diversion and make sure the residents had their control medications in place and were getting the proper treatment.</p> <p>During an interview on 1/24/25 at 3:23 p.m. with the Pharmacy Consultant (PC), the PC stated, Periodic reconciliation is not in our policy and procedure. The PC stated it was important to do periodic reconciliation to prevent diversion.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled Controlled Substances, dated 2001, the P&amp;P indicated, .Dispensing and Reconciling Controlled Substances. 1. Controlled substance inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and detection/follow-up .15. The consultant pharmacist or designee routinely monitors controlled substance storage records .</p> <p>51134</p> <p>51223</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>41166</p> <p>Based on interview and record review, the Pharmacy Consultant (PC) failed to identify and report to the facility irregularities related to:</p> <p>1. Resident 16 's Hemoglobin (Hgb - protein found in red blood cells that is responsible for transporting oxygen throughout the body) levels was 8.1 to 8.3 gm/dL (grams per deciliter- unit of measure) for five months with no Hgb level goal.</p> <p>This failure had the potential risk for Resident 16 to experience tiredness and weakness with no intervention.</p> <p>2. Resident 16, a kidney failure disease (-a long term disease that occurs when the kidneys are damaged and cannot filter blood properly) patient, was administered Ascorbic Acid (Vitamin C) 500 milligrams (mg- unit of measure) without Vitamin C blood monitoring.</p> <p>This failure had the potential risk for Resident 16 to result in toxicity from continued and unmonitored dose of Vitamin C administration.</p> <p>Findings:</p> <p>1. During a record review of Resident 16's Admission Record, dated 1/22/25, Resident 16' s' Admission Record indicated, . Diagnosis information .Iron deficiency anemia (a condition where the body does not have enough iron to produce red blood cells) .</p> <p>During a record review of Resident 16's Order Listing Report dated 1/22/25, Resident 16's Order Listing Report indicated, Procrit [medication use to treat anemia- condition in which the body does not have enough healthy red blood cells or Hgb] Injection Solution 20,000 Unit/ML [milliliter-(unit of measurement)] Epoetin Alfa Inject 1 ml subcutaneously [under the skin] one time a day every 2 weeks on Wed [Wednesday] for Acute Kidney Failure, unspecified . Hold if Hgb &gt; [greater than]11 and or HCT [hematocrit- measure of percentage of red blood cells in the blood] &gt; 33 Order Status - Active. Start Date 11/27/2024.</p> <p>During a review of Resident 16's Hematology Lab Results (HLR- blood test), dated 9/06/24, Resident 16's HLR indicated Resident 16's Hgb level result on 9/06/24 was 8.3 gm/dL.</p> <p>During a review of Resident 16's HLR dated 10/23/24, Resident 16's HLR indicated Resident 16's Hgb level result on 10/23/24 was 8.3 mg/dL.</p> <p>During a review of Resident 16's HLR dated 12/23/24, Resident 16's HLR indicated Resident 16's Hgb level result on 12/23/2024 was 8.1 gm/dL. Resident HLR report indicated for Hgb the reference range is 13.5 - 17.5 gm/dL.</p> <p>During a review of Resident 16's HLR dated 1/6/25, Resident 16's HLR indicated Resident 16's Hgb level result on 1/6/25 was 8.1 gm/dL.</p> <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and record review on 1/24/25 at 2:43 p.m. with the Director of Nursing (DON), the DON stated she was unable to locate a Hgb goal in the resident's medical record. The DON stated it was important to have a Hgb goal to determine if the medication use for Resident 16's iron deficiency anemia was effective or not.</p> <p>During an interview on 1/24/25 at 3:23 p.m. with the PC, the PC stated there should be a goal for Hgb and where the resident should be at. The PC stated if the Hgb gets below the goal level, will try something else or assess why the Hgb was low. The PC stated, Can kind of see from CBC [complete blood count - blood test that measures the number and types of various blood cells including Hgb] lab is a resident is anemic or not.</p> <p>2. During a record review of Resident 16's Admission Record dated 1/22/25, the Admission Record indicated, . Diagnosis information . Unspecified Kidney Failure . Acute Kidney Failure unspecified .</p> <p>During a review of Resident 16's Order Listing Report dated 1/22/25, the Order Listing Report indicated, . Ascorbic Acid Tablet 500 MG [milligram] Give 1 tablet by mouth one time a day for renal insufficiency. Order Status - Active. Start Date - 11/23/2024 .</p> <p>During an interview on 1/24/25 at 2:43 p.m. with the DON, the DON stated it was important to monitor Vitamin C levels to know therapeutic levels. The DON stated too much of Vitamin C could lead to toxicity.</p> <p>During an interview on 1/24/25 at 3 p.m. with the Assistant Director of Nursing (ADON), the ADON stated she was unable to provide documentation for iron and Vitamin C labs for Resident 16 because they had not been done.</p> <p>During an interview on 1/24/25 at 3:23 p.m. with the PC, the PC stated, Usually for chronic kidney disease [long-term condition where the kidneys gradually lose their ability to filter waste products from the blood] residents I try to do 250 mg [milligram] of Vitamin C. According to National Kidney Foundation, a national reference for kidney disease, an online article titled, Vitamins and Minerals in Chronic Kidney Disease, accessed 2/3/25, indicated, Although some people may need to take a low dose of vitamin C, large doses may cause a buildup of oxalate in people with kidney disease. Oxalate (is a salt that can form crystals in urine, which can stick together and form kidney stones) may stay in the bones and soft tissue, which can cause pain and other issues over time.</p> <p>51134</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>41166</p> <p>Based on observation, interview and record review the facility failed to perform adequate lab monitoring, order medications without adequate indications for use</p> <p>for Resident 16 when:</p> <p>1. Resident 16's Hemoglobin (Hgb - protein found in red blood cells that is responsible for transporting oxygen throughout the body) levels was 8.1 to 8.3 gm/dL (grams per deciliter- unit of measure) for five months with no Hgb level goal and Procrit [medication use to treat anemia- condition in which the body does not have enough healthy red blood cells or Hgb] medication was given to correct low Hgb levels without iron lab monitoring.</p> <p>This failure had the potential risk for Resident 16 to experience blood loss without adequate intervention.</p> <p>2. Resident 16 received Ascorbic Acid (Vitamin C) without Vitamin C blood monitoring and dose.</p> <p>This failure had the potential risk for Resident 16 to result in toxicity from a continued and unmonitored dose of Vitamin C administration.</p> <p>Findings:</p> <p>1. During a record review of the Admission Record, dated 1/22/25, the Admission Record indicated, . Diagnosis information .Iron deficiency anemia (a condition where the body does not have enough iron to produce red blood cells) .</p> <p>During a record review of Order Listing Report dated 1/22/25, the Order Listing Report indicated, Procrit Injection Solution 20,000 Unit/ML [milliliter] Epoetin Alfa Inject 1 ml subcutaneously [under the skin] one time a day every 2 weeks on Wed [Wednesday] for Acute Kidney Failure, unspecified . Hold if Hgb &gt; [greater than]11 and or HCT [hematocrit- measure of percentage of red blood cells in the blood] &gt; 33 Order Status - Active. Start Date 11/27/2024.</p> <p>During a review of Hematology, dated 9/06/24, the Hematology indicated Resident 16's Hgb level result on 9/06/24 was 8.3 gm/dL (grams per deciliter).</p> <p>During a review of Hematology, dated 10/23/24, the Hematology indicated Resident 16's Hgb level result on 10/23/24 was 8.3 mg/dL.</p> <p>During a review of Hematology, dated 12/23/24, the Hematology indicated Resident 16's Hgb level result on 12/23/2024 was 8.1 gm/dL. The Hematology report indicated for Hgb the reference range is 13.5 - 17.5 gm/dL.</p> <p>During a review of Hematology, dated 1/6/25, the Hematology indicated Resident 16's Hgb level result on 1/6/25 was 8.1 gm/dL.</p> <p>(continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and record review on 1/24/25 at 2:43 p.m. with the Director of Nursing (DON), the DON stated she is unable to locate a Hgb goal in the resident's medical record. The DON stated it is important to have a Hgb goal because unable to determine if the medication the resident is receiving is effective or not.</p> <p>During an interview on 1/24/25 at 3 p.m. with the Assistant Director of Nursing (ADON), the ADON stated unable to provide documentation for iron and Vitamin C labs for Resident 16 because they have not been done.</p> <p>During an interview on 1/24/25 at 3:23 p.m. with the pharmacy consultant (PC), the PC stated there should be a goal for Hgb and where the resident should be at. The PC stated if the Hgb gets below the goal level, will try something else or assess why the Hgb is low. The PC stated, Can kind of see from CBC [complete blood count - blood test that measures the number and types of various blood cells including Hgb] lab is a resident is anemic or not.</p> <p>2. During a record review of Resident 16's Admission Record dated 1/22/25, the Admission Record indicated, . Diagnosis information . Unspecified Kidney Failure . Acute Kidney Failure unspecified .</p> <p>During a review of Resident 16's Order Listing Report dated 1/22/25, the Order Listing Report indicated, . Ascorbic Acid Tablet 500 MG [milligram] Give 1 tablet by mouth one time a day for renal insufficiency. Order Status - Active. Start Date - 11/23/2024 .</p> <p>During an interview on 1/24/25 at 2:43 p.m. with the DON, the DON stated it is important to monitor Vitamin C levels to know therapeutic levels. The DON stated too much of Vitamin C can lead to toxicity.</p> <p>During an interview on 1/24/25 at 3:00 p.m. with the ADON, the ADON stated unable to provide documentation for iron and Vitamin C labs for Resident 16 because they have not been done.</p> <p>During an interview on 1/24/25 at 3:23 p.m. with the PC, the PC stated, Usually for chronic kidney disease [long-term condition where the kidneys gradually lose their ability to filter waste products from the blood] residents I try to do 250 mg [milligram] of Vitamin C.</p> <p>51134</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  056288	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/24/2025
NAME OF PROVIDER OR SUPPLIER  Hanford Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  1007 West Lacey Blvd Hanford, CA 93230	
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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 51134</p> <p>Based on observations, interviews and record reviews the facility failed to ensure two of two residents (Resident 43 and Resident 67) were free from unnecessary psychotropic (drugs that affect brain activities with mental processes and behaviors) medications when:</p> <ol style="list-style-type: none"> <li>1. Resident 43 was prescribed Aripiprazole (antipsychotic medication that helps treat mental health conditions) for behaviors of auditory hallucinations and delusions with no documentation of such behaviors; ineffective monitoring for behavior of sadness as evidence by no target goal for behavior care planned; ineffective monitoring for behaviors of distress; no non-pharmacological (behavioral) interventions were implemented for Bupropion (antidepressant medication).</li> <li>2. Resident 67's Olanzapine (antipsychotic medication that alters brain chemistry to help reduce symptoms of the mind where there has been some loss of contact with reality) order was changed from as needed (prn) to routine on admission into the facility and no assessment was completed for a psychosis (a mental health condition characterized by a loss of contact with reality) diagnosis; no non-pharmacological interventions were attempted prior to the implementation of Olanzapine and Lorazepam (anti-anxiety medication); ineffective monitoring for behaviors as evidence by no target goal for Olanzapine and Lorazepam care planned; inadequate side effect monitoring for Olanzapine and Lorazepam, and no gradual dose reduction (GDR) were attempted for the use of Olanzapine.</li> </ol> <p>These failures resulted in the potential for unnecessary psychotropic medications for Resident 43 and Resident 67 which increased the potential for medical interactions, adverse reactions, and unidentified risks associated with the use psychotropic medications including, but not limited to, sedation, respiratory depression, memory loss and death.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. During a record review of Resident 43's Admission Record (AR) dated 1/24/25, Resident 43's AR indicated, . Diagnosis Information . Alzheimer's Disease [a disease characterized by a progressive decline in mental abilities], bipolar disorder [sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs] . Unspecified Dementia [a progressive state of decline in mental abilities] .</li> </ol> <p>During a record review of Resident 43's Minimum Data Set (MDS) (a resident assessment tool) dated 12/28/20, the MDS indicated in Section E for behavior, under Potential Indicators of psychosis, none of the above box checked, indicating no hallucinations and delusions. The MDS indicated in Section I for active diagnosis, Psychiatric/Mood Disorder .Psychotic Disorder .</p> <p>During a record review of Resident 43's MDS dated [DATE], the MDS indicated in Section E for behavior, under Potential Indicators of psychosis, none of the above box checked, indicating no hallucinations and delusions. The MDS indicated in Section I for active diagnosis, Psychiatric/Mood Disorder .Psychotic Disorder .</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Psychologist Consultation/Follow Up dated 12/28/20, the Psychologist Consultation/Follow Up indicated, . Initial complaints/symptoms: depression, anxiety, hallucinations, delusions .</p> <p>During an observation on 1/23/25 at 1:47 p.m., Resident 43 was sitting in wheelchair and wheeling self throughout the hallway.</p> <p>During a review of Resident 43's Care Plan (CP), undated, Resident 43's CP indicated, Focus. [Resident 43] uses antidepressant medication (Bupropion) r/t [related to] Depression . Interventions . Monitor for episodes/behavior of Depression M/B [manifested by] sadness over loss of life roles causing resident distress/BUPROPION MEDICATION USE . Resident 43's CP did not indicate specific resident distresses to observe for.</p> <p>During a review of Resident 43's Electronic- Medication Administration Record (E-MAR) dated 1/2025, Resident 43's E-MAR indicated, Monitor for episodes/behavior of depression M/B by sadness over loss of life roles causing resident distress/BUPROPION MEDICATION USE every shift - Start date - 6/3/24 1800 . The E-MAR indicated one occurrence on 1/3/25, two occurrences on 1/4/25, two occurrences on 1/5/25, five occurrences on 1/17/25, five occurrences on 1/18/25, five occurrences on 1/19/25, two occurrences on 1/21/25, six occurrences on 1/22/25, and six occurrences on 1/23/25. Resident 43's E-MAR did not specify what type of distress Resident 43 showcased.</p> <p>During a review of Resident 43's E-MAR dated 1/2025, Resident 43's E-MAR indicated, Monitor for episodes/behavior of Psychosis M/B Auditory Hallucinations resident hears people that are not there causing resident distress/[brand name] MEDICATION USE every shift - Start date - 6/3/2024 1800 . Resident 43's E-MAR indicated three occurrences on 1/17/25, two occurrences on 1/18/25, two occurrences on 1/29/25, four occurrences on 1/22/25, and four occurrences on 1/23/25. Resident 43's E-MAR did not specify what type of distress Resident 43 showcased.</p> <p>During a concurrent interview and record review on 1/23/25 at 3:05 p.m. with License Vocational Nurse (LVN) 10, LVN 10 stated Resident 43's behaviors was dependent on the day. LVN 10 stated one minute Resident 43 could be happy and the next Resident 43 could be crying. LVN 10 stated, I have not heard resident talking to people [that aren't there] and no staff has told me anything. LVN 10 unable to find documentation for hallucinations and delusions. LVN 10 stated if the resident did have any behaviors, they would be documented in a progress note with monitoring behavior. LVN 10 stated there was no documentation for what non-pharmacological interventions done for Resident 43.</p> <p>During an interview and record review on 1/24/25 at 2:14 p.m. with the Director of Nursing (DON) the DON stated there was no documentation seen on hallucinations and delusions by staff for Resident 43 on admission and throughout Resident 43's stay. The DON stated it was important to have specific definitions of distresses for the resident seen on the MAR (Medication Administration Record) order, so the nurses know what to look for and what is specific to the resident. The DON stated there was no documentation for non-pharmacological interventions for Resident 43 in the care plan from admission and currently. The DON stated if staff witness the resident experience a side effect for [brand name], the expectation was for the nurse to document the specific side effect seen in progress not and let the provider know.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 1/24/25 at 3:23 p.m. with the pharmacy consultant (PC), the PC stated, .there should be documentation to suppose hallucinations and delusions for [Resident 43]. The PC stated doing non-pharmacological interventions was a better way to help minimize a resident's behaviors. The PC stated if a resident was responsive to non-pharmacological interventions, the use of antipsychotic medications can be decrease, therefore decreasing side effects.</p> <p>2. During a review of Resident 67's AR dated 1/30/25, the AR indicated, .Diagnosis Information . muscle weakness .anxiety disorder . bipolar disorder . Unspecified Dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety .Unspecified Psychosis not due to a substance or known physiological condition .</p> <p>During a review of Resident 67's Order Listing Report (OSR) 1/2025, the OSR indicated the resident receives [brand name] 0.5 mg (milligram) daily for anxiety m/b repetitive health concerns causing resident distress. The E-MAR indicated the start date for [brand name] was 10/30/24 to present. The OSR indicated resident receives [brand name] 2.5 mg at bedtime for psychosis m/b verbal aggression towards staff. The OSR indicated [brand name] started on 6/3/24 to present.</p> <p>During review of hospital discharge records dated 10/10/23, Resident 67's hospital discharge records indicated resident on [brand name] 2.5 mg every six hours prn agitation and/or psychosis.</p> <p>During a review of Resident 67's MDS dated [DATE], the MDS indicated in Section E for behavior, the resident does not have hallucinations and delusions. Resident 67's MDS indicated in section I for active diagnosis, the resident had non-Alzheimer dementia, anxiety and psychotic diagnosis.</p> <p>During a review of Resident 67's CP dated 1/9/25, the CP indicated, .Attempt Non -pharmacological approaches prior to medication administration: provide quiet and dark environment, assess the presence of pain/discomfort, keep as comfortable as possible, provide back rubs as needed, offer warm beverages . The CP had no objective goal for the medication [brand name].</p> <p>During a review of Resident 67's CP for [brand name], undated, the CP indicated, . [brand name] 0.5 mg once a day in the morning for anxiety manifested by repetitive health concerns causing resident distress Date Initiated: 10/08/2024 . Non-Pharmacological Interventions Anti-Psychotic: 1) re-direct to another area in the facility, 2) re-orient resident to current situation, 3) provide safe/secure environment, 4) psych f/u as needed, 5) Divert attention to activity of choice. Date Initiated: 10/10/2024 Notify MD of any adverse reactions or complications Date Initiated: 10/08/2024 .</p> <p>During a review of Resident 67's Psychotropic MAR dated 1/2025, the Psychotropic MAR indicated 54 episodes of the resident yelling at staff and 73 episodes of anxiety.</p> <p>During an interview 1/23/25 at 2:54 p.m. with LVN 11, LVN 11 stated Resident 67 was cooperative, outspoken and demanding. LVN 11 stated the resident would get agitated quickly when his request was not acknowledged quickly.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and record review on 1/24/25 at 11:47 a.m. with LVN 6, LVN 6 stated hospital discharge orders for Resident 67 on 10/10/23 stated [brand name] 2.5 mg every six hours prn for agitation and/or psychosis. LVN 6 stated facility orders on 10/10/23 for [brand name] was 2.5 mg at bedtime for psychosis, manifested by verbal aggression towards staff. LVN 6 stated she was unable to find documentation for verbal aggression upon Resident 67's admission into the facility. LVN 6 stated she was unable to locate a target goal for number of behavior episodes in the care plan for [brand name] and [brand name]. LVN 6 stated it was important to have a target goal in the care plan to see if the medication Resident 67 was receiving was effective and to determine if the medication needed to be adjusted or discontinued. LVN 6 stated she was unable to find documentation for non-pharmacological interventions prior to the initiation of [brand name] and [brand name] for Resident 67. LVN 6 stated nursing staff was expected to do a tally and document every shift whether Resident 67 was experiencing side effects. LVN 6 stated she was unable to determine what side effects were documented in the charting if there is no note and no way to determine the type of side effect with the use of tallies. LVN 6 stated it was important to document the type of side effect Resident 67 experienced so the doctor would be aware of the side effect of the medication and make the appropriate intervention.</p> <p>During a concurrent interview and record review on 1/24/25 at 1:41 p.m. with the DON, the DON stated there was no documentation as to why [brand name] dose was changed from prn to routine on admission. The DON stated a note written on 10/13/24 indicated Resident 67 had several episodes of yelling at staff and staff able to redirect the resident. The DON stated a resident yelling at staff was not a reason for a resident to be put on an antipsychotic medication. The DON stated there was no psychiatry documentation and no documentation for non-pharmacological intervention attempted for [brand name] for Resident 67. The DON stated it was important to have measurable goals in the care plan because it gave a target to reach and showed if the plan was effective and whether the medication could be continued or reduced.</p> <p>During a concurrent interview and record review on 1/24/25 at 1:56 p.m. with the DON, the DON stated the nurses' notes should document non-pharmacological interventions. The DON stated she was unable to locate non-pharmacological interventions for both [brand name] and [brand name] for Resident 67. The DON stated she was unable to locate documentation showing a GDR was attempted for Resident 67. The DON stated doing a GDR would help the resident; the goal was to have the resident on the lowest effective dose possible.</p> <p>During an interview on 1/24/25 at 3:24 p.m. with the PC, the PC stated there should be a clinical rationale documented if a medication was going to be changed from prn to routine. The PC stated a GDR was not done for Resident 67 because the resident was readmitted. The PC stated a GDR was important to see if the resident needs to be on the medication.</p> <p>41166</p>		

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NAME OF PROVIDER OR SUPPLIER  Hanford Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  1007 West Lacey Blvd Hanford, CA 93230	

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>41166</p> <p>Based on observation, interview, and record review, the facility failed to ensure the medication error rate was less than five percent when the facility's medication error rate was 11.11 percent. There were 27 opportunities for errors and three medication errors occurred for three of nine sampled residents (Resident 72, Resident 73, and Resident 70) when:</p> <ol style="list-style-type: none"> <li>1. Resident 72's blood glucose (simple sugar - the body's primary source of energy from food) was assessed after Resident 72 began eating lunch.</li> <li>2. Resident 73 was administered Olmesartan (medication used to lower blood pressure) and Resident 73's blood pressure was below ordered parameters.</li> <li>3. Resident 70 was administered a medication not ordered by the physician.</li> </ol> <p>These failures in medication errors for Resident 72, Resident 73, and Resident 70, resulted in placing residents at risk for experiencing adverse side effects without adequate monitoring.</p> <p>Findings:</p> <p>1. During a medication pass observation on 1/21/25 at 12:06 p.m., with Licensed Vocational Nurse (LVN) 3, LVN 3 was observed retrieving Resident 72 from the dining room and taking her back to her room to check her blood glucose. Resident 72 was observed eating lunch while in the dining room. In Resident 72's room, LVN 3 was observed performing blood glucose check on Resident 72, with a blood glucose reading of 158. LVN 3 informed Resident 72 no Insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) coverage was needed based on Resident 72's blood glucose reading of 158.</p> <p>During a review of Order Listing Report, (undated), the Order Listing Report indicated, Order Summary Insulin Regular Human Injection Solution [short-acting human made insulin helps to control blood sugar levels] (Insulin Regular (Human)) Inject as per sliding scale .give .subcutaneously [under the skin] before meals and at bedtime for DM 2 [Diabetes Mellitus type 2 - a chronic condition where the body does not use insulin effectively or does not produce enough insulin, leading to high blood sugar levels] if BS [blood sugar] &lt; [less than] 60 or &gt; [greater than] 400 notify MD [Doctor of Medicine].</p> <p>During an interview on 1/21/25 at 3:49 p.m. with LVN 3, LVN 3 stated Resident 72 had started eating her lunch before her blood glucose was assessed. LVN 3 stated the Insulin order was to check blood glucose level before meals. LVN 3 stated blood glucose check done after eating would not be an accurate assessment of blood glucose per the order.</p> <p>(continued on next page)</p>

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. During a medication pass observation on 1/22/25 at 8:46 a.m. with LVN 4, LVN 4 entered Resident 73's room and assessed the resident's blood pressure with a result of 98/52. LVN 4 stated she will be holding and not administering the medications Chlorthalidone (a diuretic (water pill) that reduces the amount of water in the body by increasing the flow of urine, which helps to lower blood pressure) and Furosemide (a diuretic pill used to treat high blood pressure, heart failure (a condition where the heart muscle is weakened and cannot pump blood effectively) and a buildup of fluid in the body) due to Resident 73's blood pressure being below parameters as indicated in both medication orders. LVN 4 was observed administering Olmesartan (antihypertensive drug used to treat high blood pressure) to Resident 73.</p> <p>During a review of Resident 73's Electronic Medication Administration Record (E-MAR), dated 1/23/25, the E-MAR stated, Olmesartan Medoxomil Oral Tablet 5 mg . Give 1 tablet by mouth one time a day for HTN [hypertension - high blood pressure] Nurse to obtain B/P [blood pressure] SBP [systolic blood pressure - the pressure in the arteries when the heart beats and pumps blood throughout the body] &lt; 100 hold medication and notify MD, if SBP &gt;180 give medication and notify MD. - Start Date - 06/04/2024 0900.</p> <p>During an interview on 1/22/25 at 2:09 p.m. with LVN 4, LVN 4 stated MD was notified that she administered Olmesartan to Resident 73, with blood pressure outside of parameters. LVN 4 stated administering a medication outside of parameters could cause Resident 73's blood pressure to drop further.</p> <p>3. During medication pass observation on 1/22/25 at 9:33 a.m. with LVN 4, LVN 4 was observed preparing Resident 70's medications. LVN 4 was observed preparing and administering one tablet of [brand name] to Resident 70.</p> <p>During a review of Resident 70's E-MAR, dated 1/23/25, the E-MAR stated, Senna-S Oral Tablet 8.6-50 MG (Sennosides-Docusate Sodium) Give 1 tablet by mouth two times a day for Constipation hold for loose stools. - Start date - 12/05/2024 0800.</p> <p>During a concurrent interview and record review on 1/22/25 at 2:05 p.m. with LVN 4, LVN 4 confirmed the active ingredient for [brand name] was sennosides, and did not contain docusate. LVN 4 stated a medication error did occur because she administered a Sennoside only tablet. LVN 4 stated it was important to give medication as ordered by the physician because of potential adverse reactions to the resident.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled Administering Medications, dated 2001, the P&amp;P indicated, . 4. Medications are administered in accordance with prescriber orders . 10. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication .</p> <p>51134</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>51134</p> <p>Based on observation, interview and record reviews, the facility failed to ensure drugs and biologicals used in the facility were labeled and stored in accordance with the facility policy and procedures when:</p> <p>1. The room temperature for two of two medication storage rooms was not monitored.</p> <p>This failure had the potential risk for medications to be exposed in extreme temperatures which could alter the medication chemical composition and reduce shelf life.</p> <p>2. Resident 40 and Resident 11 discontinued medications were stored in the west wing medication cart, and Resident 16's discontinued ointment medication was stored in the east wing treatment cart.</p> <p>This failure had the potential risk to result in a medication error.</p> <p>3. Resident 27, Resident 36, Resident 343, Resident 9, Resident 59, Resident 62, Resident 42, Resident 20, Resident 5, Resident 54, and Resident 3's inhaler medications stored in the respiratory therapy (RT) cart did not have an open date label (the date when a medication was first open).</p> <p>This failure had the potential risk for license nurses to administer expired medications to residents which could result to medication adverse reactions and decreased medication efficacy.</p> <p>4. Resident 57's medication stored in the west wing treatment cart did not have a change of direction sticker.</p> <p>This failure had the potential risk for the license nurses to administer the wrong amount and frequency of the medication.</p> <p>Findings:</p> <p>1. During an observation on 1/21/25 at 9:33 a.m., in the east front east wing, the medication storage room did not have a room temperature log.</p> <p>During a concurrent observation and interview on 1/21/25 at 9:42 a.m. with the Director of Staff Development (DSD), the OTC (over the counter) medication storage room did not have a room temperature log. The DSD stated Central Supply (CS) was in charge of temperature monitoring and documentation of the medication storage room.</p> <p>During a concurrent observation and interview on 1/21/25 at 9:53 a.m. with the CS in the OTC medication storage room, the CS was unable to provide the room temperature log. The CS stated there was no room temperature log for the OTC medication storage room. The CS stated it was important to monitor and have a room temperature log to make sure temperature ranges are accurate for medications storage and not too hot or too cold.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent observation and interview on 1/21/25 at 10:17 a.m. with Licensed Vocational Nurse (LVN) 3, LVN 3 stated IV (intravenous) medication and emergency kit are stored in the east front wing medication storage room. LVN 3 was unable to locate room temperature log for the east front wing medication storage room. LVN 3 stated there was no temperature monitoring and documentation for the medication storage room. LVN 3 stated it was important to monitor room temperature for the medication storage room to ensure the room temperature was not too high and too cold to maintain the effectiveness of the stored medications.</p> <p>During an interview on 1/22/25 at 11:48 a.m. with the Assistant Director of Nursing (ADON), the ADON stated refrigerator temperatures logs are being done for medication rooms but not medication room temperature log because there are no medications in the room. The ADON stated the expectation was to monitor temperatures in both medication rooms and the OTC medication supply room. The ADON stated it was important to monitor room temperatures because medications stored in these rooms could become ineffective if they were stored in a temperature that was out of range. The ADON stated residents could have an adverse reaction from medications stored in a room that was too hot or too cold.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Storage of Medications, dated 2001, the P&amp;P indicated, .11. All drug storage areas will be temperature-controlled between 15? [degree Celsius] (59? [degree Fahrenheit]) and 30? (86?). The ambient temperature will be observed at least daily. If the temperature is noted to be outside of the required range the facility administrator will be notified, and corrective action will be taken to return the temperature to the specified range.</p> <p>2. During an observation on 1/21/25 at 3:13 p.m. with LVN 6, the medication cart on the west wing stored Resident 40's two Pot-Cl (potassium chloride - a mineral supplement used to treat or prevent low amounts of potassium in the blood) 20 mEq (milliequivalents-unit of measurement) micro (small) tablets inside a bubble packet, and Resident 11's Vitamin D Cap (capsule) 5,000 inside a bubble packet.</p> <p>During a concurrent interview and record review on 1/21/25 at 3:33 p.m. with LVN 6, Residents 40 and Resident 11's physician orders were reviewed. Resident 40's physician order for potassium chloride had an end date of 1/18/25. Resident 11's physician order for Vitamin D had an end date of 1/7/25. LVN 6 stated Resident 40's potassium chloride order was for 15 days, and the order ended on 1/18/25. LVN 6 stated Resident 11's Vitamin D order ended 1/7/25. LVN 6 stated discontinued and completed medications for Resident 40 and Resident 11 should have been removed and discarded from the medication cart. LVN 6 stated the license nurse could mistakenly administered discontinued and completed medications stored in the medication cart which could lead to a medication error.</p> <p>During a concurrent observation and interview on 1/22/25 at 10:35 a.m. with LVN 9 in the east wing, the treatment cart stored Resident 16's one mupirocin ointment 22 grams. LVN 9 stated Resident 16's mupirocin ointment was discontinued on 11/23/24. LVN 9 stated discontinued medications should be remove from the medication cart.</p> <p>During an interview on 1/22/25 at 11:45 a.m. with the ADON, the ADON stated the expectation for discontinued medications was for the nurse to remove the medication from the medication cart and destroy it. The ADON stated when discontinued medications were not pulled from the medication cart, there was a potential for the license nurse to administer the medication which could lead to a medication error.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Hanford Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  1007 West Lacey Blvd Hanford, CA 93230	
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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Order Listing Report dated 1/22/25 for Resident 40, the Order Listing Review indicated, . Potassium Chloride ER [extended release] Oral Tablet Extended Release 20 MEQ (Potassium Chloride) Give 1 tablet by mouth one time a day for 15 days . Order Status - Completed . Potassium Chloride ER Oral Tablet Extended Release 20 MEQ (Potassium Chloride ) Give 1 tablet by mouth one time a day for 2 days . Order Status - Completed .</p> <p>During a review of Order Listing Report dated 1/24/25 for Resident 11, the Order Listing Review indicated, . Vitamin D (Ergocalciferol) Oral Capsule 50000 UNIT (Ergocalciferol) Give 50000 unit by mouth one time a day every Wed until 12/25/2024 23:59 weekly x(for) 13 weeks . Order Status - Completed. Start Date - 10/02/2024 .</p> <p>During a review of Order Listing Report dated 1/22/25 for Resident 16, the Order Listing Report indicated, Mupirocin External Ointment 2% (Mupirocin) Apply to diabetic ulcer to right topically three times a day for infection for 7 days . Order Status - Discontinued. Start Date - 11/22/2024. End Date - 11/29/2024 .</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Storage of Medications dated 2001, P&amp;P indicated, . 4. The facility shall not use discontinued, expired or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed .</p> <p>During a review of the facility's P&amp;P titled, Medication Labeling and Storage, dated 2001, the P&amp;P indicated, . 3. If the facility has discontinued, outdated or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items .</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. During a concurrent observation and interview on 1/21/25 at 4:08 p.m. with RT 3 in the west wing, the RT medication cart stored Resident 27's two [brand name] inhalers (medication used to prevent airflow obstruction and reduce flare-ups for chronic obstructive pulmonary disease [COPD - a chronic lung disease causing difficulty in breathing] patients) 62.5 mcg (microgram-unit of measurement) removed from the manufacturer package without an open date label. Resident 36's two [brand name] inhaler 200-25 mcg (medication used long term to prevent and control symptoms of asthma - a chronic lung condition characterized by inflammation and narrowing of the airways in the lungs) removed from the manufacturer package without an open date label. Resident 343's one [brand name] Inhaler 200-25 mcg removed from the manufacturer package without an open date label. Resident 9's one [brand name] Inhaler 200 mcg (medication used to prevent and control symptoms of asthma for better breathing) removed from the manufacturer package without an open date label. Resident 59's one [brand name] inhaler 200-25 mcg removed from the manufacturer package without an open date label. Resident 62's one [brand name] inhaler 200-62.5-25 mcg inhaler mcg removed from the manufacturer package without an open date label. Resident 42's one [brand name] inhaler 100-50 mcg (medication used to treat asthma and COPD) removed from the manufacturer package without an open date label. Resident 20's one [brand name] 200-62.5-25 mcg removed from the manufacturer package without an open date label. Resident 5's one [brand name] 230-21 mcg removed from the manufacturer package without an open date label. Resident 54's box containing [brand name] single dose (combination of medication used to treat COPD) nebulas 0.5mg (milligram-unit of measure)/3mg/3ml (milliliter- unit of measure) (inhaled solutions that are delivered to the lungs in the form of a fine mist) removed from the manufacturer package without an open date label. Resident 3' box containing 19 open vials of [brand name] nebulas 0.5mg/3mg/3ml removed from the manufacturer package without an open date label. RT 3 stated Resident 27, Resident 36, Resident 343, Resident 9, Resident 59, Resident 62, Resident 42, Resident 20, Resident 5, Resident 54, and Resident 3's medication inhalers did not have an open date label. RT 3 stated it was important to label open inhaler medications with an open date to prevent license nurses from administering expired and ineffective medications to residents.</p> <p>During an interview on 1/22/25 at 11:47 p.m. with the ADON, the ADON stated the expectation was for license nurse to label medications with an open dates and expiration dates to prevent license nurse from administering expired medications. The ADON stated expired medications could result to medication adverse reactions and decreased medication efficacy.</p> <p>During a review of the facility's P&amp;P titled Medication Labeling and Storage dated 2001, indicated, . Medication Labeling . 8. If medication containers have missing, incomplete, improper or incorrect labels, contact the dispensing pharmacy for instructions regarding returning or destroying these items .</p> <p>During a review of the manufacturer package instructions for [brand name] inhaler retrieved from, the manufacturer indicated, [brand name] should be stored inside the unopened moisture-protective foil tray and only 408 removed from the tray immediately before initial use. Discard [brand name] 6 weeks 409 after opening the foil tray .</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. During an observation on 1/22/25 at 10:21 a.m. with LVN 5, on east wing, the treatment cart stored Resident 57's three 15-gram tubes of clotrimazole-betamethasone cream (medications used to treat fungal infections) with an administration direction label to apply [brand name] 1-0.05% (Clotrimazole-Betamethasone) topically three times a day for itchiness to peri area. Resident 57's Order Listing Report (OLR), was reviewed. Resident 57's OLR indicated, [brand name] 1-0.05% (Clotrimazole-Betamethasone) Apply to per additional directions topically three times a day for itchiness to peri area Apply to affected area. Order Status - Discontinued. Start Date - 08/28/2024 . [brand name] 1-0.05% (Clotrimazole-Betamethasone) Apply to per additional directions topically as needed for Itchiness to peri area Apply to affected area. Order Status -Active. Start Date - 11/09/2024 . LVN 5 stated the medication administration direction label for Clotrimazole-Betamethasone did not match the Physician's order change of direction. LVN 5 stated the medication administration directions label should have been updated to ensure the physician's order was followed.</p> <p>During an interview on 1/22/25 at 11:48 a.m. with the ADON, the ADON stated the expectation was for the license nurses to place a change of direction label to a medication with a new physician order for administration. The ADON stated the medication label for administration should match the physician's order.</p> <p>During a review of the facility's P&amp;P titled Medication Labeling and Storage dated 2001, indicated, . Medication Labeling . 10. Only the dispensing pharmacy may label or alter the label on a medication container or package . 12. The nursing staff must inform the pharmacy of any changes in physician orders for a medication.</p> <p>41166</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>51223</p> <p>Based on observation, interview and record review, the facility failed to prepare food in accordance with professional standards for food service safety for 90 of 91 sampled residents when:</p> <ol style="list-style-type: none"> <li>1. A towel and a pair of rubber gloves were found on the floor behind the 3-compartment wash station.</li> <li>2. The stove top had caramel colored residue under the grill and pan supporter, dark shiny residue was on the grill, pan supporter and stove elements, and yellow particles sprinkled on the inner burners.</li> <li>3. Four pieces of toasted bread were on the floor behind the toaster.</li> <li>4. The resident refrigerator had food residue on the door shelving and ice buildup in the freezer.</li> <li>5. The four tiles in front of the ice machine were cracked and broken with missing pieces which created an uneven surface and exposed a dark colored flooring.</li> </ol> <p>These failure had the potential to result in cross contamination (the unintentional transfer of bacteria from one substance or object with harmful effect) which could lead to food borne illness (a condition where a person becomes sick after consuming contaminated food) for 90 residents' who received food from the kitchen.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. During a concurrent observation and interview on 1/21/25 at 9:21 a.m. with the Dietary Aide (DA) in the kitchen, a towel and pair of blue rubber gloves were laying on the floor behind the three-compartment wash station. The DA stated the towel and gloves are used by the cooks to wash pots and pans and should have not been on the floor behind the three-compartment wash station. The DA stated the towel and gloves on the floor had the potential risk for cross contamination.</li> </ol> <p>During an interview on 1/23/25 at 10:25 a.m. in CDM office in the kitchen, the CDM stated kitchen cleaning tasks are assigned daily and weekly. The CDM stated the kitchen should be cleaned daily to maintain a clean and sanitized environment to prevent the growth of microbes which could spread to residents who have compromised health and lead to food borne illness.</p> <p>During a review of Job Description: Dietary Aide, dated 2/24, the Essential Duties indicated .sweep and mop kitchen .to leave the kitchen in a clean and sanitary manner .clean work surfaces and refrigerators .sweep, mop and maintain floors .</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. During a concurrent observation and interview on 1/21/25 at 9:24 a.m. with the DA in the kitchen, the stove top had caramel colored residue under the grill and pan supporter, dark shiny residue was on the grill, pan supporter and stove elements, and yellow particles were sprinkled on the inner burners; and four pieces of toasted bread were on the floor behind the toaster. The DA stated the stove was dirty and did not look like it was cleaned the day before. The DA stated the stove should have been cleaned daily or more often if needed. The DA stated the dirty stove posed an increased risk of fire.</p> <p>During an interview on 1/23/25 at 10:25 a.m. in CDM office in the kitchen, the CDM stated kitchen cleaning tasks are assigned daily and weekly. The CDM stated the shift cook was assigned and responsible to clean the stove and grill. The CDM stated the stove and grill should be cleaned daily to maintain a clean and sanitized environment to prevent the growth of microbes which could spread to residents who have compromised health and lead to food borne illness.</p> <p>During a review of Job Description: Dietary Supervisor, dated 9/16, the Essential Duties indicated .maintain kitchen and food storage area in a safe, orderly, clean and sanitary manner .ensures continued compliance with all federal, state and local regulations .</p> <p>During a review of Job Description: Cook, dated 10/16, the Essential Duties indicated Maintain kitchen and cooking area in a safe, orderly, clean and sanitary manner .clean cooking area .to make sure all cleaning schedules are followed .</p> <p>3. During a concurrent observation and interview on 1/21/25 at 9:27 a.m. with the [NAME] in the kitchen, four pieces of toasted bread were on the floor behind the toaster. The COOK stated the back of the toaster panel becomes dislodge and toasted bread would fall to the floor. The COOK stated toasted bread should not be on the floor as it may create a risk for cross contamination and pest infestation.</p> <p>During an interview on 1/23/25 at 10:25 a.m. in CDM office in the kitchen, the CDM stated kitchen cleaning tasks are assigned daily and weekly. The CDM stated the kitchen should be cleaned daily to maintain a clean and sanitized environment to prevent the growth of microbes which could spread to residents who have compromised health and lead to food borne illness.</p> <p>During a review of Job Description: Cook, dated 10/16, the Essential Duties indicated Maintain kitchen and cooking area in a safe, orderly, clean and sanitary manner .clean cooking area .to make sure all cleaning schedules are followed .</p> <p>During a review of Job Description: Dietary Aide, dated 2/24, the Essential Duties indicated .sweep and mop kitchen .to leave the kitchen in a clean and sanitary manner .clean work surfaces and refrigerators .sweep, mop and maintain floors .</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. During a concurrent observation and interview on 1/21/25 at 9:29 a.m. with the Certified Dietary Manager (CDM) in the kitchen, the resident refrigerator had a piece of a green leaf and orange/yellow dried liquid on the door storage compartment and the freezer had ice buildup along the left wall and ceiling of the freezer. The CDM stated the food residue was left over from a resident's food and should have been cleaned by staff upon identification. The CDM stated the resident refrigerator was scheduled to be cleaned on Tuesday or more often if needed but was not. The CDM stated the piece of green leaf and orange/yellow dried liquid left in the refrigerator could lead to food borne illness.</p> <p>During a review of Job Description: Dietary Supervisor, dated 9/16, the Essential Duties indicated .maintain kitchen and food storage area in a safe, orderly, clean and sanitary manner .ensures continued compliance with all federal, state and local regulations .</p> <p>During a review of Job Description: Dietary Aide, dated 2/24, the Essential Duties indicated .sweep and mop kitchen .to leave the kitchen in a clean and sanitary manner .clean work surfaces and refrigerators .sweep, mop and maintain floors .</p> <p>5. During a concurrent observation and interview on 1/21/25 at 9:29 a.m. with the Certified Dietary Manager (CDM) in the kitchen, four tiles in front of the ice machine were cracked and broken with missing pieces that created an uneven surface and exposed dark colored flooring. CDM stated he was aware of the broken tiles and had notified the Director of Environmental Services (DES) to request repair.</p> <p>During an interview on 1/23/25 at 10:25 a.m. with the CDM, the CDM stated he notified the DES of the broken tiles needing repair one week ago. The CDM stated the DES informed him the facility would need to order the replacement tile and wax, upon receipt of both tile and wax the DES would prepare the tile with wax and then schedule installation/repair. The CDM stated the kitchen should be cleaned daily to maintain a clean and sanitary environment to prevent the growth of microbes (a microorganism which can cause disease) and food borne illness (a condition where a person becomes sick after consuming contaminated food) which could spread to residents who have compromised health.</p> <p>During an interview on 1/24/25 at 9:16 a.m. with the Director of Nurses (DON) in the DON office, the DON stated cracked or broken tiles were a safety hazard as staff and residents could trip or fall and posed an infection risk as it would be difficult to sanitize the broken surface.</p> <p>During an interview on 1/24/25 at 9:38 a.m. with the DES, the DES stated he was informed of the broken kitchen tile approximately 10-11 days prior. The DES stated he initially scheduled the replacement on Thursday 1/16/25 but identified the facility had to order wax to prepare the tile for installation. The DES stated if tiles were installed without wax an infection control issue would occur because the surface would not be smooth making it difficult to sanitize.</p> <p>During a review of Job Description: Dietary Supervisor, dated 9/16, the Essential Duties: .Maintain kitchen and food storage area in a safe, orderly, clean and sanitary manner .Ensures continued compliances with all federal, state and local regulations .</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Hanford Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  1007 West Lacey Blvd Hanford, CA 93230	

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Job Description: Maintenance Director, dated 9/18, the Essential Duties: .Coordinate maintenance services and activities with other related departments (i.e. dietary .). .Maintain and implement infection control and universal precaution policies and procedures to assure that a sanitary environment is maintained at all times .</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48739</p> <p>Based on interview, and record review, the facility failed to ensure accurate and complete medical records in accordance with professional standards of practices for three of five sampled residents (Residents 31, 43, and 54) when the Physician Orders for Life-Sustaining Treatment (POLST- a form that contains written medical orders for healthcare professionals regarding specific medical treatments that can or cannot be done at the end-of life) was not accurate and complete with section D - (physician/NP (Nurse Practitioner)/PA (Physician Assistant) License Number, NP Certificate Number, Physician/NP/PA Phone Number fields were not filled in, and the physician and the Resident or Resident Responsible Party (RP - legally recognized decision maker) signature and/or date fields were missing.</p> <p>These failure had the potential for Resident 31, 43, and 54's decisions regarding treatment options and end-of-life wishes to not be honored.</p> <p>Findings:</p> <p>During a review of Resident 31'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), dated [DATE], the AR indicated Resident 31 was admitted to the facility on [DATE] with diagnoses of metabolic encephalopathy (a condition where brain function is disturbed due to different diseases or toxins [poisons] in the blood), pulmonary edema (a buildup of fluid in the lungs), Type 2 Diabetes Mellitus (when the blood sugar levels in the body are too high), dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), heart failure (a condition when the heart muscle doesn't pump enough blood to meet the body's needs which can cause fatigue and shortness of breath), and major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities).</p> <p>During a review of Resident 31's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated [DATE], the MDS section C indicated Resident 31 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of ,d+[DATE] ) score of 10 (a score of ,d+[DATE] suggests severe cognitive impairment, ,d+[DATE] suggests moderately impaired, ,d+[DATE] suggests cognitively intact), which suggested Resident 31 was moderately impaired.</p> <p>During a review of Resident 31's POLST, dated [DATE], the POLST indicated Section D (physician/NP (Nurse Practitioner)/PA (Physician Assistant) License Number, NP Certificate Number, Physician/NP/PA Phone Number fields were not filled in, and the Resident or Resident Responsible Party (RP - legally recognized decision maker) signature and date fields were missing.</p> <p>During a review of Resident 31's Order Summary Report, dated [DATE], the Order Summary Report indicated . Do Not Attempt Resuscitation/DNR - Selective Treatment-No Artificial means of nutrition, including feeding tubes .</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and record review on [DATE] at 12:07 p.m. with the Medical Records (MR) Coordinator, Resident 31's POLST, dated [DATE] was reviewed. The POLST indicated section D had incomplete fields and the fields for Resident 31 and Resident 31's RP signature and date were missing. The MR stated a POLST informed staff and providers what the resident's wishes were for end-of-life care. The MR stated a POLST was a physician order. The MR stated physician orders needed to be signed and dated. The MR stated if there was an emergency with Resident 31 and Resident 31's POLST was not complete, staff would be expected to perform a full code (CPR - cardiopulmonary resuscitation [an emergency lifesaving procedure performed when the heart stops beating or breathing stops]) even if Resident 31 was a DNR (DNR - Do Not Resuscitate- a medical order written by a doctor to instruct health care providers NOT to do CPR). The MR stated all fields Resident 31's POLST should have been complete and filled in. The MR stated the time frame for POLST completion was upon admission. The MR stated the Medical Records department was responsible for making sure all fields of the resident's POLST were complete. The MR stated the physician phone number was important to be filled in so the receiving facility could call the physician if they had any questions regarding care. The MR stated the resident's POLST would go with the resident if they needed to be transferred out to another facility.</p> <p>During a concurrent interview and record review on [DATE] at 1:50 p.m. with Licensed Vocational Nurse (LVN) 1, Resident 31's POLST dated [DATE] was reviewed. LVN 1 stated Resident 31's signature and date sections of his POLST were cut off and fields of section D were not filled in. LVN 1 stated the signature section was important as it had the RP information and signature confirming Resident 31's wishes were discussed. LVN 1 stated Resident 31's POLST in the electronic medical record did not show a completed POLST. LVN 1 stated if Resident 31 was sent out of the facility, staff would print the POLST in system to send it with Resident 31. LVN 1 stated all areas in the POLST should have been complete.</p> <p>During a review of Resident 43's AR, dated [DATE], the AR indicated Resident 43 was admitted to the facility on [DATE] from the acute care hospital with diagnoses of cerebral ischemia (a condition in which a blockage in an artery restricts the delivery of oxygen-rich blood to the brain, resulting in damage to brain tissue), cognitive communication deficit (difficulty with thinking and how someone uses language), Type 2 Diabetes Mellitus (when the blood sugar levels in the body are too high), dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills, and eventually, the ability to carry out the simplest tasks), psychosis (a mental disorder characterized by a disconnection from reality), pneumonia (an infection that affects one or both lungs, causing the air sacs of the lungs to fill with fluid), major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities), and repeated falls.</p> <p>During a review of Resident 43's MDS, dated [DATE], the MDS section C indicated Resident 43 had a BIMS score of six, which suggested Resident 43 was severely cognitively impaired.</p> <p>During a review of Resident 43's Order Summary Report, dated [DATE], the Order Summary Report indicated, . DNR, Comfort focused Treatment, No artificial means of nutrition including feeding tubes .</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Hanford Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  1007 West Lacey Blvd Hanford, CA 93230	
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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and record review on [DATE] at 10:54 a.m. with LVN 2, Resident 43's POLST, dated [DATE] was reviewed. The POLST indicated section C had missing entries of Physician/NP/PA name, Physician/NP/PA phone number, Physician/PA license number and NP certification number. LVN 2 stated the POLST was a physician's order. LVN 2 stated the POLST informed staff if the resident was a DNR or if CPR was to be performed in an emergency. LVN 2 stated if the POLST was not complete, staff would perform CPR in an emergency and the resident's wishes would not be respected if he was a DNR. LVN 2 stated Resident 43's POLST should have had the physician phone number and license number areas filled in.</p> <p>During a concurrent interview and record review on [DATE] at 12:13 p.m. with the MR, Resident 43's POLST, dated [DATE] was reviewed. The POLST indicated section C had missing entries of Physician/NP/PA name, Physician/NP/PA phone number, Physician/PA license number and NP certification number. The MR stated not all fields of Resident 43's POLST were filled in. The MR stated the time frame to complete a resident's POLST was upon admission The MR stated the Medical Records Coordinator was responsible to be sure all fields were complete on the resident's POLST form. The MR stated the physician's phone number was important so the receiving facility could call the physician if they had any questions. The MR stated the POLST form would go with the resident if they needed to be transferred out of the facility.</p> <p>During a concurrent interview and record review on [DATE] at 2:02 p.m. with LVN 1, Resident 43's POLST, dated [DATE] was reviewed. The POLST indicated section C had missing entries of Physician/NP/PA name, Physician/NP/PA phone number, Physician/PA license number and NP certification number. LVN 1 stated section D of resident's POLST was not complete. LVN 1 stated Resident 43's POLST was not a completed POLST. LVN 1 stated all sections should have been filled in. LVN 1 stated Resident 43's POLST was important so staff would know what treatment to give if Resident 43 were to get into distress. LVN 1 stated a POLST would let staff know if they were to provide or not provide CPR according to Resident 43 or his family's wishes. LVN 1 stated staff would not know exactly what to do for Resident 43 if his POLST were not complete. LVN 1 stated staff would do CPR even if Resident 43 or his family did not want CPR if Resident 43's POLST was not complete.</p> <p>During a review of Resident 54's AR, dated [DATE], the AR indicated Resident 54 was admitted to the facility on [DATE] from the acute care hospital with diagnoses of Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), dysphagia (difficulty swallowing), dysarthria (difficulty speaking due to weak speech muscles), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), Type 2 Diabetes Mellitus (when the blood sugar levels in the body are too high), major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities), and repeated falls.</p> <p>During a review of Resident 54's MDS, dated [DATE], the MDS section C indicated Resident 54 had a BIMS score of s12, which suggested Resident 54 was moderately impaired.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and records review on [DATE] at 11:05 a.m. with LVN 2, Resident 54's POLST, dated [DATE] was reviewed. The POLST indicated Section D was not complete with Physician/NP/PA name, Physician/NP/PA phone number, Physician/PA license number and NP certificate numbers were not filled in. The Physician Signature and Resident Signature fields were not dated. LVN 2 stated Resident 54's POLST should have had the physician phone number and license number filled in, and the physician signature on Resident 54's POLST should have been dated. LVN 2 stated a POLST was a physician's order. LVN 2 stated the resident's POLST informed staff if the resident was a DNR or if staff was to perform CPR during an emergency. LVN 2 stated if the physician's signature was not dated, the order would be invalid, and staff would perform CPR. LVN 2 stated Resident 54's wishes would not be respected if he had a DNR order.</p> <p>During a concurrent interview and record review on [DATE] at 12:07 p.m. with the MR, Resident 54's POLST, dated [DATE] was reviewed. The POLST indicated Section D was not complete with Physician/NP/PA name, Physician/NP/PA phone number, Physician/PA license number and NP certificate numbers were not filled in. The Physician Signature and Resident Signature fields were not dated. The MR stated a POLST was important so staff would know what Resident 54 wanted done in case of an emergency. The MR stated the POLST was a physician order and physician orders needed to be signed and dated. The MR stated staff would be expected to do a full code on a resident even if the resident was a DNR, due to the POLST not being dated. The MR stated the time frame for POLST completion was upon admission. The MR stated the Medical Records Department was responsible to be sure all fields of the POLST were complete. The MR stated the physician phone number was important so the receiving facility could call the physician if they had any questions. The MR stated a copy of the POLST would go with the resident if he needed to be transferred out to another facility.</p> <p>During an interview on [DATE] at 3:28 p.m. with the Director of Nursing (DON), the DON stated her expectation was for resident's POLST to be filled out completely and signed by the appropriate people. The DON stated all sections of the resident's POLST should have been filled out. The DON stated the resident's POLST indicated the resident's code status and how staff would treat the resident in case of an emergency. The DON stated if the resident's status was a DNR and the POLST was incomplete, the resident would have to be a full code with CPR performed. The DON stated the resident's wishes would not be met. The DON stated a POLST was considered a physician's order, and if the POLST was not dated it was considered incomplete. The DON stated her expectations would be for residents to have a legible, fully completed POLST to be in the resident's medical record and sent with the resident if they were transferred to another facility.</p> <p>During a review of the facility's job description document titled, Medical Records Staff, dated ,d+[DATE], the document indicated, . the medical records department has the responsibility for the initiation, maintenance and filing of resident records . check new admissions for completion of required data to meet Licensing and Certification requirements . audit medical records .</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48739</p> <p>Based on observation, interview and record review the facility failed to maintain an effective infection prevention and control program for four of 14 sampled residents (Residents 29, 31, 73 and 84) when:</p> <ol style="list-style-type: none"> <li>1. Resident 29's urinary catheter (a flexible tube that drains urine from the bladder into a bag) bag was dragging on the ground while being pushed in his wheelchair.</li> </ol> <p>This failure placed Resident 29 at potential risk for cross contamination (the process by which bacteria or other microorganisms are unintentionally transferred from one substance or object to another, with harmful effect).</p> <ol style="list-style-type: none"> <li>2. Resident 29's urinary catheter bag was laying on the floor.</li> </ol> <p>This failure placed Resident 29 at potential risk for cross contamination.</p> <ol style="list-style-type: none"> <li>3. Resident 31's oxygen nasal cannula (O2 nasal cannula - a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) tubing was wrapped around the handle of his wheelchair, and his oxygen humidifier bottle (a sealed bottle of water that infuses moisture to the flow of oxygen) was on the floor.</li> </ol> <p>This failure placed Resident 31 at potential risk for cross-contamination which could led to respiratory infection (an illness that inflames the respiratory system, which includes the throat, nose, airways, and lungs).</p> <ol style="list-style-type: none"> <li>4. Resident 73's O2 nasal cannula tubing was placed on top of the oxygen concentrator (machine that delivers oxygen to a resident) and not stored in a bag.</li> </ol> <p>This failure placed Resident 73 at potential risk for cross-contamination which could led to respiratory infection.</p> <ol style="list-style-type: none"> <li>5. Resident 84's O2 nasal cannula was on the floor.</li> </ol> <p>This failure placed Resident 84 at potential risk for cross-contamination which could led to respiratory infection.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. During an observation on 1/24/25 at 1:45 p.m., in the south hallway, Resident 29's wheelchair was being pushed by Certified Nursing Assistant (CNA) and Resident 29's urinary catheter bag was dragging on the floor beneath his wheelchair.</li> </ol> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 29'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), dated 1/24/25, the AR indicated, Resident 29 was admitted to the facility on [DATE] with a diagnosis of muscle weakness (loss of muscle strength), muscle wasting (when your muscles shrink and lose strength), benign prostatic hyperplasia (prostate gland enlarges, which can make it difficult to urinate) and unsteadiness on his feet.</p> <p>During a review of Resident 29's Minimum Data Set (MDS - a resident assessment tool used to identify resident cognitive and physical function) assessment dated [DATE], Resident 29's MDS assessment indicated Resident 29's Brief Interview for Mental Status (BIMS -assessment of cognitive status for memory and judgment) assessment score was 8 out of 15 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07 indicates severe impairment). The BIMS assessment indicated Resident 29 was moderately impaired.</p> <p>During an interview on 1/24/25 at 3:37 p.m., with the Infection Preventionist (IP), the IP stated Resident 29's bag should have never touched the floor. The IP stated Resident 29 could have acquired an infection from the urinary bag touching the floor. The IP stated the policy and procedure for urinary catheter care was not followed.</p> <p>During an interview on 1/24/25 at 4:36 p.m., with the Director of Nursing (DON), the DON stated Resident 29's urinary catheter should have never touched the floor and was unacceptable. The DON stated Resident 29 had the potential risk for an infection which could led to sepsis (a life-threatening condition that occurs when the body's immune system overreacts to an infection). The DON stated the policy and procedure for urinary catheter care was not followed.</p> <p>During a review of the policy and procedure (P&amp;P) titled Catheter Care, Urinary, dated August 2022, the P&amp;P indicated, .The purpose of this procedure is to prevent urinary catheter-associated complications, including urinary tract infections . Infection Control: . Be sure the catheter tubing and drainage bag are kept off the floor .</p> <p>During a professional reference review from the Centers for Disease Control and Prevention (CDC) titled, Guideline for Prevention of Catheter-Associated Urinary Tract Infections 2009, dated 6/6/2019, (retrieved from <a href="https://www.cdc.gov/infection-control/media/pdfs/Guideline-CAUTI-H.pdf">https://www.cdc.gov/infection-control/media/pdfs/Guideline-CAUTI-H.pdf</a>) indicated, .Proper Techniques for Urinary Catheter Maintenance . 2. Keep the collecting bag below the level of the bladder at all times. Do not rest the bag on the floor .</p> <p>2. During a concurrent observation and interview on 1/24/25 at 2:45 p.m. with Licensed Vocational Nurse (LVN) 8, in Resident 29's room, Resident 29's urinary catheter bag was on the floor. LVN 8 stated the urinary catheter bag should not have been on the floor because it could cause cross contamination.</p> <p>During an interview on 1/24/25 at 3:08 p.m. with the IP, the IP stated Resident 29's urinary catheter bag on the floor was unacceptable. The IP stated Resident 29 could develop an infection from the urinary catheter on the floor.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 1/24/24 at 4:46 p.m. with the DON, the DON stated Resident 29's urinary catheter should have not been on the floor. The DON stated because Resident 29 was elderly he could be more at risk to develop an infection from the urinary catheter and would have a hard time recovering from the infection.</p> <p>During a review of the facility's P&amp;P titled, Catheter Care, Urinary, dated 10/22 indicated, . be sure the catheter tubing and drainage bag are kept off the floor .</p> <p>3. During an observation on 1/21/25 at 9:43 a.m. in Resident 31's room, Resident 31 was observed sleeping in bed. Resident 31's O2 concentrator was turned on, the O2 nasal cannula was on the bed, and the O2 humidifier bottle was on the floor.</p> <p>During a review of Resident 31's AR, dated 1/23/25, the AR indicated Resident 31 was admitted to the facility on [DATE] with diagnoses of pulmonary edema (a buildup of fluid in the lungs), heart failure (a condition when the heart muscle doesn't pump enough blood to meet the body's needs which can cause fatigue and shortness of breath), and major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities).</p> <p>During an interview on 1/23/25 at 10:39 a.m. with the IP, the IP stated Resident 31's cannula should have been placed inside a zip lock bag when not in used and not on the bed. The IP stated the O2 humidifier bottle should have never touched the floor. The IP stated Resident 31 was at risk for cross contamination which could result to a respiratory infection.</p> <p>During a review of the facility lesson plan document titled, IC - O2 Supply Safe Handling &amp; Storage, undated, indicated, . store items not in use in bags when in resident care area . O2 supplies found to be contaminated or found on floor, discard and notify LN for replacement process .</p> <p>4. During a concurrent observation and interview on 1/21/25 at 10:38 a.m. with Resident 73, Resident 73's nasal cannula was on top of the O2 concentrator. Resident 73 stated she had (COPD- condition in which the airways shrink making it harder to breath) and had trouble breathing which she needs extra oxygen.</p> <p>During an interview on 1/23/25 at 10:48 a.m. with CNA 5, CNA 5 stated O2 tubing when not in used should be placed inside a bag to prevent contamination.</p> <p>During a review of resident 73's AR, dated 1/23/25, the AR indicated, Resident 73 was admitted with COPD, acute and chronic respiratory failure (condition in which the lungs have a hard time loading the blood with oxygen) and shortness of breath (the feeling of not being able to breathe normally or deeply enough).</p> <p>During an interview on 1/23/25 at 4:23 p.m. with Respiratory Therapist (RT) 1, RT 1 stated Resident 73's nasal cannula should not have been placed on top of the O2 concentrator when not in use and should be inside a bag to prevent cross contamination.</p> <p>During an interview on 1/24/25 at 2:39 p.m. with the IP, the IP stated oxygen tubing needed to be placed inside a bag when not in use to prevent cross-contamination which could result to respiratory infection.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a professional reference review, retrieved from <a href="https://masvidahealth.com/oxygen-concentrators/maintenance-guide-how-to-clean-a-nasal-cannula-of-an-oxygen-concentrator">https://masvidahealth.com/oxygen-concentrators/maintenance-guide-how-to-clean-a-nasal-cannula-of-an-oxygen-concentrator</a> titled, Maintenance Guide: How To Clean A Nasal Cannula Of An Oxygen Concentrator, undated, indicated, . Always store the nasal cannula in a clean, dry place .Use a dedicated storage container or bag that is also clean and free from contaminants .</p> <p>5. During an observation on 1/21/25 at 10:15 a.m. Resident 84 was observed lying in bed with their nasal cannula (device that delivers additional oxygen through your nose) on the floor.</p> <p>During the review of Resident 84's AR dated 1/3/25, the AR indicated Resident 84 was admitted on [DATE] with the diagnoses of: Acute (condition developed suddenly) and chronic (condition developed slowly overtime) respiratory failure (lungs cannot get enough oxygen into the blood) and pneumonia (infection had caused inflammation and fluid buildup in the lungs, making it difficult to breath).</p> <p>During an interview on 1/23/25 at 11:07 a.m. with RT1, RT1 stated the O2 nasal cannula should be stored inside a bag when not used to prevent cross contamination.</p> <p>During an interview on 1/24/25 at 2:15p.m. with the IP, the IP stated nasal cannulas were considered contaminated if not stored inside a bag when not in use. The IP stated the expectation was for license nurses to store nasal cannulas inside a bag when not used.</p> <p>During a review of the facilities lesson plan titled 02 Supply Safe Handling and Storage dated 1/21/25, indicated, .when and how to replace oxygen tubing .storing tubing when not in use .store items not in use in bags .oxygen supplies found to be contaminated or found on floor, discard and notify of replacement process .</p> <p>48424</p> <p>51271</p> <p>51134</p> <p>41166</p>		

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<p>F 0912</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47888</b></p> <p>Based on observation and staff interview during the survey period from 1/21/25 through 1/24/25, the facility failed to ensure each bedroom had 80 square feet of usable living space for residents in four different rooms (room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER] and room [ROOM NUMBER]).</p> <p>Findings:</p> <p>Throughout the survey period from 1/21/25 through 1/24/25 four resident bedrooms had more than three residents in each bedroom. Rooms 106, room [ROOM NUMBER], room [ROOM NUMBER] and room [ROOM NUMBER] had four residents per room and had less than 80 square feet for each resident. Although the bedrooms accommodated less than 80 square feet for each resident, each room met the required needs of the residents. The residents had a reasonable amount of privacy, and closet and storage space was adequate. Bedside stands were available. There was sufficient room for nursing care and for the mobility of the residents. Wheelchairs, devices, and toilet facilities were accessible. The health and safety of the residents will not be adversely affected by the continuance of this waiver.</p> <p>Room Number: Number of Beds/Residents: Square Footage per Resident:</p> <p>106 4 318.3 square feet (sq ft- unit of measurement: 79.5 square feet per resident)</p> <p>108 4 295.1 sq ft (73.7 sq ft per resident)</p> <p>110 4 300.2 sq ft (75 sq ft per resident)</p> <p>119 4 317.0 sq ft (79.2 sq ft per resident)</p> <p>Recommend waiver continue in effect</p> <p>Don [NAME], HFES</p> <p>Health Facilities Evaluator Supervisor Date</p> <p>Request waiver continue in effect.</p> <p>-----</p> <p>Administrator Date</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51271</b></p> <p>Based on observation, interview, and record review the facility failed to ensure call lights were within reach for two of three sampled residents (Resident 20 and 65) when call lights were observed clipped to privacy curtains and out of reach.</p> <p>This failure had the potential for Resident 20 and 65 not to receive help when in need or in the event of an emergency.</p> <p>Findings:</p> <p>During a review of Resident 20's Admission Record (AR- a document that provides resident contact details, a brief medical history, level of functioning, preferences, and wishes) dated 7/13/23, the AR indicated Resident 20 was readmitted on [DATE] with the diagnosis of: generalized muscle weakness, gait, and mobility abnormalities (abnormal pattern of foot movement and muscle coordination), and history of falling.</p> <p>During a review of Resident 20's Minimum Data Set (MDS- resident assessment tool which indicated physical and cognitive abilities), dated 12/17/24, the MDS indicated a Brief Interview for Metal Status (BIMS- an assessment of cognitive function) score of five (0-7 severe cognitive impairment, 8-12 moderate cognitive impairment, 13-15 no cognitive impairment), which indicated Resident 20 had severe cognitive impairment.</p> <p>During a concurrent observation and interview on 1/21/24 at 9:30 a.m. in Resident 20's room, Resident 20 was observed lying in bed with their call light clipped to the privacy curtain, out of reach. Resident 20 stated she could not reach her call light.</p> <p>During a review of Resident 20's Care Plan (CP is a document that outlines the care and support a person will receive), initiated 7/14/24, the CP indicated Resident 20 was to have their call light within reach.</p> <p>During the review of Resident 65's AR, dated 8/17/22, the AR indicated Resident 65 was admitted on [DATE] with the diagnosis of: Hemiplegia (weakness of muscles on one side of the body that affected the arms, legs and facial muscles), history of falling, cognitive communication deficit (struggled with effective communication), and gait and mobility abnormalities (abnormal pattern of foot movement and muscle coordination).</p> <p>During a review of Resident 65's MDS, dated [DATE], the MDS indicated a BIMS score of thirteen, which indicated Resident 65 had no cognitive impairment.</p> <p>During a concurrent observation and interview on 1/21/24 at 10:47 a.m. in Resident 65'S room, Resident 65 was observed sitting up in bed with their call light clipped to the privacy curtain, out of reach. Resident 65 stated that he could not reach his call light and that the call light on his bed would be better. Resident 65 stated that he waited until staff came into his room to ask for assistance.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  056288	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/24/2025
NAME OF PROVIDER OR SUPPLIER  Hanford Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  1007 West Lacey Blvd Hanford, CA 93230	
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 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 65's MDS, dated [DATE], the MDS section GG indicated Resident 65 required maximum assistance with toileting and personal hygiene.</p> <p>During a review of Resident 65's CP, initiated 11/4/24, the CP indicated Resident 20 is to have their call light within reach.</p> <p>During an interview on 1/23/25 at 11:35 a.m. with Certified Nursing Assistant (CNA) 2, CNA 2 stated the call light should have been placed on Resident 20 and Resident 65's bed and not on a bedrail or privacy curtain. CNA 2 stated the call lights were clipped on Resident 20 and Resident 65's privacy curtain and were out of reach, preventing the residents from using them. CNA 2 stated it was important to have call lights within reach to avoid Resident 20 and Resident 65 from attempting to get up or move around without assistance, reducing the risk for falls. CNA 2 stated residents were at risk for falling if they attempted to get up by themselves.</p> <p>During an interview on 1/23/25 at 2:38 p.m. with License Vocational Nurse (LVN) 2, LVN 2 stated call lights should be placed next to the residents, ensuring they had access to assistance when needed. LVN 2 stated call lights were essential for residents to request help, get their questions answered, and have their needs met. LVN 2 stated Resident 20 and Resident 65' call lights should have been clipped to the bed within reach and not secured to the bed rail or curtain which were out of reach. LVN 2 stated Resident 20 and Resident 65 were not able to use their call lights to request for assistance and were at risk for falls.</p> <p>During an interview on 1/24/25 at 3:05 p.m. with the Director of Nursing (DON), the DON stated call lights should be clipped on the bed's fitted sheet within reach and not secured to the bed rail or privacy curtains which were out of reach. The DON stated it was her expectation of staff to ensure the residents' call lights were always within reach.</p> <p>During a review of the facilities policy and procedure (P&amp;P) titled Answering the Call Light dated 10/2010, indicated, .when the resident is in bed, or confined to a chair be sure the call light is within easy reach of the resident .answer the resident's call as soon as possible .</p>		