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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555513	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/02/2024
NAME OF PROVIDER OR SUPPLIER: Palm Village Retirement Comm.		STREET ADDRESS, CITY, STATE, ZIP CODE: 703 W Herbert Ave, Reedley, CA 93654	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38517 Based on interview, record review, and facility policy review, the facility failed to provide one of one resident (Resident (R)118) reviewed for hospital transfers out of a total sample of 33 residents a written transfer notice when R118 was transferred to the hospital. This failure placed all residents and their representatives at risk of having incomplete information, misunderstand the reason of transfer/discharge, and the discharge appeal process. Findings include: Review of the facility's policy titled Transfer and Discharge Notice dated 06/2017 read in part 1. The resident and, if known, a family member or resident representative shall be notified in writing and in a language and manner they understand, of the transfer or discharge and the reason for the move before a transfer or discharge takes place. Review of R118's undated Facesheet located in the resident's electronic medical record (EMR) under the Profile tab revealed the resident was admitted to the facility on [DATE]. Review of R118's Notice of Transfer/Discharge, revealed R118 was transferred to hospital on 05/09/24. Notice of Transfer/Discharge was not signed by R118 or R118's representative. The facility lacked evidence that written notice was given to R118 or the representative for R118. During an interview on 08/01/24 at 11:13 AM, the Social Worker (SW) confirmed the facility failed to provide the written notice of transfer/discharge form to R118 or the representative for R118 upon or soon thereafter the resident's transfer to the hospital. The SW confirmed the facility generated the form themselves and sent it to the ombudsman; however, residents nor their representatives were provided the written notice of transfer/discharge form.

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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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palm Village Retirement Comm.	703 W Herbert Ave Reedley, CA 93654

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38517 Based on interview, record review, and facility policy review, the facility failed to provide one of one residents (Resident (R) 118) reviewed for hospital transfers out of a total sample of 33 residents a written bed hold when R118 was transferred to the hospital. This failure This failure placed all residents of the facility at risk for the resident and/or responsible parties to not have the information needed to safeguard their return to the facility. Findings include: Review of the facility's policy titled Bed-Hold Notification dated 01/2017 read in part .Inform the resident or resident's representative, in writing, of their right to exercise the bed hold provision and the state bed-hold policy of seven (7) days, which will permit the resident to return and resume .provide written information at the time of admission and transfer to general acute care hospital or for a therapeutic leave. Review of R118's undated Facesheet located in the resident's electronic medical record (EMR) under the Profile tab revealed the resident was admitted to the facility on [DATE]. Review R118's Progress Note dated 05/09/24 and located in the resident's EMR under the Progress Notes tab, revealed R118 was ordered to the hospital by their physician on 05/09/24. the Progress Note stated R118 had a bed hold for 7 days. Review of R118's EMR revealed no documented evidence the facility provided R118 or R118's representative a copy of the facility's bed hold notice at the time of transfer to the hospital. During an interview on 08/01/24 at 2:33 PM, the Admission Director (AD) confirmed the facility failed to provide the facility's bed hold notices to R118 upon transfer to the hospital. The AD confirmed the facility was not aware they were supposed to be doing bed hold notices upon a resident's transfer to the hospital. During an interview on 08/02/24 at 11:03 AM, the Administrator stated it was their expectation for bed holds to be done upon admission and upon a resident's transfer or discharge from the facility. The Administrator confirmed the facility failed to provide written bed hold notices and stated they were only doing them verbally.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 38517 Based on interview, record review, and review of the facility's policy, the facility failed to ensure a Registered Nurse (RN) was on duty eight consecutive hours in a 24 hour period, seven days a week. This placed all residents of the facility at risk for unmet clinical needs either directly by the lack of RN coverage or indirectly by the Licensed Practical Nurses (LPNs) or the Certified Nurse Aides (CNAs) for whom the RN was responsible for overseeing resident care. Findings include: Review of a facility's policy titled Departmental Supervision, Nursing, revised 08/2022 revealed .2. A registered nurse provides services at least eight (8) consecutive hours every 24 hours, seven (7) days a week. RNs may be scheduled more than eight hours depending on the acuity needs of the resident . Review of the facility's Nursing Schedules, dated 12/24/23 through 08/02/24, provided by the Administrator indicated no documented evidence a RN worked eight consecutive hours in a 24 hour period on 01/01/24, 01/06/24, 01/07/24, 01/01/24, 01/19/24, 01/20/24, 01/28/24, 02/03/24, 02/04/24, 02/10/24, 02/18/24, 03/02/24, 03/09/24, 03/16/24, 03/29/24, 03/30/24, 04/13/24, 04/26/24, 04/27/24, 05/10/24, 05/11/24, 05/18/24, 05/25/24, 06/02/24, 06/08/24, 06/09/24, 06/15/24, 06/22/24 and 06/30/24. During an interview on 08/02/24 at 10:58 AM, the Administrator confirmed the facility did not have RN coverage eight consecutive hours seven days a week for the dates listed above. The Administrator also stated the facility had been actively searching for RNs to hire. The Administrator further stated the facility had supported several of their LPNs in transitioning to RNs; however, they do not stay with the company.