STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555866	A. Building B. Wing	08/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sierra Vista Healthcare	1715 South Cedar Fresno, CA 93702

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47298 Based on observation, interview and record review, the facility failed to ensure residents received adequate supervision to prevent accident hazards (an unexpected injury or illness that occurred due to the resident ' s environment) for one of three sampled residents (Resident 1) when Resident 1 who had dementia (condition of progressive loss of memory, language and other thinking abilities which requires increased supervision of the individual) and had a known behavior of moving around in the facility in the wheelchair independently, exited unsupervised to the rose garden outside. Resident 1 was found in an area of the rose garden exposed to the sun for an unknown amount of time on a day temperatures reached up to 108 degree Fahrenheit (unit of temperature measurement). This failure resulted in Resident 1 sustaining second- degree burns (a burn that affects the outer and middle layers of skin which results in blistering, swelling, redness and pain) on top of his scalp, right ear, posterior (back side) neck, left shoulder and both knees and an acute kidney injury (a sudden episode of kidney damage), which required treatment at an acute care hospital. Findings: During record review of Resident 1 ' s Admission Record (AR- a document that provides resident contact details, a brief medical history), the AR indicated, Resident 1 had diagnoses which included .BURN OF SECOND DEGREE SCALP .CHRONIC KIDNEY DISEASE, STAGE 3 (CKD- a condition where the kidneys have moderate damage and are less able to filter waste and fluid from the blood) .TYPE 2 DIABETES MELLITUS (a problem in the way the body regulates and uses blood sugar) .ALZHEIMER ' S DISEASE (brain disorder which slowly destroys memory and thinking skills) .UNSPECIFIED DEMENTIA .BURN OF SECOND DEGREE OF NECK .BURN OF SECOND DEGREE OF RIGHT KNEE .BURN OF SECOND DEGREE OF LEFT SHOULDER .BURN OF SECOND DEGREE OF RIGHT EAR . During a review of Resident 1's Minimum Data Set (MDS- a standardized assessment and care screening tool), dated 7/22/24, the MDS indicated, Resident 1's Brief Interview for Mental Status (BIMS- an evaluation of attention, orientation and memory recall) indicated a score of 6 (0-7 severe cognitive impairment, 8-12 moderate cognitive impairment, 13-15 no cognitive impairment), indicating Resident 1 had severe cognitive impairment (an intense inability to think, remember, use judgement and make decisions which requires frequent supervision of the individual). (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 8/2/24 at 10:22 a.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated, staff would always have to supervise Resident 1 because he would wheel himself around the facility in his wheelchair and was always trying to go home. CNA 1 stated, Resident 1 was a fall risk and had alarms on his bed and wheelchair to alert the staff when he got up without assistance. CNA 1 stated, the staff should not have allowed Resident 1 to be outside alone without staff supervision due to the risk of being sunburned. During an interview on 8/2/24 at 10:31 a.m. with Social Services Director (SSD), SSD stated, Resident 1 was discharged from the facility on 7/22/24 with orders for nursing care to treat his wounds. SSD stated, Resident 1 had a right ear second degree burn, right knee second degree burn, left shoulder second degree burn, posterior neck second degree burn and a second degree burn to the top of Resident 1 ' s scalp. During an interview on 8/2/24 at 10:48 a.m. with Director of Nursing (DON), DON stated, Resident 1 had sundowners (a person with dementia who becomes increasingly irritable as the day progresses) behaviors and yelled out for his wife. DON stated, Resident 1 was in a wheelchair and liked to go outside. DON stated, Resident 1 was admitted to the hospital from 6/24/24 until 7/2/24 to be treated for the burns that were sustained while residing at the facility which required further evaluation and treatment. During an interview on 8/2/24 at 10:57 a.m. with Assistant Director of Nursing (ADON), ADON stated, Resident 1 opened the door and wheeled himself out into the sun-exposed area of the rose garden patio on 6/23/24 and was outside without staff supervision for an unknown amount of time. ADON stated, an AM (morning shift that works from 7 am to 3 pm) CNA saw Resident 1 outside, alerted a PM (night shift that works 3 pm to 11 pm) CNA of Resident 1 ' s location outside and the PM CNA brought Resident 1 inside. ADON stated, it was not known how long Resident 1 was outside for. ADON stated, blisters were found on Resident 1 ' s scalp and neck and treatments to the affected areas were completed. ADON stated, Resident 1 was found to have inflammation and swelling to the face, neck and scalp on 6/24/24. ADON stated, Resident 1 was sent to the hospital for evaluation due to the swelling and was gone from the facility for about a week. During an interview on 8/2/24 at 11:03 a.m. with DON, DON stated Resident 1 was originally admitted on [DATE] to the facility and the first blisters were observed during the NOC (overnight shift that works 11 pm to 7 am) shift by staff on 6/23/24. DON stated, Resident 1 had a popped blister to the posterior neck which was open and contained slough (material covering wound bed that is made of dead tissue, pus and other debris) when he came back from the hospital. DON stated, Resident 1 also had an open and popped blister to the scalp, a popped left shoulder blister, a popped right ear blister, a popped right knee blister and an intact left knee blister when Resident 1 returned back from the hospital. During an interview on 8/2/24 at 11:29 a.m. with DON, DON stated, staff interviews were completed regarding this incident and staff reported Resident 1 was at the sun-exposed, far end of the rose garden prior to being brought inside. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an observation on 8/2/24 at 11:46 a.m. outside in the rose garden, the rose garden was positioned in the center of facility. The rose garden contained concrete paths around the perimeter, a covered patio area and grass. The covered patio area was located on the side closest to the only door used to access this outdoor area. The farthest area of the rose garden had a concrete path and was unshaded. During an interview on 8/2/24 at 11:58 a.m. with CNA 2, CNA 2 stated, she worked the AM shift on 6/23/24 and saw Resident 1 sitting in the rose garden at the end of the shift. CNA 2 stated, CNA 2 went and told PM shift staff that Resident 1 was outside and needed to be brought back inside. CNA 2 stated, Resident 1 was a fall risk. CNA 2 stated, Resident 1 should have been supervised and not left unattended outside because it was the staff ' s responsibility to ensure safety and security for the residents. During a phone interview on 8/8/24 at 9:41 a.m. with CNA 4, CNA 4 stated, she was working the PM shift on 6/23/24 and at the start of the shift, another CNA was leaving, looked out to the rose garden and saw a resident sitting outside alone. CNA 4 stated, Resident 1 was in the rose garden on the sidewalk on the far side, which was unshaded. CNA 4 stated, Resident 1 was strong enough to open the door, get outside and wander in the rose garden. CNA 4 stated, the temperature outside was at least 110 degrees Fahrenheit. CNA 4 stated, she went outside, approached Resident 1 and said Resident 1 should come inside due to the excessive heat. CNA 4 stated, it was unknown how long Resident 1 had been outside and the skin on Resident 1 ' s arm was warm to touch. CNA 4 stated, CNA 4 brought Resident 1 inside to cool down. CNA stated, Resident 1 was provided with cold water and a popsicle in order to make Resident 1 ' s temperature lower. CNA 4 stated, Resident 1 was placed near his assigned nurse for the shift so the nurse could assess Resident 1. CNA 4 stated, facility staff did not pay attention where Resident 1 wandered to and should have supervised Resident 1 because it was so hot outside. CNA 4 stated, it was best to monitor the residents and residents should not be left unattended at any point. During a phone interview on 8/9/24 at 3:22 p.m. with Licensed Vocational Nurse (LVN) 1, LVN stated, Resident 1 had a diagnosis of dementia. LVN 1 stated, LVN 1 worked the 6/23/24 NOC shift which started at 11 pm. LVN 1 stated, a CNA alerted LVN 1 of a blister on the top of Resident 1 ' s head during that shift on 6/24/24. LVN 1 stated, the RN (registered nurse) supervisor was notified to assess Resident 1, notified the NP (Nurse Practitioner) and the wound was treated. LVN 1 stated, the treatment nurse and wound doctor came in the morning of 6/24/24 and were notified to treat and evaluate Resident 1. LVN 1 stated, Resident 1 also had multiple small and intact blisters to the back of his neck. LVN 1 stated, LVN 1 was notified by the NOC CNA that Resident 1 was outside earlier in the day and was wheeled into the facility by a CNA. LVN 1 stated, it was very hot the day this incident occurred. LVN 1 stated, Resident 1 should not have been left unattended and needed monitoring. LVN 1 stated, Resident 1 should have been closely monitored to prevent Resident 1 from getting dehydrated by being outside, getting lost or sustaining a fall. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a phone interview on 8/9/24 at 3:48 p.m. with LVN 2, LVN 2 stated, Resident 1 was alert and oriented to his name only and answered questions with one word only. LVN 2 stated, she worked the PM shift on 6/23/24. LVN 2 stated, Resident 1 had been outside and the PM CNA brought Resident 1 inside. LVN 2 stated, she observed Resident 1 after PM CNA gave him water, a popsicle and checked his vitals. LVN 2 stated, the CNAs requested LVN 2 to assess Resident 1 in the evening because swelling was noted to his face. LVN 2 stated, Resident 1 had swelling to the side of his face. LVN 2 stated, the NP was notified and orders obtained to send Resident 1 to the hospital. LVN 2 stated, Resident 1 was sent to the hospital on the evening of 6/24/24 was diagnosed with second-degree burns. LVN 2 stated, Resident 1 should have been supervised outside due to the possibility of wandering, not knowing what they were doing and potentially falling. During a phone interview on 8/9/24 at 4:14 p.m. with CNA 5, CNA 5 stated, Resident 1 was confused, not fully alert, dependent on staff and a fall risk. CNA 5 stated, CNA 5 worked the AM shift on 6/23/24. CNA 5 stated, Resident 1 was outside at the end of CNA 5 ' s shift. CNA 5 stated, another CNA saw Resident 1 outside and notified the other staff about his location. CNA 5 stated, Resident 1 should have been closely supervised because Resident 1 was not alert, didn ' t know what was going on and was also a fall risk. During a concurrent phone interview and record review on 8/13/24 at 4:00 p.m. with DON, Hospital 1 ' s SNF Packet (SP- Patient documentation provided by Hospital 1 to SNF facility), dated 7/1/24 was reviewed. The SP indicated, .Chief Complaint .Blister Pt [patient] brought in by ambulance for blisters to top of head and posterior neck secondary to being outside yesterday for unknown amount of time. Today blisters popped, facility would like skin sites evaluated .found to have second degree burn in the scalp and neck. Cr [Creatinine- a chemical waste product in the blood, urine and muscle where a high result can indicate a kidney problem] increased to 2.0 from 1.3. BUN [Blood Urea Nitrogen- a substance in the blood created when protein breaks down and a high level can indicate kidney problems] 52 from 37 .Acute kidney injury superimposed [a secondary diagnosis occurring during or immediately following the original diagnosis] on CKD .Likely due to dehydration from staying under the sun yesterday Associated with second degree burn in the scalp and neck .2nd degree (blister) burn of scalp and neck from contact with sunlight; probably related to underlying dementia; Total body surface area: <10% . DON stated, Resident 1 was sent to the hospital and it was reported to the hospital staff that Resident 1 was outside for an unknown amount of time. DON stated, the hospital diagnosed Resident 1 with second-degree burns and an acute kidney injury. DON stated, Resident 1 had a known diagnosis of dementia with behaviors of wandering in his wheelchair outside and because of this should have been supervised while outside in the rose garden. DON stated, due to the lack of supervision for Resident 1 while he was alone outside unprotected on a hot day, he sustained and was hospitalized for second-degree burns to the scalp, ear, neck, shoulder and knees as well as an acute kidney injury. DON stated, staff should have done frequent rounding and checking on Resident 1 while he was outside for safety purposes, to assess for pain and to make sure staff can monitor for anything Resident 1 could not have verbalized for himself. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1 ' s Progress Notes (PN), dated 6/24/24, the PN indicated, .06/24/2024 04:57 . NOC cna reported to writer that pm cna reported to her that am cna found the resident outside (in between am and pm shift) AM cna quickly wheel in resident inside the facility. NOC cna reported to writer resident has big open blister on top of the head, multiple intact blister on the back of the neck w/ [with] redness discoloration and warm to touch. Writer assess, notified noc RN supervisor .Treatment applied as per NP order Cleanse w/ ns [normal saline], pat dry, apple triple ABX [antibiotic], covered xerofoam [a fine mesh gauze dressing that has medication within it to promote wound healing] dressing. To be evaluated by treatment nurse and wound doctor this morning . During a review of Resident 1 ' s PN, dated 6/24/24, the PN indicated, .06/24/2024 11:09 .Seen resident this morning as endorsed from previous shift, resident had blister to his head. Noted dressing on his off and open blister red in color, no bleeding, with 2 small intact fluid filled on surrounding area. Also noted scattered intact blister on posterior neck .treatment orders clarified .Monitor intact blisters for untoward signs of skin breakdown . During a review of Resident 1 ' s PN, dated 6/24/24, the PN indicated, .06/24/2024 11:16 .Report from nursing staff received that resident propels self towards lobby most of the time when he is up. Has Dx [diagnosis] of Dementia, verbally responsive .Spoke with resident, verbalizes wants to go home, resident in his room at this time. NP .made aware via phone, ordered to apply wander guard [an alarm system used to monitor residents who are at risk of leaving a safe area] due his exit seeking behavior . During a review of Resident 1 ' s PN, dated 6/24/24, the PN indicated, .06/24/2024 22:29 [10:29 p.m.] . Nurse was notified of swelling to resident ' s face, head and neck swelling with scattered large blisters .NP . notified with orders to send out for further evaluation. Patient sent out to [name of Hospital- Hospital 1] . During a review of Resident 1 ' s Hospital 1 ' s Emergency Department Timeline (EDT), dated 6/24/24, the EDT indicated, .ED [Emergency Department] Pt Care Timeline .Arrival .06/24/2024 21:28 [9:28 p.m.] .Chief Complaints .Blister (Pt brought in by ambulance for blisters to top of head and posterior neck secondary to being outside yesterday for unknown amount of time. Today blisters popped, facility would like skin sites evaluated) .IV fluid Indication .clinical dehydration .SW [Social Worker] Consult .SW called [ADON] .to ask if patient was locked out of the facility. Per [ADON], patient went out to the garden to sit .she is not sure how long patient sat outside. When patient came inside, they realized there were blisters on his head .Case Management Initial Screening .Contacted pt ' s spouse .Spouse reports she .was told pt was found outside and ended up getting blisters due to the heat .Contacted .admissions at [skilled nursing facility name] .Per . staff did not bring pt outside as it was over 100 degrees yesterday . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1 ' s Admission Readmission Screen and Baseline Care Plan (RS), dated 7/2/24, the RS indicated, .07/02/2024 21:42 [9:42 p.m.] .admitted From .Acute Hospital .Admitting Diagnosis . Acute Kidney injury .Level of cognitive impairment .Severe impairment (affecting all areas of judgment) .With exit-seeking behavior .Amoxicillin [medication used to treat infections] Oral Tablet 500 MG [milligram- unit of weight measurement] .1 tablet by mouth every 8 hours for Partial thickness [second-degree] burn of scalp . Resident is a returning patient of this facility, prior to transfer to acute care, resident noted to have multiple areas of popped blisters, as per skin assessment upon arrived, popped blister to posterior neck- L [length] 6. 5 cm (centimeter- unit of length measurement), W [width] 7 cm, D [depth] UTD [depth unknown] - wound bed 90% necrotic [death of normally living tissue] tissue, mild drainage noted, no mal [foul] odor .popped blister to left shoulder, wound bed pink in color, popped blister to top of head . The RS indicated, Resident 1 had a popped blister to the top of his head which measured 17 cm by 10 cm by 0.1 cm; a popped blister to the right ear which measured 2.5 cm by 2 cm by 0.1 cm; a popped blister to the right knee which measured 2.5 cm by 4 cm by 0.1 cm; a popped blister to the left shoulder which measured 3.5 cm by 5 cm by 0.1 cm; a popped blister to the posterior neck which measured 6.5 cm by 7 cm by an undetermined depth; an intact blister to the left knee. During a review of Resident 1 ' s PN, dated 7/2/24, the PN indicated, .resident readmitted with diagnosis of Acute Kidney Injury .Resident is a returning patient of this facility, prior to transfer to acute care, resident noted to have multiple areas of popped blisters . During a review of Resident 1 ' s Progress Note Details (PND), dated 7/8/24, the PND indicated, .complaints of increased Pain .initial exam- pt wound consulted and tx [treatment] in place. pt with stable wound with numerous complex medical conditions .patient high risk for medical complications, skin breakdown, infection, sepsis [life-threatening emergency when the body ' s response to an infection damages vital organs] and even death . Wound #1 Scalp is a Burn .measurements are 11cm x 10cm width x 0.2 cm depth . small amount of serous [clear, watery fluid] drainage .Wound bed has 71-80, bright red, granulation [development of new tissue and blood vessels], 11-20% slough . Wound #2 Posterior Neck .measurements are 4cm length x 7 cm width with no measurable depth Small amount of serous drainage .Wound bed has 41-50%, bright red, granulation, 41-50% slough .Wound #3 Left Shoulder is a Burn . measurements are 4cm length x 2cm width with no measurable depth .Small amount of serous drainage .Wound bed has 81-100% slough . During a review of Resident 1 ' s PND, dated 7/15/24, the PND indicated, .Wound #1 Scalp is a Burn . Subsequent wound encounter measurements are 11cm x 10 cm width x 0.2 cm depth .Small amount of serous drainage .Wound bed has 71-80%, bright red, granulation, 11-20% eschar [hardened, dry black or brown dead tissue] .Wound #2 Posterior Neck .Subsequent wound encounter measurements are 4cm length x 7cm width with no measurable depth .no drainage noted .Wound bed has 91-100% eschar .Wound #3 Left Shoulder is a Burn .Subsequent wound encounter measurements are 3cm length x 1cm width with no measurable depth .no drainage noted .wound bed has 91-100% eschar .Wound #4 Right Knee is a Burn . Initial wound encounter measurements are 1cm length x 1cm width with no measurable depth .no drainage noted .91-100% eschar . During a review of Resident 1 ' s PN, dated 7/22/24, the PN indicated, .Resident seen by Dr [doctor] .this morning. Burn (2nd degree burn) wound to Scalp, posterior neck, and shoulder .100% necrotic area . awaiting referral to wound clinic. To continue with present treatment orders . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of Order Summary Report (OSR), dated 8/2/24, the OSR indicated .Active Orders As Of: 07/21/2024 .Cleanse [clean] 2nd degree burn wound on top of scalp with NS [normal saline], pat dry and apply [Silver Sulfadiazine brand name- medication used to prevent and treat burn wound infection] cream and leave open to air in the morning for 14 Days . Cleanse 2nd degree burn wound on L [left] shoulder with NS, pat dry and apply Silvadene cream and leave open to air in the morning for 14 Days . Cleanse 2nd degree burn wound on Posterior neck with NS, pat dry and apply Silvadene cream and leave open to air in the morning for 14 Days . Cleanse R [right] ear 2nd degree burn with NS, pat dry and apply Silvadene cream and leave open to air in the morning for 14 Days . Cleanse R knee 2nddegree burn with NS, pat dry and apply Silvadene cream and leave open to air in the morning for 14 Days .Refer to Burn clinic for further evaluation and management of 2nd degree burn to scalp, neck shoulder .Resident may discharge to home on 7/21/24 with same medications .RN for wounds .Silver SulfaDIAZINE External [outer] Cream 1% .Apply to scalp, neck topically every day and evening shift for Burn . During a review of Resident 1 ' s Care Plan (CP), undated, the CP indicated, .Altered skin integrity r/t [related to] LEFT SHOULDER OPEN AREA .Date Initiated: 07/02/2024 .LEFT SHOULDER OPEN AREA will be free from signs and symptoms of redness, swelling and foul smelling drainage .Observe for s/s [signs and symptoms] of pain, redness, swelling and foul smelling drainage on site and notify MD [doctor of medicine] and responsible party as indicated .Check resident ' s skin condition for presence of skin breakdown during care, bathing and shower .Treatment as order .Monitor response to treatment During a review of Resident 1 ' s CP, undated, the CP indicated, .Altered skin integrity r/t OPEN AREA TO RIGHT EAR .Date Initiated: 07/02/2024 .OPEN AREA TO RIGHT EAR will be free from signs and symptoms of redness, swelling and foul smelling drainage .Observe for s/s of pain, redness, swelling and foul smelling drainage on site and notify MD and responsible party as indicated .Check resident ' s skin condition for presence of skin breakdown during care, bathing and shower .Treatment as order .Monitor response to treatment During a review of the AccuWeather website https://www.accuweather.com/en/us/fresno/93702/june-weather/327144, dated 6/24, the website indicated the temperature on 6/23/24 was a high of 108 degrees Fahrenheit. During a review of the facility ' s policy and procedure (P&P) titled, Safety and Supervision of Residents, 7/17, the P&P indicated, .Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities .The interdisciplinary care team shall analyze information obtained from assessments and observations to identify any specific accident hazards or risks for individual residents .The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision .Resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the individual resident ' s assessed needs and identified hazards in the environment .