

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555866	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/01/2024
NAME OF PROVIDER OR SUPPLIER  Sierra Vista Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27137</b></p> <p>Based on interview and record review, the facility failed to ensure one of three residents (Resident 1) was free from injury when he attempted to self-transfer out of his bed with the bed 's wheels unlocked, resulting in a bedside fall and fracture to his left hip.</p> <p>This failure had the potential to contribute to the fall with fracture when the bed 's unlocked wheels caused the bed to move when he attempted to transfer out of bed.</p> <p>Findings:</p> <p>During a review of Resident 1 's Admission Record (AR), dated 10/11/24, the AR indicated Resident was a [AGE] year old male admitted to the facility in 2021 with diagnosis that included neurocognitive disorder with Lewy bodies ( a type of progressive dementia that leads to a decline in thinking, reasoning and independent function); bipolar disorder (mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration, can make it difficult to carry out day-to-day tasks); and dementia (a chronic condition that causes a decline in mental abilities, such as thinking, remembering, and reasoning, that interferes with daily life).</p> <p>During a review of Resident 1 's Minimum Data Set (or MDS, a standardized, comprehensive assessment tool), dated 8/2/24, the MDS indicated at Question C0500 Brief Interview for Mental Status a score of 15 out of 15, which indicated Resident 1 was cognitively intact. The MDS indicated at Question GG0115 B, a score of 2, which indicated he had impairments on both sides of his lower extremities (hip, knee, ankle, foot). The MDS indicated at Question GG0120 that he was wheelchair bound. The MDS indicated at Questions GG0170: D, Sit to stand: The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed a score of 2, which indicated Resident 1 needed Substantial/maximal assistance [from staff] - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort; E, Chair/bed-to-chair transfer: the ability to transfer to and from a bed to a chair (or wheelchair), a score of 2, which also indicated Resident 1 needed Substantial/maximal assistance [from staff] - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort; and I, Walk 10 feet: Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space, a score of 9, which indicated a score of 9, which indicated this assessment question was Not Applicable - Not attempted and the resident did not perform this activity.</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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1 ' s Physical Therapy Evaluation and Treatment (PTET), dated 9/17/24, the PTET indicated Resident 1 needed Max Assist for transfers, and that his Gross Motor Coordination = impaired.</p> <p>During a review of Resident 1 ' s Progress Notes (PN), dated 10/6/24, at 8:20 a.m., the PN indicated, . informed that resident [1] was laying on the floor. Upon entering room resident was laying on the floor in a prone position [face down] to the bed attempting to get up. Resident was asked what he was trying to do as per resident he was trying to transfer himself to the wheelchair.</p> <p>During a review of Resident 1 ' s Progress Notes (PN), dated 10/7/24, at 10:10 a.m., the PN indicated Resident 1 . needs supervision in transferring. [Resident 1] further stated that he thinks the bed had moved when he was transferring. ordered to obtain Xray, today Xray done, resulted [in a fracture of the thigh bone near the hip] . ordered to send resident out to a [General Acute Care Hospital, or GACH] for further evaluation.</p> <p>During a review of Resident 1 ' s Progress Notes (PN), dated 10/10/24, at 7:02 p.m., the PN indicated Resident 1 was readmitted to the facility from the GACH with a diagnosis of Left Femur fracture, s/p left hip hemiarthroplasty on 10/8/24 [a fracture of the left hip, with surgical repair].</p> <p>During a review of Resident 1 ' s Progress Notes (PN), dated 10/21/24, at 9:01 p.m., the PN indicated, . stopped by to see [Resident 1] this afternoon to discuss concerns. regarding a recent fall he had. [Resident 1] stated the night he fell , a CNA [Certified Nursing Assistant] came in and asked him for permission to move his bed back in its original place to allow the CNA to be able to help [Resident 1 ' s roommate] with resident care. [Resident 1] stated that when the CNA left they must of forgot to lock the bed because he then got up to get out of bed and fell to the floor.</p> <p>During an interview on 10/22/24, at 9:30 a.m., with Resident 1, Resident 1 stated that before he fell on [DATE], at about 1 or 2 a.m., my roommate was on his call light, and the staff that came in asked me if it was ok to move my bed to tend to him. I said OK. After they left, they forgot to lock my bed wheels. There ' s red and green colored foot pedals, see? I fell out of bed that morning, I began to get out of bed, I pushed off the bed for a bit of leverage, and boom, I went face down on the left side. Resident 1 stated a male nurse came into the room and found him on the floor. Resident 1 stated, I explained to him the bed was unlocked.</p> <p>During an interview on 10/22/24, at 11:50 a.m., with CNA 1, CNA 1 stated when a resident is in bed, the wheel locks should be locked at all times.</p> <p>During an interview on 10/22/24, at 11:44 a.m., with CNA 2, CNA 2 stated, resident beds should be locked when they are in bed.</p> <p>During an interview on 10/22/24, at 5 p.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated she was on duty on 10/6/24 when Resident 1 fell to the floor. LVN 1 stated, When I went into the room, the bed was moved to the side and [Registered Nurse, or RN 1] was in there with me. The bed was moved to the side maybe like a foot and a half from its normal position. I don ' t know if somebody pushed it or if [RN 1] pushed it.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/24/24, at 2:45 p.m., with RN 1, RN 1 stated he recalled being the first staff person to find Resident 1 on the floor next to his bed on the morning of 10/6/24. RN 1 stated, I was walking down the hallway when I saw him on the floor. I was first staff who saw him on floor. He was face down, face was turned to the left, he was alert, he said he was trying to transfer to [his wheelchair] but he didn ' t make it. Yeah, the bed was not straight, a little bit to the side, like it was pushed. The bed was like that when I found it. About one foot from normal resting position. I don ' t recall checking if the brakes were locked. No, bed would not be able to move if brakes were locked, they are kind of heavy. [Resident 1] said the brakes were unlocked. The bed rolled easily when we moved it, we got him up into the wheelchair. This bed is the type with foot pedals to lock and unlock. When resident is in bed, it should be locked.</p> <p>During an interview on 11/1/24, at 4:45 p.m., with Registered Nurse Supervisor (RNS), RNS stated resident bed wheel locks should be locked when residents are in bed, of course. They should be locked all the time.</p> <p>During a review of the Federal Drug Administration (FDA) website page titled, A Guide to Bed Safety Bed Rails in Hospitals, Nursing Homes and Home Health Care: The Facts, dated 12/11/17, the FDA website page indicated, Meeting Patients ' Needs for Safety - Keep the bed in the lowest position with wheels locked.</p>