STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056325	A. BUILDING _____ B. WING _____	**06/17/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DYCORA TRANSITIONAL HEALTH - FRESNO	**2715 FRESNO STREET FRESNO, CA 93721**

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 -** Immediate jeopardy **Residents Affected -** Some	**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** Based on observation, interview and record review, the facility failed to evaluate and analyze hazards and risk for residents in the memory care unit (a form of senior living that provides special care with memory issues) and implement interventions of safety for 11 of 22 sliding room windows when one of 23 sampled residents (Resident 1) removed a sliding bedroom window from the window track and climbed onto the window ledge and jumped out of the window on 5/25/20. Resident 1 fell from the 7 foot (ft) high bedroom window which resulted in fractures to both legs, left heel, left metatarsal (long bone on the outside of the foot) and bruises to her head and face. Resident 1 required an emergency room evaluation, experienced a prolonged hospitalized from [DATE] to 6/8/2020, and surgical intervention of multiple fractures (broken bones), which subsequently required two blood [MEDICAL CONDITION]. The facility maintenance personnel failed to conduct periodic window safety inspections to ensure all window mechanisms remained functional and safe. The facility did not provide evidence that the 11 windows were inspected for safety within the past month. The 11 windows were observed to have faulty safety mechanisms, which caused the windows to lift and dislodge from the window tracks. The faulty window safety mechanisms allowed each of the 11 windows to slide over the designated window [MEDICATION NAME] designed to prevent the window from fully sliding open. Because of these failures to maintain the safety of resident bedroom windows, and the identified serious harm sustained by Resident 1 and the potential serious harm to 23 ambulatory (with the ability to walk) memory care residents of the facility, an Immediate Jeopardy Situation (IJ) was called under Code of Federal Regulations (CFR) 483.25 (F 689 -Free of Accidents and Hazards) on 5/28/2020 at 5:30 p.m., with the Administrator's Assistant (AA) and the Nursing Consultant (NC). The facility submitted an acceptable IJ removal plan on 5/29/2020 at 5:27 p.m., which addressed the inspection and security of all 11 windows. Each window lock mechanism was inspected by the maintenance personnel, with guidance from a window vendor specialist to ensure each window lock mechanism was present, tightened and functional to prevent windows from being lifted and removed from their window track. The facility included the process for the completion of window inspections, frequency of inspection and supervision requirement needed by residents who resided in the memory care unit. The IJ Removal Plan was validated and implemented to address the security, inspection, and repair of all affected windows and the supervision provided to the residents of the memory care unit. The IJ situation was removed while in the facility on 5/29/2020 at 5:42 p.m., with the, Administrator, AA, and ME in attendance. Findings: During a review of Resident 1's general acute care hospital (GACH) record titled, (emergency department) ED Provider Notes dated 5/25/2020 at 6:59 p.m., indicated, Chief Complaint Patient presents with Fall .(Resident 1) . history of [MEDICAL CONDITION] (brittle and weak bones), Alzheimer's dementia (progressive brain disease that causes memory loss and loss and confusion) .presenting from skilled nursing facility for fall out of window that was 7 (foot) high, complaining of left hip pain and bilateral (both) leg tingling .hematoma (localized bleeding outside a blood vessel due to injury) to the back of her head . Bruising to head and left upper lip .Closed fracture of fourth lumbar vertebra (back bone) .Assessment/Plan .Found to have a left and right proximal (tibia (shin leg bone), fibula (outer leg bone) fractures, left calcaneus (heel) fracture . During an interview on 5/28/2020, at 1:30 p.m., with the AA, the AA stated Resident 1 sustained an unwitnessed fall from her bedroom window on 5/25/2020 around 5:30 p.m. The AA stated Resident 1 was able to slide her bedroom window open and jumped out of her window. The AA stated Resident 1 attempted to land on top of a local city six-foot tall electrical power box, located outside of the facility and approximately two feet from her bedroom window. The AA stated Resident 1 fell down and landed on the unpaved dirt exterior. The AA stated Resident 1 was found in between the building and the six-foot electrical power box. The AA stated Resident 1 did not have exit-seeking behaviors and had no known attempts of opening her bedroom window prior to the day of the fall on 5/25/2020. The AA stated Resident 1's window was found open and off the window tracks the day of the fall. The AA stated some of the windows in the memory care unit had one [MEDICATION NAME] positioned a few inches from the window track to limit the extent of the window opening. The AA stated she told the maintenance man to inspect the windows and to make sure the window [MEDICATION NAME] were placed on every window track after Resident 1's fall. The AA stated she requested the maintenance man add additional [MEDICATION NAME] to the window tracks. The AA stated the maintenance man had a few [MEDICATION NAME] available and were not sufficient to add to all of the windows in the memory care unit. The AA stated no additional repairs or inspections were completed to the windows in the memory care unit after Resident 1's fall. During a review of Resident 1's Brief Interview for Mental Status (BIMS) assessment dated [DATE], indicated Resident 1 had severe cognitive impairment with a score of 5 out of 15 (0-7 severe impairment, 8-12 moderately impaired, 13-15 no impairment). During a review of Resident 1's progress notes dated 5/25/2020, at 11:40 p.m., the progress notes indicated, At approximately (5:30 p.m.,) resident was noted on the ground outside her room window .At approximately 5:30 p.m., writer entered resident's room to administer medication. Resident's walker was by her bedside but resident was not in her room and noted the window open. Writer called resident's name and looked out the window then saw the torn (window) screen. Writer looked out to see resident on the ground laying on her left side. Two staff members were alarmed and ran to her aid .resident stated, I wanted to get to my daughter by any means necessary. I saw the box and I thought I could make it .I opened (the window) sat and turned, I could not hold myself on the window seal and I fell . It's further than it looks . During an observation on 5/28/2020, at 1:50 p.m., with the AA, the AA walked outside of the facility building and identified the location of Resident 1's fall. The AA pointed to the unpaved dirt ground where Resident 1 landed. The AA stated the paramedics responded to the emergent call of Resident 1's fall and had a difficult time getting her onto a gurney because of the location of the fall. The AA stated Resident 1 landed between the building and the six-foot electric box. During a concurrent observation and interview on 5/28/2020, at 1:55 p.m., with the AA and the Maintenance employee (ME), the AA and ME entered Resident 1's room to view the window opened by Resident 1 on 5/25/2020. The sliding bedroom window was 57 inches long by 35.25 inches wide. There was a window [MEDICATION NAME] secured to the bottom window track, four inches to the right of the sliding window. The AA explained Resident 1's bedroom window was found opened and over the dedicated [MEDICATION NAME] on 5/25/2020. The AA stated the [MEDICATION NAME] was designed to stop the window from sliding open. The ME was asked to provide a detail of the repairs made to Resident 1's bedroom window. The ME stated the unit windows were inspected on 5/26/2020 to verify placement of the window [MEDICATION NAME] and no additional inspections or repairs were made to any of the windows in the unit. The ME proceeded to open Resident 1's sliding bedroom window, which slid open past the window [MEDICATION NAME]. The ME lifted the window and moved it off and out from the window track. The ME stated the windows were not supposed to open passed the window [MEDICATION NAME] and should have caught and stopped the window from sliding further. The ME stated the windows were not inspected to ensure they were secured to the window frame and were not inspected to ensure the sliding windows did not lift nor dislodge from the window track. During a concurrent observation and interview on 5/28/2020, at 2:05 p.m., with the

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 1) AA and ME, resident rooms were inspected in the memory care unit to determine whether there was safe window placement and to ensure security mechanisms worked. The AA stated there were a total of 22 resident rooms. The following rooms were identified with faulty window safety mechanisms similar to Resident 1's bedroom window where the safety window [MEDICATION NAME] did not function: one bedroom window in room [ROOM NUMBER], one bedroom window in room [ROOM NUMBER], two bedroom windows in room [ROOM NUMBER], one bedroom window in room [ROOM NUMBER], one bedroom window in room [ROOM NUMBER], one bedroom window in room [ROOM NUMBER], one bedroom window in room [ROOM NUMBER], one bedroom window in room [ROOM NUMBER], and one window in the boutique dining room. Each room window measured 57 inches long by 35.25 inches wide, with a window [MEDICATION NAME] located within four inches from the window slide. During an interview on 5/28/2020 at 4:30 p.m., with the ME, the ME described the windows were designed with a wheel lock that was not adjusted to function. The ME stated, The windows have a window track wheel that is not in working condition. It does not stop the window from sliding over the [MEDICATION NAME]. The ME stated the window wheel lock served as a safety mechanism to ensure the wheel did not slide pass the [MEDICATION NAME]. The ME stated the wheel mechanism needed adjustment in order to reduce the gap in the window from the frame. The ME stated this would help the wheel catch on to the bumper and stop the window from sliding. During an interview on 5/28/2020 at 4:35 p.m., with the Maintenance Supervisor (MS), the MS stated the window inspections were completed on a monthly basis. The MS stated he conducted the last window inspection (on 5/6/2020). The MS stated the inspection included verification of the presence of the window latch and gap. The MS stated the latch was the closure mechanism of the window and the gap was a measurement of the [MEDICATION NAME] located at the bottom of the window track. The MS stated he did not inspect whether or not the wheel mechanism worked or verify if the window lifted or dislodged from their window tracks. The ME confirmed the inspection was of the latch and gap and not an inspection of whether or not the safety lock for the windows worked. During a concurrent interview and record review on 5/28/2020 at 4:45 p.m., with the ME, the ME stated the monthly window inspection was documented on their window inspection log. During the review of the inspection log dated 5/6/2020, the ME stated there were no notes to detail the findings of the inspection. The ME stated the inspection note indicated, Fire Doors and Windows: Inspection-Latch and Gap Marked done on time by (MS) on 5/6/2020. The ME stated the inspection did not include verification of all window components or inspection of window security to ensure windows did not lift nor dislodge when being opened. During an interview on 5/28/2020 at 5 p.m., with Licensed Nurse (LN) 1, LN 1 stated Resident 1 did not exhibit any unusual behaviors the day of the fall from the window. LN 1 stated Resident 1's daughter visited Resident 1, however due to visitation restrictions related to [MEDICAL CONDITION] (COVID-19- respiratory infection transmitted from person to person) could no longer visit Resident 1. LN 1 stated staff easily redirected Resident 1. LN 1 stated Resident 1 did not ask to visit with her daughter and was not exit seeking prior to her fall on 5/25/2020. LN 1 stated on 5/25/2020, during the Memorial Day Activity part of the discussion with the residents included reminiscing about Memorial Day functions shared with their families. LN 1 stated this might have contributed to Resident 1's wanting to see her daughter. LN 1 stated the memory care census included 49 residents of which 23 were ambulatory and had access to sliding windows. During a concurrent interview and record review on 5/28/2020 at 5:15 p.m., the AA stated the census of the memory care unit was 49. The AA listed all 23 ambulatory and mobile residents with the capability of accessing windows in the 11 rooms of the memory care unit. The AA listed Residents 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, and 24. During a review of Resident 1's GACH clinical record titled, Orthopedic (bone specialist) Surgery Progress Notes dated 6/1/2020, indicated, 5/25/2020 Bilateral (both) tibia and fibula fractures, left calcaneus fracture, left 5th metatarsal neck fracture. Procedures Right proximal (near) tibia ORIF (open reduction internal fixation-surgical repair of a broken bone) left tibia IMN (intramedullary nailing-surgery to repair a broken bone by permanent placement of nail or rod into the center of the bone. Left calcaneus short leg splint (no surgery) 5/26/2020 .Assessment .(Resident 1) who is status [REDACTED]. She is doing well post operatively. Baseline dementia present. Wound check of the (lower legs) shows low concern for wound infection. Wounds healing well . During a review of Resident 1's GACH clinical record titled, Acute surgical Service Progress Note dated 6/4/2020, indicated, Subjective: Significant mental changes this morning, patient very agitated and angry at RN (Registered Nurse)/providers, demanding to see her husband . (Resident 1) .Ortho surgery took patient to (operating room) for bilateral open reduction internal fixation and closed reduction of her left calacaneus fracture. Post operatively (after surgery) patient requiring 3 units (blood transfusion) and two days later one unit of packed red blood cells (blood transfusion) .Palliative (care focused on providing relief from the symptoms and stress of a serious illness) services consulted due to patients mental status, and significant injuries. Patient made DNR/DNI (do not resuscitate-no heroic measure to revive) do not intubate (no breathing tubes for the purposes to help breathing) as of 5/29/2020. And later family decided to place patient in hospice care (services that focus on end of life care) . During a review of Resident 1's GACH clinical record titled, Case Management Follow up dated 6/8/2020, indicated, Per discharge nurse (Resident 1) was a accepted at skilled nursing facility. Social Worker (SW) contacted (Resident 1) spouse and confirmed (discharge to skilled nursing facility) with hospice services .Pt. was receptive to Social Worker contacting eldest son in the developing (discharge) plans stated he will inform .SW stated he will inform (Resident 1) son when (Resident 1) is discharged . During a review of the facility document titled, Job Description dated 10/12/13, indicated, Job Title: Director Facilities Maintenance (MS) .GENERAL PURPOSE Responsible for the comprehensive maintenance and life safety of buildings .Responsible for establishing, directing, analyzing, and monitoring systems for all aspects of services that focus on safety, physical plant and preventive maintenance programs that meet or exceed all state and federal codes, regulations .Provides oversight of maintenance .programs .to ensure that work is performed in full compliance . During a review of the facility document titled, Job Description dated 2/21/14, indicated, Job Title: Specialist Maintenance 1 (ME) GENERAL PURPOSE Assist in ensuring the building(s) equipment and utilities are maintained in good working order and grounds are properly maintained in accordance with company policies. ESSENTIAL JOB DUTIES Make rounds, assess and make minor repairs .Conduct preventive maintenance as assigned .
F 0835 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Administer the facility in a manner that enables it to use its resources effectively and efficiently.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility administrative staff failed to ensure effective oversight of day-to-day operations when the licensed Administrator (ADM) appointed a non-licensed Administrator as the Administrator Assistant (AA) who did not meet the qualifications necessary to perform the duties of an AA. The AA failed to ensure maintenance personnel conducted window safety inspections to ensure window safety mechanism worked. This practice resulted in an unsafe resident environment from the failure to conduct window safety inspections and 11 of 22 windows were found with faulty safety mechanism. (Cross reference F 689) Findings: During an interview on 5/28/2020, at 1:30 p.m., with the AA, the AA stated Resident 1 sustained an unwitnessed fall from her bedroom window on 5/25/2020 around 5:30 p.m. The AA stated Resident 1 was able to slide her bedroom window open and jumped out of her window. The AA stated Resident 1's window was found open and off the window tracks the day of the fall. The AA stated some of the windows in the memory care unit had one [MEDICATION NAME] positioned a few inches from the window track to limit the extent of the window opening. The AA stated she told the maintenance man to inspect the windows and to make sure the window [MEDICATION NAME] were placed on every window track after Resident 1's fall. The AA stated she requested the maintenance man add additional [MEDICATION NAME] to the window tracks. The AA stated the maintenance man had a few [MEDICATION NAME] available and were not sufficient to add to all of the windows in the memory care unit. The AA stated no additional repairs or inspections were completed to the windows in the memory care unit after Resident 1's fall. During a concurrent observation and interview on 5/28/2020, at 1:55 p.m., with the AA and the Maintenance employee (ME), the AA and ME entered Resident 1's room to view the window opened by Resident 1 on 5/25/2020. The sliding bedroom window was 57 inches long by 35.25 inches wide. There was a window [MEDICATION NAME] secured to the bottom window track, four inches to the right of the sliding window. The AA explained Resident 1's bedroom window was found opened and over the dedicated [MEDICATION NAME] on 5/25/2020. The AA stated the [MEDICATION NAME] was designed to stop the window from sliding open. The ME was asked to provide a detail of the repairs made to Resident 1's bedroom window. The ME stated the unit windows were inspected on 5/26/2020 to verify placement of the window [MEDICATION NAME] and no additional inspections or repairs were made to any of the windows in the unit. The ME proceeded to open Resident 1's sliding bedroom window, which slid open past the window [MEDICATION NAME]. The ME lifted the window and moved it off and out from the window track. The ME stated the windows were not supposed to open passed the

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During an interview on 6/11/2020 at 9:52 a.m., with the ADM, the ADM stated he made final approvals for all hired employees. The ADM stated he hired the AA and appointed her as the Assistant Administrator in April of 2020. The ADM stated the AA employment began as a licensed vocational nurse since 2004. The ADM stated the AA met the qualifications used by the facility corporation and met the years of service. The ADM stated he used guidance from the document titled, Administrator In Training (AIT) Years of service. During an interview on 6/15/2020 at 12:20, with the AA, the AA stated she and the ADM had a conversation in March 2020 during which he offered her the position of AA. The AA stated the ADM used the corporate AIT Years of Service track to qualify her for the position. The AA stated she assumed the position of AA in the middle of April 2020. The AA stated she became a Licensed Vocational Nurse (LVN) in March 2013 and verified her approximate total nursing experience as seven years and three months of which she was MCU Manager only five years. During a telephone interview on 6/17/2020 at 11:47 a.m., with the AA, the AA stated she did not meet the qualifications to participate in an AIT program. The AA stated she did not have a Bachelor's degree or have ten years of experience. The AA stated she was not in the AIT program and was not a Registered Nurse. The AA stated she did not meet the qualifications listed under her job description. During a review of Dycora Transitional Health, Job Description for (AA) undated, page two under Qualifications bullet point one, Must be a Licensed Administrator .or .waiting to take the exam. Bullet point two, Completion of a Bachelor's degree or appropriate education to meet State Licensure requirements, and .a level necessary to accomplish the job. Bullet point three, Completion of Company AIT program .prior experience as an ADM or AADM During review of Nursing Home ADM page nine of 12 under AIT PROGRAM, one, Have a Doctorate .two, Have a baccalaureate degree .three, Have ten years .experience .as a Registered Nurse .four, Have ten years experience .with at least 60 semester units .five, Have ten years .hospital administration .