| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056351 | A. BUILDING _____ B. WING _____ | C 12/11/2024 |

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| F 000 | INITIAL COMMENTS<br><br>The following reflects the findings of the California Department of Public Health during an abbreviated standard survey.<br><br>Facility Reported Incident Number: CA00932340.<br><br>The inspection was limited to the specific Facility Reported Incident investigated and does not represent the findings of a full inspection of the facility.<br><br>Two deficiencies were issued for the Facility Reported Incident: CA00932340 (Refer to F558 and F656). | F 000 | | 12/31/24 |
| F 558 SS=D | Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3)<br><br>§483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, the facility failed to ensure a resident's call light (a device used by a resident to signal his/her need for assistance from staff) was within reach for one of three sampled residents (Resident 2).<br><br>This deficient practice had the potential to delay the provision of services and residents' needs not being met.<br><br>Findings: | F 558 | *How corrective action will be accomplished for those residents found to have been affected by the identified practice. Immediate Corrective action(s) for resident(s) found to have been affected by the deficient practice:*<br><br>- DSD placed the call light with reach of Resident 2 immediately.<br><br>*How the facility will identify other residents having the potential to be affected by the same identified practice and what corrective action will be taken.*<br><br>- Facility conducted facility wide Call Light check on 12/11/2024 and no other residents were noted to be affected by the same identified practice.<br><br>*What measures will be put into place or what systemic changes will the facility make to ensure that the identified practice does not recur.*<br><br>On 12/12/24, the DSD inserviced staff on Call Lights within reach and answered in a | 12/31/24 |

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

Kevin Amerguita | ADMINISTRATOR | 12-31-24

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 558 | Continued From page 1<br><br>During a review of Resident 2 ' s Admission Record, the Admission Record indicated the facility admitted the resident on 7/11/2021 with diagnoses that included dementia (a progressive state of decline in mental abilities) and cerebral infarction (also known as a stroke, refers to damage to tissues in the brain due to a loss of oxygen to the area).<br><br>During a review of Resident 2 ' s Minimum Data Set (MDS - a resident assessment tool) dated 10/1/2024, the MDS indicated Resident 2 sometimes made self-understood and sometimes had the ability to understand others, and Resident 2 ' s cognition (mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was severely impaired. The MDS further indicated that Resident 2 was dependent on staff with oral hygiene, toileting hygiene, shower/bathing, upper/lower body dressing, personal hygiene, bed mobility (movement), and transfer.<br><br>During a review of Resident 2 ' s untitled care plan initiated on 9/1/2023 and revised on 4/19/2024, the care plan indicated Resident 2 had activities of daily living (ADL- activities related to personal care) self-care performance deficit (an inability to perform certain daily functions related to health and well-being) related to Resident 2 ' s impaired mobility and dementia. The care plan indicated an intervention to encourage Resident 2 to use bell (call light) to call for assistance.<br><br>During a concurrent observation and interview on 12/10/2024 at 9:40 a.m., with the Director of Staff Development (DSD), in Resident 2 ' s room, observed Resident 2 in bed with their call light | F 558 | - timely manner.<br>- The DSD and or designee will perform daily rounds to ensure proper call light placement.<br><br>*How the facility plans to monitor its performance to make sure that solutions are sustained. The plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system.*<br><br>- DSD will log any identified instances presented or observed during their daily rounds of call lights being out of reach daily and present the findings to the Monthly QA meeting for the length of 3 months.<br><br>*Completion date of corrective actions*<br><br>- Compliance date 12/31/2024 | |

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| F 558 | Continued From page 2<br>placed on the floor between Resident 2 ' s bed and the nightstand table, out of reach. Resident 2 stated the purpose of the call light is that Resident 2 needed to use the call light for an emergency situation when Resident 2 needed help. The DSD stated that Resident 2 could not use Resident 2 ' s call light in case of emergency because it was out of reach at that moment.<br><br>During an interview on 12/11/2024 at 10:22 a.m., with the Director of Nursing (DON), the DON stated that the residents ' call light should be always placed within reach so the residents would be able to use it when needing the staff ' s services.<br><br>During a review of the facility ' s policy and procedure titled, "Nursing Clinical - Call Light/Bell," revised 2/2024, the policy indicated, "It is the policy of this facility to provide the resident a means of communication within nursing staff ... Answer the call light/bell within a reasonable time .... Place the call device within resident ' s reach before leaving room." | F 558 | | |
| F 656 SS=D | Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3)<br><br>§483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - | F 656 | ***How corrective action will be accomplished for those residents found to have been affected by the identified practice. Immediate Corrective action(s) for resident(s) found to have been affected by the deficient practice:***<br><br>- Both bilateral landing pads were placed right away once identified by the facility staff on 12/11/24.<br><br>***How the facility will identify other residents having the potential to be affected by the same identified practice and what corrective action will be taken.***<br><br>- All 7 residents with orders for bilateral | |

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| F 656 | Continued From page 3<br>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and<br>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).<br>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.<br>(iv)In consultation with the resident and the resident's representative(s)-<br>(A) The resident's goals for admission and desired outcomes.<br>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.<br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(iii) Be culturally-competent and trauma-informed.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, the facility failed to implement and revise a comprehensive person-centered care plan (a plan for an individual's specific health needs and | F 656 | pads have the potential to be affected by the same identified practice.<br>- DSD inserviced Licensed Nurses and CNA's on 12/11/24 and 12/15/24 regarding proper placement of bilateral landing pads and Q-shift checks to ensure they are properly placed.<br><br>*What measures will be put into place or what systemic changes will the facility make to ensure that the identified practice does not recur.*<br><br>- DSD or designee will check bilateral landing pad placement daily to ensure they are properly placed and provide education when incorrect placement is identified.<br><br>*How the facility plans to monitor its performance to make sure that solutions are sustained. The plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system.*<br><br>- DSD will check bilateral landing pad placement daily provide education, log any instances and present the findings to the Monthly QA meeting for the length of 3 months.<br><br>*Completion date of corrective actions*<br><br>- Completion date 12/31/2024. | |

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| F 656 | Continued From page 4 | F 656 | | |

desired health outcomes) for one of three sampled residents (Resident 3) by failing to ensure Resident 3 was provided with bilateral (both sides) floormats (padding placed on the floor to help prevent injuries related to falls) and was monitored for placement.

This deficient practice had the potential to negatively affect the delivery of care and services to Resident 3 and miscommunication among the care team regarding the resident ' s needs.

Findings:

During a review of Resident 3 ' s Admission Record indicated the facility admitted the resident on 11/25/2024 with diagnoses that included Huntington ' s disease (HD - inherited brain disorder that causes nerve cells to break down, leading to a variety of symptoms included uncontrolled movements), epilepsy (a disorder of the brain characterized by repeated seizures [a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness]), and history of falling.

During a review of Resident 3 ' s Minimum Data Set (MDS - a resident assessment tool) dated 12/29/2024, indicated Resident 3 was able to sometimes be understood and understands by others. The MDS indicated Resident 3 ' s cognition (mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was severely impaired. The MDS further indicated that Resident 3 needed maximum assistance from staff with toileting hygiene, and moderate assistance from staff with eating, oral hygiene,

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| F 656 | Continued From page 5 | F 656 | | |

personal hygiene, bed mobility (movement), and transfer.

During a review of Resident 3 ' s Change in Condition (COC - when there is a sudden change in a resident ' s health) Evaluation dated 12/2/2024 timed at 1 p.m., indicated, Resident 3 had a witnessed fall. The COC indicated Resident 3 slid down from Resident 3 ' s wheelchair.

During a review of Resident 3 ' s Post-Event Interdisciplinary Team (IDT - a group of professional and direct care staff that have primary responsibility for the development of a plan for the care and treatment of a patient) Review dated 12/4/2024 timed at 10:16 p.m., under the IDT recommendations section indicated to monitor and document the use of floormat.

During a review of Resident 3 ' s untitled care plan initiated on 12/2/2024 indicated Resident 3 had an actual fall related to hypotension (low blood pressure), poor balance, poor communication/comprehension, psychoactive (affecting in mind) drug use, and unsteady gait. The care plan indicated a goal for Resident 3 to resume usual activities without further incident through the review date of 12/9/2024. The interventions included the use of floormat.

During a concurrent observation, interview, and record review on 12/10/2024 at 10:33 a.m., with Licensed Vocational Nurse 2 (LVN 2) in Resident 3 ' room, observed Resident 3 was in bed. LVN 2 stated that Resident 3 had only one floormat on the left side of the resident ' s bed, and no floormat was placed on the right side of the resident ' s bed. When LVN 2 was asked why the

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| F 656 | Continued From page 6 | F 656 | | |

facility placed the floormat only for Resident 3 ' s left side of the bed, LVN 2 stated that the nursing staff should place the floormats on both sides of the floors for safety due to Resident 3 ' s uncontrolled movements related to the diagnosis of Huntington disease. LVN 2 stated that the purpose of the floormat use is to mitigate the possible injuries when a resident falls from the bed. LVN 2 reviewed Resident 3 ' s physician orders and stated staff did not monitor and document the use of floormat for Resident 3 because there was no order for the use of floormats.

During a concurrent interview and record review on 12/11/2024 at 10:25 a.m., with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON), the ADON reviewed Resident 3 ' s physician ' s order for bilateral landing mat (floormats) for protection dated 12/10/2024 and reviewed the care plan related to actual fall developed on 12/2/2024. The ADON stated that staff did not implement the intervention indicated in Resident 3 ' s care plan by not monitoring the floormats ' placements. The ADON stated that the purpose of the floormats is to reduce or minimize the possible injuries such as during fall incidents. The DON stated that a physician order should have been in placed on 12/2/2024 when the use of floormat was initially added as an intervention in Resident 3 ' s actual fall care plan. The DON stated nursing staff should have also monitored the use of the floormat and should have documented in the Medication Administration Record (MAR). The DON stated that the nursing staff were not able to monitor the use of floormats until yesterday, 12/10/2024, because the physician order was missed on 12/2/2024. The ADON stated that the care plan

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| F 656 | Continued From page 7<br>for Resident 3 ' s floormat use to reduce the possible injuries when a fall incident occurs from the bed was not individualized or person centered.<br><br>During a review of the facility's policy and procedure titled "Resident Services - Care Plan Policy", last reviewed on 1/11/2024, indicated, "It is the policy of this facility to ensure resident needs are met and documented in a written care plan .... The care plan shall be updated to reflect the results of the assessment." | F 656 | | |