DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/17/2023 FORM APPROVED DMB NO 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT/FIGATION NUMBER.		E CONSTRUCTION	(X3) DATE COMP	LETED
		555737	B. WNG		03/:) 14/2023
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1740 S SAN DIMAS AVE SAN DIMAS, CA 91773		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES (CY MUST BE PRECEDED BY FULL R LSC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(XS) COMPLETIO DATE
F 000	California Departme	ets the findings of the ent of Public Health (CDPH) tion of one complaint and one cident (FRI).	F 000	Disclaimer: The following plan of completed in accordance with St Federals laws. It is not an admiss alleged findings shown in the sta deficiencies.	ate and sion to the	
SS=H	The inspection was and one FRI investig the findings of a full Two deficiencies we complaint CA008215 incident CA0082467 Develop/Implement CFR(s): 483.21(b)(1) The faimplement a compression of the care plan for each resident rights set for §483.10(c)(3), that is objectives and timefinedical, nursing, anneeds that are identical assessment. The condescribe the following (i) The services that or maintain the resid physical, mental, and required under §483 (ii) Any services that	Comprehensive Care Plan)(3) mensive Care Plans actility must develop and whensive person-centered esident, consistent with the rth at §483.10(c)(2) and includes measurable rames to meet a resident's id mental and psychosocial fied in the comprehensive imprehensive care plan must	F 656	The resident who 's requirement we per review of clinical record during investigation is no longer an active. The facility initiated a QAPI on 3/23 regarding completion of resident comprehensive care plan with partithe medical director, Don, DSD, Mimedical records director. Medical residents on 3/23/23 for completion comprehensive plan of care. No ot were found with incomplete nor not comprehensive plan of care.	this resident. 8/23 entered icipation of DS and ecords/ active n of her residents	3/30/20

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.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID, 82G7.11

Facility ID CA9500X0277

If continuation sheet Page 1 of 15

Revised: H

Administrator

4/10/23

CENTERS FOR MEDICARE & MEDICAID SERVICES

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION

(31) PROVIDER/SUPPLIER/CLIA

(X2) MULTIPLE CONSTRUCTION
A BUILDING

PRINTED: 03/17/2023 FORM APPROVED OMB NO 0938 0391

(x3) DATE SURVEY COMPLETED

С

SERENTO CASA

SUMMARY STATEMENT OF DEFICIENCIES

B WING

STREET ADDRESS, CITY, STATE, ZIP CODE

1740 S SAN DIMAS AVE

SAN DIMAS, CA 91773

(X4) ID

PROVIDER'S PLAN OF CORRECTION

PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC (DENTIFYING INFORMATION)

PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

COMPLETION DATE

F 656 Continued From page 1

provided due to the resident's exercise of rights under §483.10, including the right to refuse freatment under §483.10(c)(6).

(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.

(iv)In consultation with the resident and the resident's representative(s)-

- (A) The resident's goals for admission and desired outcomes.
- (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.
- (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.

§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-

(iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by:

Based on interview and record review, the facility failed to develop and implement a resident-centered comprehensive care plan to prevent a fail for one of two sampled residents (Resident 1), who had blindness on both eyes (visual impairment/unable to see) and a history of fails by failing to:

Ensure the Interdisciplinary Team (IDT, a team of health care professionals who work together to

All IDT members and nursing staff were inserviced F 656 by DSD and DON on 03/23, 3/24, & 3/30

timely initiating, formulating and completion of resident-centered plan of care per policy and procedure. Audits will be conducted 5 x a week starting 3/24/23 by medical records director //designee and will be discussed in stand-up meeting under 3n of the DON and Administrator. On 3/24/23, MDS/Designee provide a calendar to the DIT members, DON, Administrator and medical records for a scheduled review of resident centered comprehensive plan of care. Timely completion of resident on 3/24/23 resident centered comprehensive care plan will be reported 5 x a week in stand up meeting and to the monthly QA committee. Record of audit completion will be provided to the DON and Administrator weekly.

the DON and Administrator weekly. The facility initiated a QAPI on 3/22/23 regarding IDT meetings on falls with participation of the 'medical director, Don, DSD, MDS, DOR and medical records director. Medical records director/designee has completed an audit on 03/23/2023 on all active residents with falls Audits were reviewed and submitted to the DON and Administrator: no other active residents iwere found to be deficient by this practice. Medical records director/ designee has reviewed all residents with recent falls for completion of IDT meeting and updated plan of care by 03/27/2023 All IDT meetings for post falls will be completed and discussed in stand-up meeting for review and revision of plan of care if indicated. Record of such meetings will reflect in each resident's clinical record. All IDT members and nursing staff were inserviced by :DSD and DON on 03/23/2023, Regarding: Falls, managing fall risks, IDT meetings for falls and timely completion and revision of resident-centered plan of care per policy and procedure ito address changes needed to meet

CENTERS FOR MEDICARE & MEDICAID SERVICES OME NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A BUILDING_ 555737 B. WING 03/14/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1740 S SAN DIMAS AVE SERENTO CASA SAN DIMAS, CA 91773 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEIVED BY FULL PREFIX PREFIX VEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE TAG REGULATORY OR USC IDENTIFYING IMPORMATION). TAG DEFICIENCY) All incidents of falls and completed IDT Continued From page 2 meetings will be reported and discussed in the establish plans of care for the residents) met and monthly QA committee and QAPI members for updated Resident 1's Fall Care Plan as indicated review and evaluation. in the facility's policy and procedure, titled "Falls -Assessing Falls and Their Causes," after Resident 1 fell on 12/26/2023, 1/6/2023, and 1/13/2023. As a result, Resident 1 sustained multiple falls (12/26/2023, 1/6/2023, 1/13/2023, and 1/15/2023,) in the facility and was hospitalized due to injuries sustained from the falls. On 1/15/2023, the facility transferred Resident 1 to General Acute Care Hospital (GACH) 1's Emergency Department (ED) due to head trauma (damage to the scalp, skull, or brain caused by injury) and cephalohematoma (an accumulation of blood under the scalp) Cross reference F689 Findings: A review of Resident 1's Admission Record (face sheet) indicated the facility admitted Resident 1 on 12/21/2022 with diagnoses that included unsteadiness on feet, muscle weakness, blindness on both eyes, and a history of falling at A review of Resident 1's Physician Progress Notes, dated 12/22/2022, at 9:01 PM, indicated Resident 1 had a fall with head injury from the previous admission (10/25/2022). The note indicated Resident 1 lost 80 percent of her eyesight. A review of Resident 1's Falls Care Plan, initiated on 12/22/2022, indicated Resident 1 was at high

risk for falls related to unsteady (unable to

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O COLLINS	to . OI. MELLIOPINE &	MEDICAID SERVICES			ONB	NO. 0938-039	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION G		DATE SURVEY COMPLETED	
		555737	B. WNG_			C 03/14/2023	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO			
			1	1740 S SAN DIMAS AVE			
SERENTO	CASA			SAN DIMAS, CA 91773			
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F 656	stabilize without staff decreased mobility (a intolerance. The goa sustain serious injury included to anticipate provide prompt responsistance, provide a walking, ensure the concouragement for R A review of Resident meeting note), dated Resident 1 had unsterisk due to visual impindication that the ID	atinued From page 3 cilize without staff assistance) gait (walk), reased mobility (ability to move), and activity lerance. The goal was for Resident 1 to not tain serious injury. The nursing interventions uded to anticipate Resident 1's needs and vide prompt response to all requests for stance, provide appropriate footwear when king, ensure the call light was within reach and ouragement for Resident 1 to use it. view of Resident 1's Care Conference (IDT titing note), dated 12/23/2022, indicated ident 1 had unsteady gait and remained a fall due to visual impairment. There was no cation that the IDT discussed falls and ventions to prevent falls due to unsteady gait visual impairment.		56			
	(MDS, standardized a screening tool), dated Resident 1 had sever to think and process indicated Resident 1 Resident 1 required assistance during toil assistance from one proom. The MDS indic steady when moving position and when was A review of Resident Assessments (MRS, rapid and simple metilikelihood of falling), d	extensive physical et use and limited physical person when walking in the ated Resident 1 was not from seated to standing alking with a walker.					

walking, and overestimating or forgets her limits. Resident 1 scored 80 points (a score of 45 or

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PRINTED: 03/17/2023 FORM APPROVED

STATEMEN	T OF DEFICIENCIES	O(1) SPOUDODISING				IO. 0936-039
AND PLAN (OF CORRECTION	(X1) PROVIDER/SUPPLIFICATION ROLLBER:	(X2) MULT A. GUILDIN	IPLE CONSTRUCTION IG	(X3) DAT	TE SURVEY MPLETED
		555737	B WING		1	C
NAME OF	PROVIDER OR SUPPLIER	100	D ANIAG	0.70	0:	3/14/2023
SERENT	0.0484			STREET ADDRESS, CITY STATE, ZIP CODE		
	o onon			1740 S SAN DIMAS AVE		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		SAN DIMAS, CA 91773		
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(XS) COMPLETION DATE
F 656	Continued From page	4	F 65	6		
A rainit act into chall for chall fo	indicated Resident 1 extended and was found sitting resident's walker. The management of confusion and forget required encouragement prompt anticipation to at needs. A review of Resident 1's Assessment and Recomposition record be a seath care team) Communication record be a seath care team) Communication record by the seath care team and recomposition and activity intolerance by the limits. Resident 1 did sed furniture to hold on was unable to walk more decided to sit down sesident 1 complained of ted). The form indicated one assistance (not indicated and activities).	s Progress Note - Change 26/2022, timed at 4:15 PM, sperienced an unwitnessed g on the floor next to the lote indicated Resident 1 monitoring due to periods ulness. Resident 1 to use the call light, and tend to the resident's Situation Background mendation (SBAR, etween members of the function Form, dated leted Resident 1 indicated Resident 1 indicated Resident 1 indicated Resident 1 ut overestimated her into use the walker and while walking. Resident te steps to the bathroom lowly on the floor. In lower back pain (not Resident 1 required leted type of assistance) g (ADL, activities related lessing, eating and citial Fall Care Plan, and Resident 1 had an inteady gait, poor rance. The goal was soual activities Nursing onlitor Resident 1 for and to determine and				

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MENT OF	DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A BUILDING			C /14/2023
		555737	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE		
ME OF PR	OVIDER OR SUPPLIER		1	1740 S SAN DIMAS AVE		
ERENTO	CASA			SAN DIMAS, CA 91773 PROVIDER'S PLAN OF CORE	RECTION	(X5) COMPLETION
(X4) ID PREFIX TAG	SUMMARY S	ITATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION S (EACH CORRECTIVE ACTION S (ROSS-REFERENCED TO THE A DEFICIENCY)		DATE
F 656	Continued From pa	at 1's SBAR Communication	F 65	56		
	Form, dated 1/13/2 indicated Resident on her right side, rwalker. Resident 1 bed and lost balar to the bathroom. Fpain (unrated). Lic 2) notified Reside of Medicine), MD (rush/immediate) bones and soft tiship to rule out fra results were neg. A review of Reside Form, dated 1/19 indicated Resides.	1 was found lying on the floor, lext to the resident's bed and reported that she slid off her fice when trying to get up to go Resident 1 complained of body bensed Vocational Nurse 2 (LVN int 1's Physician (MD 1, Doctor 1 ordered STAT X-rays (image study of the saue) of the right shoulder and ctures (breaking). The X-ray ative for fractures. Ident 1's SBAR Communication of 12023, timed at 11:44 PM, and 1 was found sitting on the floor that left ring figner, hematoma (a				
	bruise) on the b both buttocks. F hospital via ami call for emerger A review of Res Documentation AM, indicated I	sident 1's GACH 1's Emergency , dated 1/16/2023, timed at 12:22 Resident 1 was admitted from the				
	cephalhemator head or skull). walking with h documentation falls in the pas and had an of	Resident 1 stated, she was er walker and had a fall. The n indicated Resident 1 had several st, was on blood thinner medication ovious head injury. The Computed CT, medical imaging used to obtain nal images of the body) result was the brain bleed. The diagnoses	n	Facility ID: CA950000277	If cont	inuation sheet Page

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ENTERS	F DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER SUPPLICECLIA	(X2) MULTIPLE CON	COM	(X3) DATE SURVEY COMPLETED	
TEMENT OF	CORRECTION	ISTALLIS IN INCIDENTIAL IN INCIDENTIAL IN INCIDENTIAL	A BUILDING	A		C
		555737	B WNG		0:	3/14/2023
	- TOTAL OR CURRULER			ET ADDRESS, CITY, STATE, ZIP CODE		
AME OF PR	OVIDER OR SUPPLIER			S SAN DIMAS AVE		
SERENTO	CASA		SAN	DIMAS, CA 91773 PROVIDER'S PLAN OF COR	RECTION	(X5)
(X4) ID PREFIX TAG		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD DE	COMPLETION
F 656	Continued From pag	ge 6 and cephalohematoma.	F 656			
	dated 1/16/2023, at 1 returned to the fact sustaining a fall. The was stable with diag on the left parietal (side of the head) at	It 1's Nurse Progress Notes, 10:02 AM, indicated Resident cility from GACH 1 after e note indicated Resident 1 gnosis of cephalohematoma forming part of the top and rea. The note indicated ras intact, had multiple bruises and multiple discolorations on				A many administration of the state of the st
	Census List, dated was discharged fro	nt 1's Admission Discharge 2/6/2023, indicated Resident 1 om the facility at 8:40 PM.				
	Director of Nursing meet after Resider on direct resident contact with reside diagnosis, treatme stated the fall care each fall and state nurses (in general care pians had to generalized due to	or on 2/8/2022, at 8:50 AM, the (DON) stated the IDT did not not 1's falls due to staff focused care (hands on, face-to-face ents for the purpose of ent. and monitoring). The DON a plan had to be updated after ed care plans were a guide for 1) to follow. The DON stated be specific, detailed, and not be o every resident being unique.				
	9:06 AM, with the 1's Fall Care Plan and the IDT meet DON stated Resin facility with a hist legally blind (20/2 see at 20 feet, who	ent interview on 2/8/2023, at DON and a review of Resident has, dated 12/22/2022, 1/6/2023, sing note, dated 12/23/2022, the dent 1 was admitted to the cory of multiple falls and was 200 visual acuity, a person can hat a person with 20/20 vision. The DON stated Resident 1's and IDT note did not include				ation sheet Page

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIP	E CONSTRUCTION	(X.3) DATE SURVEY COMPLETED	
		555737	B WING_		C 03/14/2023	
NAME OF PI	CASA			STREET ADDRESS, CITY, STATE, ZIP CODE 1740 S SAN DIMAS AVE SAN DIMAS, CA 91773	03/14/2020	
(X4) !D PREFIX TAG	(EACH DEFICIENC)	ALEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
	stated the IDT did not on 12/26/2023, 1/6/20 DON stated the IDT had discuss and find the not DON stated if the IDT falls, future falls could Resident 1. The DON Fall Care Plan, create include person-center the root cause of the facility titled, "Care Planning revised 3/2022, indicated for the development of Comprehensive, persobased on resident assiby the IDT. A review of the facility titled, "Care Plan, Corperson-Centered," revisional needs is defor each resident. The assessments of resident in the care significant change in the A review of the facility titled, "Falls - Managing titled, "Falls - Managing titled, "Falls - Managing the IDT on the care significant change in the care of the facility titled, "Falls - Managing the IDT on the IDT of the	Intercurrent falls. The DON meet after Resident 1 fell 123, and 1/13/2023. The ad to meet after every fall to bot cause of the falls. The met and addressed the have been prevented for stated Resident 1's Actual don 1/6/2023, did not ed interventions to address fall. I's policy and procedure, Interdisciplinary Team, Ited the IDT is responsible fresident care plans. Incorporate of care plans are resident care plans are resident care plans that objectives and timetables to reside and implemented policy indicated ents are ongoing and care information about the resident's condition. Is policy and procedure, and weloped and implemented policy indicated ents are ongoing and care information about the resident's condition. It policy and procedure, and the resident's condition. It policy and procedure, and the resident's condition. It policy and procedure, and the resident's condition.	F 65			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED 03/17/2023 FORM APPROVED OMB NO 0938-0391

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION DENTIFICATION NUMBER. A, BUILDING		(X3) DATE SURVEY COMPLETED		
			A. BOILDING	n-444 at	С
		555737	B WING	n. //	03/14/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE
CERENTO	CACA		1	740 S SAN DIMAS AVE	
SERENTO	CASA			SAN DIMAS, CA 91773	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLET DATE
F 656	Continued From page	e 8	F 656		
SS=E	A review of the facility's policy and procedure, titled, "Falls - Assessing Falls and Their Causes," dated 10/01/2022, indicated the purpose of the policy was to provide guidelines for assessing a resident after a fall and to assist the staff in identifying causes of the falls. F 689 Free of Accident Hazards/Supervision/Devices SS=E CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and		F 689	nurse on 2/26/23 and sh symptoms of change in or review was done on 2/15 risks with responsible pa expired 2/26/23. Resider by the license nurse immore to ensure call light was we	owed no signs and condition.IDT 5/23 and discussed rty. Resident 1 nt 2 was assisted rediately on 2/7/23 vilhin reach.
1	supervision and assist accidents. This REQUIREMENT by: Based on observation review, the facility faile services to prevent av	is not met as evidenced is not met as evidenced is, interview, and record and to provide care and oidable accidents for two of a (Resident 1 and Resident		Resident 2 was also ass nurse on 2/7/23 with no signs and change in condition. Res to RNA on 3/13/22 for str exercises both upper and Fall Risk Assessment wa 3/24/23. IDT Care Confer 3/24/23 and Care Plan w	symptoms of ident was referred rengthening d lower extremities. as done on rence was done on vas updated.
	This deficient practice 2 sustained multiples f	resulted in Residents 1 and falls and had the potential o sustain serious injury and		B. Starting 3/24/23, care Planesidents with recent fall residents high risk for fall Medical Records starting completed 4/7/23 to ensure were done. There were not found to have similar find.	incident All I were audited by on 3/23/23 and ure IDT reviews o other residents
	Cross Reference: F65i Findings: a. A review of Residen (face sheet) indicated to	t 1's Admission Record		rounds on 2/7/23 to ensu lights were within reach a residents were found to h findings. DSD provided a Nursing staff and IDT reg Protocol on 3/2/23,3/7/23	re that all call and no other have similar in in-service to arding Fall Risk

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		AND HUMAN SERVICES & MEDICAID SERVICES		FORM APPROVED ONE NO 0938-0391
STATEMENT	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A, BUILDING	(X3) DATE SURVEY COMPLETED
		555 7 37	B MING	C 03/14/2023
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP	
0.555170			1740 S SAN DIMAS AVE	
SERENTO	CASA		SAN DIMAS, CA 91773	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC (DENTIFYING INFORMATION)	ID PROVIDER'S PLAN O PREFIX (EACH CORRECTIVE AC TAG CROSS-REFERENCED TO DEFICIENT	OTHE APPROPRIATE DATE
The state of the s	blindness on both home. A review of Reside on 12/22/2022, indrisk for falls related stabilize without stabilize provide prompt responsible provide provide provide provide provide provide provide walking, ensure the encouragement for A review of Resided (MDS, standardized screening tool), darkesident 1 had several to think and process indicated Resident 1 required assistance during the assistance from on room. The MDS incomposition and when with position and when with the provided pro	ege 9 ess on feet, muscle weakness, eyes, and a history of falling at a history of falling, use a when walking, and orgets her limits. Resident 1 was not greats and ponse to all requests for a propriate footwear when a call light was within reach and a history of falling and a history of falling in the licated Resident 1 was not grom seated to standing walking with a walker.	F 689 C. Dn 3/2/23, The Fall Ris available at the nurses st 3/2/23, A list of residents also made available at the updated weekly by the ID Nurses are initiating hudo CNAs and ensuring to require updated list of high risk requires stations to alert st Fall Protocol in place. IDT weekly with Medical Recompletion of IDT review for Fall List update, and Oneeded weekly and report for further actions as needed weekly and report for further actions as needed weekly and report for further actions as needed weekly and report for further actions and hazard and 3/30/23. D. Starting 3/24/23, Medical admissions and Change of the IDT and Care Place as necessary. IDT will review for IDT and Care Place as necessary. IDT will review for IDT and Care Place as necessary. IDT will review and analysis. DDN of the Performance Improvements of the IDT and analysis. DDN of the Performance Improvements of the IDT and Commischeduled.	k Protocol is now made ation for reference. Dn High Risk for Fall are enurses station and DT as needed. Charge dles q shift with the mind them of the the esidents are at the taff and remind them of scheduled Fall review ords auditing , Residents High Risk Care Plan update as rt findings to the DDN ided. Fall Protocol indo on 3/2/23 and 3/7/23, nursing staff and IDT ided to IDT and staff on acds on 3/23/23, 3/24,23 and Records audits of Condition for any an updates weekly and view all incidents includes fall episodes ire Plan as needed. Ignee will monitor fall kly and report any IDN and/or IDT for I will analyze progress overment Plan weekly x ereafter and report

high risk for falls).

scored 80 points (a score of 45 or higher means

A review of Resident 1's Progress Note - Change

PRINTED: 03/17/2023 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A BUILDING _ AND PLAN OF CORRECTION 03/14/2023 B WING 555737 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1740 S SAN DIMAS AVE SAN DIMAS, CA 91773 SERENTO CASA (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION (LACH CORRECTIVE ACTION SHOULD BE SUMMARY STATEMENT OF DEFICIENCIES CRONS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY PUIL (X4) ID TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX DEFICIENCY) TAG F 689 F 689 | Continued From page 10 in Condition (COC), dated 12/26/2022, timed at 4:15 PM, indicated Resident 1 experienced an unwitnessed fall and was found sitting on the floor next to the resident's walker. A review of Resident 1's Situation Background Assessment and Recommendation (SBAR, communication record between members of the health care team) Communication Form, dated 1/6/2023, untimed, indicated Resident 1 sustained a fall. The form indicated Resident 1 did not use the walker and used furniture to hold on while walking Resident 1 was unable to walk more steps to the bathroom and decided to sit down slowly on the floor. Resident 1 complained of lower back pain (not rated). A review of Resident 1's SBAR Communication Form, dated 1/13/2023, timed at 12:03 AM, indicated Resident 1 was found lying on the floor, on her right side, next to the resident's bed and walker. Resident 1 reported that she slid off her bed and lost balance when trying to get up to go to the bathroom. Resident 1 complained of body pain (unrated). A review of Resident 1's SBAR Communication Form, dated 1/15/2023, timed at 11:44 PM, indicated Resident 1 was found sitting on the floor with bleeding on the left ring finger, hematoma (a collection of blood outside of the vessels, a bad bruise) on the back of the head, and bruising on both buttocks. A review of Resident 1's GACH 1's Emergency

Documentation, dated 1/16/2023, timed at 12:22 AM, indicated Resident 1 was admitted from the

facility after sustaining a fall with a

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A BUILDI	NG	COMPLETED
		555737	B WING_		03/14/2023
NAME OF PI	ROVIDER OR SUPPLIER	7.00		STREET ADDRESS, CITY, STATE, ZIP CODE 1740 S SAN DIMAS AVE SAN DIMAS, CA 91773	
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG	PROVIDER'S PLAN OF COR X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION
F 689	walking with her widocumentation indifalls in the past, walking and had an obvious Tomography (CT, detailed internal imnegative for a brail A review of Resided dated 1/16/2023, and returned to the fasustaining a fall. The was stable with dia on the left occiput, back, and multiple A review of Resided 1/18/2023 at 11:23 a fall on 1/17/23, but A review of Resided 2:15 AM, indicated (CNA, unidentified The note indicated go to the bathroom any pain. A review of Resided Note, dated 2/1/20 Resident 1 had rebruises. The note resident to the GA A review of Resided 2/2/2023 at 12:15 returned to the factor of the head was not the same and the resident to the factor of the head was not the same and the resident to the factor of the head was not the same and the resident to the factor of the head was not the same and the resident to the factor of the head was not the same and the resident to the factor of the head was not the same and the resident to the factor of the head was not the same and the resident to the factor of the head was not the same and the resident to the factor of the head was not the same and the resident to the factor of the head was not the same and the resident to the factor of the head was not the same and the resident to the factor of the head was not the same and the resident to the factor of the same and the resident to the factor of the same and the resident to the same	sident 1 stated, she was alker and had a fall. The icated Resident 1 had several as on blood thinner medication, is head injury. The Computed medical imaging used to obtain nages of the body) result was in bleed. Int 1's Nurse Progress Notes, at 10:02 AM, indicated Resident acility from GACH 1 after he note indicated Resident 1 agnosis of cephalohematoma multiple bruises on the lower discolorations on both legs. Int 1's nurses notes dated 3 AM, indicated Resident 1 had before lunch. Int 1's COC dated 1/31/2023 at 1 a Certified Nurse Assistant 1 found Resident 1 on the floor. If Resident 1 was getting up to in and fell. Resident 1 denied cent fall with worsening facial indicated the physician sent the indicated the resident 1 is nurses note, dated AM, indicated the resident 5 ility, and Resident 1's CT scan	F	689	

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 03/17/2023 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A BUILDING COMPLETED C 555737 B WING 03/14/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SERENTO CASA 1740 S SAN DIMAS AVE SAN DIMAS, CA 91773 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 689 Continued From page 12 F 689 Census List, dated 2/6/2023, indicated Resident 1 was discharged from the facility at 8:40 PM. During a concurrent interview on 2/8/2023, at 9:06 AM, with the Director of Nursing (DON) and a review of Resident 1's Fall Care Plans, dated 12/22/2022, 1/6/2023, and the IDT meeting note, dated 12/23/2022, the DON stated Resident 1 was admitted to the facility with a history of multiple falls and was legally blind (20/200 visual acuity, a person can see at 20 feet, what a person with 20/20 vision sees at 200 feet). The DON stated Resident 1's Fall Care Plan and IDT note did not include interventions to prevent recurrent falls. The DON stated the IDT did not meet after Resident 1 fell on 12/26/2023. 1/6/2023, and 1/13/2023. The DON stated the IDT had to meet after every fall to discuss and find the root cause of the falls. The DON stated if the IDT met and addressed the falls, future falls could have been prevented for Resident 1. The DON stated Resident 1's Actual Fall Care Plan, created on 1/6/2023, did not include person-centered interventions to address the root cause of the fall b. A review of Resident 2's admission record indicated the facility admitted Resident on 12/22/2022 with diagnoses that included nontraumatic subdural hematoma (bruise on the

brain), injury of the head, and seizures (sudden, uncontrolled body movements and changes in behavior that occur because of abnormal

A review of Resident 2's MDS dated 12/28/2022, indicated the Resident had had cognitive impairment. The MDS indicated the resident required extensive assistance with bed mobility

electrical activity in the brain).

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PARTME	ENT OF HEALTH A	ND HUMAN SERVICES			TING (EX)	SURVEY	
NTERS	FOR MEDICARE &	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	COM	PLETED	
CHENTOF	DEFICIENCIES	(X1) PROVIDENSUP LICEOSES	A BUILDING			C	
PLAN OF C	ORRECTION				03	3/14/2023	
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		335101		STREET ADDRESS, CITY, STATE, ZIP COD	_		
ME OF PRO	OVIDER OR SUPPLIER		1	1740 S SAN DIMAS AVE			
				SAN DIMAS, CA 91773		(X5)	
ERENTO !			ID ID	PROVIDER'S PLAN OF CO		COMPLETION	
-	SUMMARY	STATEMENT OF DEFICIENCIES	PREFIX	CROSS-REFERENCED TO TH	E APPROPRIATE	PAIL	
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F 689	Continued From pa	age 13	ì			1	١
	and transfers.		1			1	1
		OF Fall Rick Assessment	popper named to			1	1
	A review of Reside	ent 2's Fall Risk Assessment,	1	W.		1	1
	dated 12/23/2022	indicated the resident was at	1	Į.		Y	1
	high risk for falls.		-	#			١
		ent 2's Fall Care Plan, dated				4	-
						1	
						1	- 8
				4		Ì	
	Within reach, app	hen the resident asks for help.	ì			1	
	Visual prompts w		1			N.	
	a review of Resi	dent 2's COC, dated 12/24/2023	la la	E.		Y)	
			1	3			
	Resident 2 on fle	oor. Resident 2 had a small skin	1	<u>l</u>		1	
	tear on the right	knee and I men akin ka		(M)		1	
	back. Resident	denied any pain.				4	
			1	**		F.	
	A review of Res	ident 2's Nurses Progress Note,		Ì			
	a was found W	ng on the 11001 mate.		AAAA PP		i	
	denied any pair	n and had no injury.	(r)			1	
1						1	
	A review of Re	sident 2's Incident Note, dated	1			1	
1	1/13/2023 at 6	:02 PM, indicated e mattress in on with both hands-on top of the					
	kneeling positi	note indicated Resident 2 was		1		Ì	
1	mattress. The	note indicated resident	1			1	
1	looking for his			4			
1	No. of the second section is	esident 2's Nurses Progress Note,		7		V.	
1							
1				l.		£	
	2 was crawlin	g on floor mat toward and the bathroom.	1			Ŷ	
ì							
1	During an oh	servation and concurrent interview					
1	During an obs	Vocational Nurse 1 (LVN 1), on				1	
			rith			14	
							4
	the can agint	bed. The resident stated he was no	ot 1	Facility ID: CA950000277	If conti	nuation sheet Page	14

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CENTER	S FOR MEDICARE	& MEDICAID SERVICES		- CONSTRUCTION	(X3) DAT	E SURVEY	
TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	CON	COMPLETED	
ND PLAN OF	CORRECTION	IDENTIFICATION NOMBERS	A BUILDING			С	
		555737	B, WING			3/14/2023	
NAME OF PR	ROVIDER OR SUPPLIER	300107		STREET ADDRESS, CITY, STATE, ZIP C 1740 S SAN DIMAS AVE SAN DIMAS, CA 91773		W5	
(X4) ID PREFIX TAG	TEACH DEFICE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 689	verbalized having he could just get to bathroom was "or resident 2 was im bed without askin resident could no the call light was the call light need Resident 2 from Q. A review of the fatitled, "Falls - Ma. 10/1/2022, indicated cognitive impairm weakness, and v. A review of the fatitled, "Falls - Ast dated 10/01/2022 policy was to propose to bath of the could be compared to the could be compared to the could be compared to the could be could be compared to the could be coul	"buzzer". The resident to use the bathroom and stated up and go on his own since the hly 10 feet away." LVN 1 stated up allow and would get out of hig. LVN 1 acknowledged the to call for help to the restroom if not within reach. LVN 1 stated ded to be accessible to prevent getting up alone. Accility's policy and procedure, hasing Fall Risk," dated ated fall risk factors included: hent, lower extremity (legs) isual deficits. Accility's policy and procedure, hesessing Falls and Their Causes," 12, indicated the purpose of the lovide guidelines for assessing a hall and to assist the staff in	F 68				