STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555777	A. BUILDING _____ B. WING _____	C 09/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BISHOP CARE CENTER	**151 PIONEER LANE BISHOP, CA 93514**

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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during the investigation of a complaint survey. Complaint Number: CA00857629. Representing the Department: Health Facilities Evaluator Nurse: 45240 The inspection was limited to the specific complaint and does not represent the findings of a full inspection of the facility. Two deficiency was identified for the complaint number: CA00857629.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to follow policy and procedure to ensure call lights were answered in timely manner to provide care and services for one of three sampled residents (Resident 1).	F 684	[redacted] 10/9/2023	

[redacted]

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 684	Continued From page 1	F 684		

compromised Resident (Resident 1) health and safety at risk when residents ' activities of daily living were not met in timely manner.

Findings:

During review of Residents 1 Admission Record (general demographics), the document indicated Resident 1 was admitted to the facility on January 21, 2008, with diagnoses to include Traumatic Subdural Hemorrhage without loss of consciousness (pool of blood between the brain and its covering), Myocardial Infarction (heart attack), Hypoxic Ischemic Encephalopathy (Brain Damage), Post traumatic stress disorder(a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event, Paraplegia (Paralysis of the legs and lower body, anoxic brain damage (cessation of cerebral blood flow to brain tissue), and Type 2 Diabetes Mellitus without complication(body does not produce enough insulin).

During an observation of Resident 1 on August 28,2023 at 2:20 PM, Resident 1 was yelling for help and shortly after, I observed Resident 1 on the floor by the door yelling for help. Maintenance personnel was walking by and called staff to help the resident. As I was exiting Resident 1 ' s room, Operation manager (OM) was outside the door. He introduced himself and stated that he is aware of what had happened.

During observation with OM, call lights are pressed. and observed visible lights illuminated but no audible sound heard.

During Interview with OM on August 28, 2023, at 2:30 PM. HFEN asked how would staff know

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F 684	Continued From page 2	F 684		

when residents are calling for help when there is no audible sound being heard in the hallways. OM stated that staff always has walkie talkies with them. The Audible sound can be heard at the nurse ' s station. The secretary at the front desk would call staff on their walkie talkies to alert them when residents are calling. HFEN observed a Certified Nurse Assistant (CNA 1) walking without a walkie talkie. I asked CNA1 in front of OM to show me her walkie talkie. She was unable to visibly show me her walkie talkie.

During interview with Resident 1 on August 28, 2023, at 2:50 PM. Resident 1 stated that he stopped using his call lights because nobody comes when he uses it and instead, he scotches himself out of bed to the door and yells to get help.
During an interview on August 28, 2023, at 4:00 PM with Director of Nursing (DON), DON stated that staff were supposed to sign out their walkie talkies at the beginning of the shift. She stated that few staff did not sign out their walkie talkies. During record review and interview with DON of "Walkie Talkie Sign out sheet" on September 26, 2023, 9:00 AM. DON stated on August 28,2023, Ten out of fourteen staff did not sign out their walkie talkies.

During a review of the facility ' s policy and procedure titled, Answering the "Call light" revised October 2010, the policy and procedure indicated, "The purpose of this procedure is to ensure timely responses to the resident ' s request and needs...

During a review of the facility ' s policy and procedure titled, "Activities of Daily Living, ADLS"revised March 2018, the policy and procedure indicated, "Residents will be provided

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F 684	Continued From page 3 with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLS) ...to maintain good nutrition, grooming and personal and oral hygiene."	F 684		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility	F 725		

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F 725	Continued From page 4	F 725		

failed to provide sufficient numbers of staff when 5 out of 8 sampled days (July 16, 2023- July 23, 2023) had less than 3.5 direct care service hours per patient day (DHPPD- the total number of hours worked per patient day divided by the average daily number of residents in the facility).

This failure had the potential to result in unmet needs, such as psychosocial and physical needs, and safety concerns for 88 residents.

Findings:

During a concurrent interview and record review on August 28, 2023, at 3:00 PM, with the Staff Developer (DSD) , the facility ' s document titled, "Census and Direct Care Service Hours Per Patient Day (DHPPD- the number that results from dividing the actual nursing hours perform by direct caregivers per patient day and the number of residents in the facility)," for dates: July 16, 2023, July 17, 2023, July 20, 2023, July 21,2023, and July 23, 2023, were reviewed. The DHPPD indicated, the "Actual DHPPD" was 2.12 (facility was short of 1.38) on July 16, 2023, "Actual DHPPD" was 2.53 (facility was short of 0.97) on July 17, 2023, "Actual DHPPD" was 2.87 (facility was short of 0.63) on July 20, 2023, "Actual DHPPD" was 2.78 (facility was short of 0.72) on July 21,2023 and "Actual DHPPD" was 2.10 (facility was short of 1.4) on July 23,2023. The DSD stated she was the one who placed all the hours from staff clock-ins to calculate the DHPPD and stated it was accurate. The DSD acknowledged the facility did not meet the DHPPD required for those dates.

During a concurrent interview and record review on September 26, 2023, at 8:38 AM, with the

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F 725	Continued From page 5 DON and DSD, the facility ' s staffing waiver for certified nursing assistant (CNA), with a valid date of July 1, 2023, to June 30, 2024, which indicated, " ...2. The facility shall continue to provide a minimum of 3.5 direct care service hours per patient day. 3. When the facility cannot provide 2.4 certified nurse assistant (CNA) direct care service hours per patient day, the facility shall use licensed vocational nurses and/or registered nurses. 4. The facility shall employ, and schedule additional staff as needed to ensure quality resident care based on the needs of individual residents and to ensure compliance with all applicable state and federal staffing requirements ...". The DON and DSD acknowledged the waiver was not followed on July 16, 2023, July 17,2023, July 20,2023, July 21,2023, and July 23, 2023, due to the DHPPD being below 3.5 and stated it was important to have enough staff so patient care is not affected and for the staff working to have enough help. During a review of the facility ' s policy and procedure titled, "Staffing, Sufficient and Competent Nursing" revised August 2022, the policy and procedure indicated, "Our facility provides sufficient numbers of nursing staff with the appropriate skills and competency necessary to provide nursing care and related care and services for all residents in accordance with resident care plans and the facility assessment".	F 725		

[redacted]

Bishop Care Center
10/03/23 Plan of Correction – F725 and F684
Abbreviated Survey Visit

Please accept this Plan of Correction as our Credible Allegation Package. The deficiencies will be corrected as specified and they will be monitored to prevent recurrence no later than **10/28/23.**

Preparation and/or execution of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely to comply with the provisions of the Health and Safety Code 1280 and 42 C.F.R. 405.1907.

F725 (DHPPD Staffing)

A. ***How corrective action will be accomplished for those residents found to have been affected by the deficient practice.***

During the dates reviewed (July 2023) no resident was directly affected due to the deficient practice.

B. How the facility will identify the residents having the potential to be affected by the deficient practice and what corrective action will be taken.

- Audited Staffing ratio from September 15-30 of 2023 and found 5 days where we were short of overall DHPPD. During these days there were 2-3 Nursing Assistants not included in the PPD calculation but were providing care to our residents, as well as one RN that had not been signing documentation correctly. During the identified days no resident was affected. The facility had previously not been counting all RNA and CNA hours toward DHPPD, but that practice has since been corrected.

- Director of Staff Development identified staff who has habitual absences and DON/DSD/Admin met with the identified staff on 10/2/23.

C. ***What measure will be put in place or what system changes will the facility make to ensure that the deficient practice does not occur.***

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- Admin conducted in-service with DSD and DON on 10/2/23 on coordinating timely reporting of the projected PPD for the day, as well as updates of absences and whether they are replaced or not & how to manage the census if staffing ratio is below 2.4 for C.N.A

- Facility applied for all workforce shortage waivers and was approved for July 1 2023 – June 30 2024. Facility currently in search of waivers available to facilities in rural communities. Otherwise, facilities will continue to apply for all available waivers on an annual basis.

- DSD/Admin contracted with registry to provide the facility with 12-24 hours of LVN daily for a 6-week period while we onboard our 2 newly hired nurses (2 LVN)

- CNA Certification Courses: Facility is currently leading instruction of an approved in-house CNA class led by DSD. 10 students in the class hand-recruited by the DSD and Admin. Expected to bolster the CNAs presence on the floor significantly once certified (est. date of October 27th, 2023). Facility is also hosting clinicals for the local community college CNAs course of 6 students. Total of 13-15 new CNAs expected to be hired from the certification efforts.

- Facility leveraged contracts with 3 registry: Star Staffing, City Mobile Group, Registry Network

- Facility implemented incentive programs for staff who are willing to work extra shifts

- Facility will continue to work with Regional recruiter to hire more staff and has incurred the lease of 10 properties in Bishop to attract outside talent to relocate to our small rural town

D.**How the facility plan to monitor its performance to make sure that solutions are sustained and POC integrated into the QA system**

- Director of Staff Development will report during daily stand-up meeting, the projected PPD for the day and the actual PPD calculation for the previous day

- DON/DSD will report during QA meeting if there are days that the facility falls below the required staffing levels and monitor for trends

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F 684

A. ***How corrective action will be accomplished for those residents found to have been affected by the deficient practice.***

Resident 1 was admitted in the facility with diagnosis of Traumatic Subdural Hemorrhage, Myocardial Infarction, Hypoxic Ischemic Encephalopathy, Post traumatic stress disorder, Paraplegia and Type 2 Diabetes Mellitus without complication. He is confused and has multiple daily episodes of yelling and aggressive behavior towards staff. He has broken his call light over 3 times due to his aggressive behaviors. He can use his call light when he chooses but refuses most of the time and proceeds to crawl to the door and scream and yell. This behavior has been addressed in many care plan meetings with family and with the Ombudsman present. Facility assessed the resident post found on the floor on Aug 28,2023 and no changes were noted on ROM to BUE/BLE,no change in adl function.

B.) How the facility will identify the residents having the potential to be affected by the deficient practice and what corrective action will be taken.

The DON, DSD conducted facility rounds on 10/3/23, to ensure call light is answered promptly. A random interview conducted with 5 sample residents for each hallway and residents stated that their needs are addressed timely and content with placement. No other resident affected by the deficient practice.

C.) What measure will be put in place or what system changes will the facility make to ensure that the deficient practice does not recur

1. On 10/3/23 the DSD provided in-service to staff regarding timely response to call light including non-nursing staff to address and anticipate needs.

2. During care plan conferences and during resident council meeting the IDT would review any concern with timely response to call lights and report findings during daily stand-up meeting

3. Maintenance staff will conduct random check of call light functionality monthly and report findings to Operations Manager

D.) How the facility plans to monitor its performance to make sure that solutions are sustained and POC integrated into the QA system.

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1. Department managers will conduct room rounds weekly for 3 months to at least 3 residents per manager to ensure that the residents needs are met, and call light answered promptly. Findings will be reported during the QA quarterly meeting and daily in standup as needed to monitor trends.