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

PRINTED: 06/13/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056189	A. BUILDING _____ B. WING _____	C 06/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLA VISTA TRANSITIONAL CARE CENTER	3033 AUGUSTA ST SAN LUIS OBISPO, CA 93401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health, Licensing and Certification, during a Standard Abbreviated Survey. Entity Reported Incident (ERI) CA00585731 - Substantiated Representing the Department: 36826 - HFEN The inspection was limited to the investigation of the ERI and does not reflect the findings of a full inspection of the facility.	F 000	*Allegation of Compliance:* This plan of correction is prepared and submitted as required by law. By submitting this POC, Bella Vista Transitional Care Center (BV) does not admit that the deficiencies listed on the HCFA Form 2567 exist, nor does Bella Vista Transitional Care Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiencies. Bella Vista Transitional Care Center reserves the right to challenge in legal proceedings all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiencies. This plan of correction constitutes written credible allegation of compliance for the deficiencies noted.	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices 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 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to monitor one of two sampled resident's (Resident 2's) behaviors of wandering to other residents' rooms. This failure resulted in compromising the physical safety of Resident 1 and had the potential to affect the safety of other residents in the facility. Findings:	F 689	**F689** *How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:* Resident #1 and Resident #2 were separated immediately. Resident #1 was moved to a different room immediately after incident. Resident #2 was put on frequent wandering check by staff for her location.	

POC ACCEPTED 6/27/18 L. Mendez, HFEN

CA DEPT OF PUBLIC HEALTH
2018 JUN 27 AM 8:14
LICENSING & CERTIFICATION
VENTURA DISTRICT OFFICE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 6-26-18

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.

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

PRINTED: 06/13/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056189	A. BUILDING _____ B. WING _____	C 06/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLA VISTA TRANSITIONAL CARE CENTER	3033 AUGUSTA ST SAN LUIS OBISPO, CA 93401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 1 The facility policy and procedure titled "Abuse Prevention", revised 11/28/16, indicated "Prevention ...Assess, care plan, and monitor residents with history of aggressive behaviors, behaviors such as entering other residents' rooms, self-injurious behavior, communication disorders, totally dependent on staff ...Definitions ...Physical Abuse: This includes but is not limited to hitting, slapping, pinching, and kicking." The facility policy and procedure titled "Accident Intervention", revised 5/07, indicated "It is the policy of this facility that the resident environment remains as free of accident hazards as is possible and that each resident receives adequate supervision and assistance devices to prevent accidents ...The purpose is to ensure that the facility provides an environment that is free from hazards over which the facility has control and provides appropriate supervision to each resident to prevent avoidable accident." During record review of the clinical record for Resident 2 on 5/8/18, the Admission Record, undated, indicated Resident 2 had diagnoses of a Conduct Disorder (repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate norms are violated), Violent behavior, Restlessness, and Agitation. Review of Resident 2's comprehensive assessment (MDS) on 5/23/18, dated 2/12/18, indicated Resident 2 was ambulatory with supervision and had severely impaired cognition. During record review of Resident 1's comprehensive assessments (MDS) on 5/23/18,	F 689	*How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:* DON and Administrator met on June 18, 2018 to discuss other residents that have wandering tendencies. No others residents were found to be a risk of compromising physical safety of other residents. For new admissions, records are reviewed by DON or nurse supervisor to screen for patient behaviors, placement, and level of supervision that is appropriate. The roommate for Resident #2 and residents in [redacted] will be screened and discussed with staff regarding compatibility and any issues that might present. *What measures will be put into place or what systematic changes the facility will make to ensure that the deficient practice does not recur:* IDT consisting of DON, Administrator or designee, DSD, SS Director, Activities Director, and Maintenance Director will meet monthly to discuss residents who exhibit wandering tendencies and	

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

PRINTED: 06/13/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056189	A. BUILDING _____ B. WING _____	C 06/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLA VISTA TRANSITIONAL CARE CENTER	3033 AUGUSTA ST SAN LUIS OBISPO, CA 93401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 2 dated 4/24/18, indicated Resident 1 was non-ambulatory, used a wheelchair, and had intact cognition. Review of Resident 2's nurses' notes on 5/9/18, Progress Note dated 5/5/18, indicated "Res (Resident 2) on COC (change of condition) for Physical aggression towards a Res (Resident 1). Res (Resident 2) physically harmed Res (Resident 1) [redacted] (Resident 1's room number at the time of the incident) @ (at) 1300 (1 p.m.) [redacted] (Resident 1) stated that the Res (Resident 2) came up behind her the shook her (Resident 1's) w/c (wheelchair) before turning around and dodging her (Resident 2's) attempts to physically harm her (Resident 1). CNAs (Certified Nursing Assistants) came in to separate the two (Resident 1 and 2). Both Res (Residents 1 and 2) are separated and are to be monitored. No injuries was sustained between the two Res (Residents 1 and 2). Continue to monitor Res (Residents 1 and 2) as needed." During an interview with Resident 1, on 5/8/18, at 2:36 p.m., Resident 1 indicated on the day of the incident (5/5/18) Resident 1 was in her room ([redacted] and was eating her lunch. Resident 1 was sitting in her wheelchair with her back towards the joined bathroom (situated and joined by two separate rooms [redacted]). Resident 1 felt her wheelchair shaking and initially thought it was due to an earthquake. When Resident 1's wheelchair started shaking harder, Resident 1 turned around and saw Resident 2 standing behind her and shaking the wheelchair. Resident 1 stated "She (Resident 2) immediately put a head choke (a tight grip around a person's neck, used to restrain him or her by restricting breathing) on me. I slipped out of it and put a	F 689	behaviors that have the potential to affect the wellbeing of other residents. The IDT will address any necessary changes or patterns in behavior that may need interventions and update residents care plans as necessary. *How the facility plans to monitor its performance to make sure that solutions are sustained. The plan must be implemented, evaluation for effectiveness, and integrated into the quality assurance system:* Monthly IDT meetings will be held regarding residents who exhibit wandering tendencies and behaviors that have the potential to affect the wellbeing of other residents. Changes in behavior will be discussed and the plan of care will centered to address individual needs for resident safety. Findings will be reported to QAPI Committee for further recommendations as needed. *Date completed:* June 29, 2018	

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

PRINTED: 06/13/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056189	A. BUILDING _____ B. WING _____	C 06/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLA VISTA TRANSITIONAL CARE CENTER	3033 AUGUSTA ST SAN LUIS OBISPO, CA 93401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 3 head chock on her ...I was defending myself." Resident 1 started to cry on two occasions during the interview and stated "She (Resident 2) really upset me ...I do not want to leave my room because I do not want to see her (Resident 2). She (Resident 2) says she does not remember, but I think she does. I feel sad. I keep my door closed." During an interview with Resident 2, on 5/8/18, at 2:50 p.m., Resident 2 indicated she did not recall having any conflict with other residents and did not recall who Resident 1 was. During an interview with a Certified Nursing Assistant (CNA 1), on 5/8/18, at 2:22 p.m., CNA 1 confirmed he was the first responder to the incident between Residents 1 and 2 on 5/5/18. CNA 1 confirmed Resident 1's statement and indicated the incident happened in [redacted] during lunch. CNA 1 stated "I was going to the elevator. Heard someone cry for help. I ran to the room. Saw (Resident 1's name) both arms around (Resident 2's name) neck. Pulled them (Residents 1 and 2) apart. (Resident 2's name) slapped (Resident 1's name). (Resident 1' name) was sitting in the wheelchair. (Resident 2's name) was standing and bending over and (Resident 1's name) hands were in the back of (Resident 2's name) neck. CNA 1 indicated after he responded to the incident a Charge Nurse came in to the room and pulled Resident 2 out from Resident 1's room. CNA 1 indicated he asked Resident 1 about what happened and Resident 1 indicated she was eating her lunch when she felt someone rocking her wheelchair. CNA 1 indicated Resident 1 told him Resident 2 put a chokehold on her. CNA 1 confirmed [redacted] had a joined bathroom and indicated Resident 2 resided in	F 689		

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

PRINTED: 06/13/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056189	A. BUILDING _____ B. WING _____	C 06/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLA VISTA TRANSITIONAL CARE CENTER	3033 AUGUSTA ST SAN LUIS OBISPO, CA 93401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 4 [redacted] at the time of the incident. Review of Resident 2's nurses' notes on 5/9/18, Progress Notes dated from 5/8/17 to 5/9/18, indicated Resident 2 was going inside other residents' rooms at least on 18 different occasions in the past year on the following dates: 5/18/17 5/9/17 5/10/17 7/30/17 8/2/17 8/4/17 8/6/17 8/10/17 9/1/17 9/3/17 9/8/17 9/14/17 9/15/17 9/16/17 9/20/17 9/21/17 9/26/17 1/18/18 Review of Progress Note dated 8/4/17, indicated Resident 2 had a potential incident when Resident 2 went inside another resident's room and placed a pillow over the face of the resident residing in that room. During an interview with the Social Worker (SW), on 5/8/18, at 4:26 p.m., SW confirmed on 8/4/17 another resident reported Resident 2 went inside her room and placed a pillow over her face. Review of Resident 2's care plans on 5/9/18, care	F 689		

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

PRINTED: 06/13/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056189	A. BUILDING _____ B. WING _____	C 06/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLA VISTA TRANSITIONAL CARE CENTER	3033 AUGUSTA ST SAN LUIS OBISPO, CA 93401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 5 plan titled "Potential for a behavior problem r/t (related to) history of wandering to other resident's rooms unwelcomed", dated 8/7/17, indicated "Interventions/Tasks ...Staff to monitor resident's whereabouts frequently as often as possible and redirect as needed." During record review and a concurrent interview with the SW, on 5/9/18, at 4:32 p.m., SW confirmed Resident 2's clinical record contained no documentation Resident 2's behaviors of wandering to other residents' rooms were monitored. SW also confirmed Resident 2's clinical record contained no documentation to show the pattern and the frequency of Resident 2's wandering behaviors to other residents' rooms. SW indicated the facility staff "have their eyes on her (Resident 2)." During an interview with Resident 2's Certified Nursing Assistant (CNA 1), on 5/9/18, at 12:23 p.m., CNA 1 indicated before the incident on 5/5/18, he was not aware Resident 2 required to be monitored for behaviors of wandering to other residents' rooms. During an interview with Resident 2's Licensed Practical Nurse (LPN 1), on 5/9/18, at 12:27 p.m., LPN 1 confirmed Resident 2's behaviors of wandering to other residents' rooms were not being monitored. During an interview with the Director of Nursing (DON), on 5/9/18, at 12:48 p.m., the DON confirmed Resident 2's clinical record contained no documentation Resident 2's behaviors of wandering to other residents' rooms were being monitored.	F 689		