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	056132	A. BUILDING _____ B. WING _____	C 10/15/2024

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GOLDEN SAN ANDREAS CARE CENTER	900 MOUNTAIN RANCH ROAD SAN ANDREAS, CA 95249

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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during the investigation of two complaints and one facility reported incident (FRI). Complaint Number(s): #CA00923690 and #CA00923622 Facility Reported Incident Number(s): #CA00924697 The inspection was limited to the specific complaints and facility-reported incidents investigated and does not represent the findings of a full inspection of the facility. One deficiency was identified for Complaint #CA00923690 at F689. No deficiencies were issued for Complaint #CA00923622 and Facility Reported Incident #CA00924697.	F 000		
F 689 SS=G	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 observation, interview, and record review, the facility failed to ensure one of five	F 689		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Cindy Richardson TITLE: ED (X6) DATE: 11/27/24

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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sampled residents (Resident 1) received adequate supervision and that care plan (an individualized set of goals and interventions specific to the Resident 1 ' s needs) interventions were implemented to prevent an injury when, Resident 1 ' s care plan interventions of a fall mat (a soft pad at the side of the bed to soften a fall) and two person staff assist with activities of daily living (ADL ' s; a term used to collectively describe fundamental skills required to independently care for oneself, such as eating, bathing, and mobility) were not implemented and Resident 1 fell from the bed on 9/24/24.

This failure led to Resident 1 sustaining multiple skin tears, pain, a broken clavicle (also called collarbone; is a long, slightly curved bone that connects your arm to your body and located in your upper chest area), and a decline in ability to feed herself.

Findings:

During a review of Resident 1 ' s undated clinical record titled "ADMISSION RECORD," (a document that contained Resident 1 ' s demographic information) indicated, Resident 1 ' s diagnosis included encephalopathy (a brain dysfunction that caused confusion, memory loss, and personality changes), muscle weakness, and Parkinson ' s disease (a long-term brain disorder that caused involuntary body movements, stiffness, and difficulty with balance and coordination).

A review of Resident 1 ' s clinical record titled, "Brief Interview of Mental Status," (BIMS - an interview that assessed Resident 1 ' s mental function), dated 6/26/24, indicated Resident 1 ' s

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F 689	Continued From page 2 BIMS score was 11 (8 to 12 points suggests moderate cognitive impairment; Problems with a person's ability to think, learn, remember, use judgement, and make decisions). A review of Resident 1 ' s clinical record titled, "Morse Fall Scale," (an assessment tool that determined Resident 1 ' s fall risk factors and targeted interventions to reduced fall risks), dated 1/12/24, indicated Resident 1 ' s fall risk score was 55 (45 and higher indicated a high risk for falls). Resident 1 ' s contributing factors for falls included a history of falls, use of a wheelchair, overestimated or forgot physical limits, and had more than one medical diagnosis. A review of Resident 1 ' s clinical record titled, "[FACILITY NAME] Progress Notes *New* Post Fall Evaluation," dated 9/10/24, at 4:42 p.m., by the Licensed Nurse (LN 1), indicated the Certified Nursing Assistant (CNA 1) witnessed Resident 1 fall on 9/10/24, at 4:07 p.m., in Resident 1 ' s room. At the time of the fall, CNA 1 was changing Resident 1 ' s brief (adult diaper). After the fall, Resident 1 was sent to the Emergency Department (ED) at [ACUTE CARE HOSPITAL NAME] where it was determined Resident 1 had a fractured (broken) left clavicle. A review of Resident 1 ' s clinical record titled, "[ACUTE CARE HOSPITAL NAME] Progress Notes *New*," dated 9/10/24, at 9:06 p.m., by LN 5, indicated Resident 1 rolled out of bed and had complaints of pain scored at 10 out of 10 using the Numerical Rating Pain Scale (assessment tool 0 through 10; 0 = no pain and 10= the worst pain). A review of Resident 1 ' s fall risk care plan,	F 689		

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initiated on 8/29/22, indicated Resident 1 was at risk for falls related to her diagnosis of Parkinson's disease, weakness, urinary incontinence (unable to hold urine), use of antianxiety and antidepressant medications, history of falls, and required staff assistance with transfers and toileting. Interventions included fall mats at the bedside which was initiated on 9/1/2022.

A review of Resident 1 ' s clinical record titled, "Post Fall Evaluation," dated 9/10/24, at 4:42 p.m., indicated there was no fall mat in place at the time of the fall.

A review of Resident 1 ' s clinical record titled, "Interdisciplinary Team [IDT - a group of health care providers and other staff members that work together to discuss the care of Resident 1] Post Fall Meeting", dated 9/11/24, at 9:55 a.m., by LN 1, indicated Resident 1 rolled out of bed on 9/10/24, at 4:07 p.m. and sustained a fracture to her left clavicle, skin tears to the right and left side of her wrists, skin tears to the right index (finger next to the thumb) finger, a knot (bump) to the left side of her head, and complained of severe left shoulder pain that radiated (sent out) down to the elbow. At 4:45 p.m., Resident 1 was sent to [ACUTE CARE HOSPITAL NAME] for further evaluation.

A review of Resident 1 ' s clinical record titled, "[ACUTE CARE HOSPITAL NAME] Progress Notes *New*", dated 9/11/24, at 2:12 a.m., by LN 4, indicated Resident 1 returned to the facility from [ACUTE CARE HOSPITAL NAME] on 9/11/24, at 1:31 a.m.

During a concurrent observation and interview on

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10/16/24, at 11:50 a.m., in Resident 1 ' s room, Resident 1 had skin tears on her right hand that had steri-strips (thin, sticky bandages that are applied to the skin to help small cuts or wounds stay closed as they heal) in place, and a scabbed wound (a rough surface made of dried blood that forms over a cut or broken skin while it is healing) on her left fourth finger. There was no fall mat on either side of the bed. Resident 1 stated she was unsure how she fell out of bed on 9/10/24.

During a concurrent observation and interview on 10/16/24, at 11:57 a.m., with LN 2, LN 2 stated Resident 1 required two staff members on each side of the bed when Resident 1 was turned and/or her brief was changed because Resident 1 was very fragile. LN 2 acknowledge there was not a fall mat at the bedside and that Resident 1 required a fall mat as part of her fall precaution interventions.

During an interview on 10/15/24, at 12:05 p.m., with CNA 2, CNA 2 stated Resident 1 was a one person assist with brief changes and transfers (move from bed to wheelchair). CNA 2 stated she was unsure if Resident 1 needed a fall mat and was not sure where to look in Resident 1 ' s clinical record to verify if Resident 1 needed a one person or a two person assist with care needs. CNA 2 was unsure where to locate Resident 1 ' s care plan.

During an interview on 10/15/24, at 12:10 p.m., with LN 3, LN 3 stated Resident 1 was a two person assist with brief changes (staff assistance to remove and replace an absorbent cloth or disposable products which is worn by humans who are incapable of, or have difficulty, controlling their bladder or bowel movements) and transfers

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F 689	Continued From page 5 because of her limited ability to assist with cares and because Resident 1 was very weak. During a phone interview on 10/15/24, at 12:36 p.m. with CNA 1, CNA 1 stated before Resident 1 ' s fall on 9/10/24, Resident 1 sometimes required a one person assist and sometimes required a two person assist with cares (depending on Resident 1 ' s strength on a given day). CNA 1 stated on the day of the fall, CNA 1 rolled Resident 1 ' s body away from her on the bed and then CNA 1 turned to grab the brief off of the nightstand. CNA 1 stated that was when Resident 1 fell out of bed. CNA 1 stated after the fall, Resident 1 declined in her physical ability to be helpful with her own cares. CNA 1 stated after the fall Resident 1 complained her head and shoulder hurt and Resident 1 was later transferred to [ACUTE CARE HOSPITAL NAME]. During a concurrent interview and record review on 10/15/24, at 1:20 p.m., with the Minimum Data Set (MDS - standardized assessment of Resident 1) Nurse, Resident 1 ' s clinical record titled, "Section GG - Functional Abilities and Goals" (a section of a comprehensive assessment that reviewed Resident 1's physical abilities), dated 6/30/24 and "Section GG - Functional Abilities and Goals", dated 9/16/24, were reviewed. Section GG, dated 6/30/24 (before the fall), indicated Resident 1 required supervision or touch assistance (the helper provided verbal cues and/or touching/steadying assistance and the helper set up or cleaned up, but Resident 1 completed the activity) when she ate her meals. Resident 1 was dependent on staff when she rolled to the right and to the left (the helper did all the effort) and with all other ADLs. "Section GG - Functional Abilities and Goals", dated 9/16/24	F 689		

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(after the fall), indicated Resident 1 was dependent on assistance when she ate her meals (the helper did all the effort and Resident 1 did none of the effort to complete the activity). Resident 1 remained dependent on staff when she rolled to the right and to the left and with all other ADLs. The MDS Nurse stated before the fall, Resident 1 was able to feed herself most of the time and after the fall she needed total assistance with eating. The MDS Nurse stated Resident 1 ' s care plan was supposed to be read and followed by all CNAs, Licensed Vocational Nurses (LVN), Registered Nurses (RNs), and the entire care team to guide them in how to specifically care for Resident 1.

During an interview on 10/15/24, at 2:04 p.m., with the Occupational Therapist (OT), the OT stated before the fall, Resident 1 was able to feed herself independently more often than she was not able to feed herself independently and Resident 1 had started Occupational Therapy on 10/7/24 to increase independence with ADLs. The OT stated before the fall Resident 1 had use of both of her arms (Resident 1 was right-handed). The OT stated after the fall, Resident 1 had increased trouble with feeding and did not have use of her left arm (arm was in a sling; a device used to support and keep still (immobilize) an injured part of the body). The OT stated all health care professionals were supposed to read and follow Resident 1 ' s care plan to ensure safety during cares and treatments.

A review of Resident 1 ' s clinical record titled, "Occupational Therapy (exercises designed to increase independence with Activities of Daily Living (ADLs - brushing teeth, getting dressed, toileting, eating) Treatment Encounter Note(s)",

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dated 10/11/24, at 2:24 p.m., by the Occupational Therapist (OT - health care provider who assisted Resident 1 with Occupational Therapy), indicated Resident 1 attempted therapy and then immediately requested to lay back down in bed. A two-person assist (two health care providers assisted Resident 1) was used when Resident 1 was repositioned. Resident 1 ' s body movements led to pain (as evidenced by Resident 1 yelled out) and limited her functional activities.

During a phone interview on 10/15/24, at 2:39 p.m., with the Medical Director (MD), the MD stated the facility should have provided the correct number of staff while providing cares to Resident 1 to ensure quality care was delivered.

During a follow-up interview on 10/15/24, at 2:50 p.m., with CNA 1, CNA 1 stated on 10/15/24, the Director of Staff Development (DSD) showed CNA 1 (for the first time) that the information regarding the amount of assistance Resident 1 required was located in Resident 1's care plan in the Electronic Heath Record (a digital version of a patient's medical history that can be used to improve patient care) and in the Kardex (a system that nurses used to organize and access resident ' s information for care planning). CNA 1 stated prior to 10/15/24, CNA 1 was unsure where to find information regarding the amount of assistance Resident 1 required during cares. CNA 1 stated after Resident 1 ' s fall, Resident 1 had a decline in her ability to feed herself. CNA 1 stated before the fall, Resident 1 used to call CNA 1 by name and after the fall Resident 1 did not recall CNA 1 ' s name.

During a concurrent phone interview and record review on 10/16/24, at 12:27 p.m., with the

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Director of Nursing (DON), Resident 1 ' s Medication Administration Record (MAR - a document that indicated when and what medication was administered to Resident 1), dated 9/24, was reviewed. The DON stated Tramadol (a government regulated pain mediation used to treat moderate pain (4 through 6 on the Numerical Rating Pain Scale) to severe pain (7 through 9 on the Numerical Rating Pain Scale) 50 milligrams (mg - unit of measurement) was ordered to be given every 6 hours following the fall on 9/10/24. The DON verified Resident 1 was given Tramadol 54 times for pain control in the month of September 2024.

A review of Resident 1 ' s left clavicle fracture care plan, initiated on 9/11/24, in the section titled "Interventions," indicated for Resident 1 to use a sling to her left arm at all times and was not supposed to put weight on the left arm.

During a concurrent interview and record review on 10/15/24, at 3:25 p.m., with the DON, the following documents were reviewed:
- Resident 1 ' s care plan related to ADL deficits, initiated on 8/30/22,
- "[Resident 1 ' s] Kardex," undated,
- "Certified Nursing Assistant Job Description," dated 10/20,
- The facilities "Fall and Fall Risk, Managing" Policy and Procedure (P&P), dated 9/23, and
- The facilities "Care Plan, Comprehensive Person-Centered" P&P, dated 3/22.

The DON confirmed Resident 1 ' s ADL deficit care plan, initiated on 8/30/22, indicated Resident 1 ' s ADL interventions, also initiated on 8/30/22, included: extensive assistance by two staff members when Resident 1 was turned in bed and toileted. The DON confirmed Resident 1 ' s

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F 689	Continued From page 9 clinical record titled, "Kardex," indicated Resident 1 required two staff members to assist Resident 1 when she was repositioned in bed, turned in bed, and with brief changes. A concurrent interview and record review with the DON continued with a review of the facility ' s document titled, "Certified Nursing Assistant Job Description", indicated, " ... Duties and Responsibilities ...review care plans daily to determine if changes in the resident ' s daily care routine have been made on the care plan ...." The facility ' s P&P titled, "Fall and Fall Risk, Managing", indicated, ..." the staff will identify interventions related to the resident ' s specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling ...". The facility ' s P&P titled, "Care Plan, Comprehensive Person-Centered", indicated, " ... The ... team ... develops and implements a ... person centered care plan for each resident ... " After reviewing Resident 1 ' s ADL deficit care plan, Resident 1 ' s "Kardex," the "Certified Nursing Assistant Job Description," the "Fall and Fall Risk, Managing" P&P, and the "Care Plan, Comprehensive Person-Centered" P&P, the DON stated that CNA 1 should have used a two person assist to turn Resident 1 and two persons assist to change Resident 1 ' s brief. The DON stated Resident 1 ' s care plan was created to ensure Resident 1 received safe care from the healthcare team. The DON stated her expectation was that all the staff members would have read and followed Resident 1 ' s care plan. The DON verified Resident 1 ' s care plan, the CNA Job Description, and the above listed P&Ps were not followed. A review of the facility ' s undated educational power point titled, "Lifting and Transferring," indicated, " ...WHEN CHANGING A RESIDENT-TIPS AND REMINDERS ... Ensure	F 689		

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F 689	Continued From page 10 there are appropriate staff to assist. For example, if the resident requires a 2 person assist, be sure to have 2 CNAs to assist ... Ensure that all supplies are within reach, so you do not have to leave the resident ' s side. Always review the Care Plan or Kardex prior to providing care to ensure proper plan of care is maintained ..." A review of the facility ' s P&P titled, "Repositioning," dated 5/13, indicated, " ...check the care plan, ... or the communication system to determine resident ' s specific positioning needs including .... Resident level of participation and the number of staff required to complete the procedure ..."	F 689		

F689 Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)

SS=G

Corrective action(s) for residents found to have been affected by this deficiency:

1. On 9/11/2024, the fall care plan and all associated fall interventions were reviewed to ensure appropriateness for Resident 1.
2. On 9/11/2024 and 9/13/24, the Director of Staff Development in-serviced facility Certified Nursing Assistants and Licensed Nurses regarding implementation of resident specific care-planned fall interventions to minimize risk of falls or resident decline.

Corrective action(s) for residents that may be affected by this deficiency:

1. All residents who are at risk for falls may be affected by this deficient practice.
2. On 11/19/2024, the ADL care plans and Fall Risk care plans for all residents were reviewed to ensure appropriateness and implementation.

Measure(s) that will be put in place to ensure that this deficiency does not recur:

1. On 9/11/2024, 9/13/24, 9/27/24, 10/3/24, 10/15/24, 10/16/24, and 10/21/24 all Licensed Nurses were educated regarding fall prevention with an emphasis on implementation of documented care plan interventions as written in the policy and procedure for the facility Fall Program.
2. On 9/11/2024, 9/13/24, 9/27/24, 10/3/24, 10/15/24, 10/16/24, and 10/21/24 all Certified Nursing Assistants were educated regarding the Resident Kardex and care plans with an emphasis on how to access, review, and ensure implementation of interventions.
3. Beginning 11/18/2024, the Director of Staff Development will ensure all new hire Certified Nursing Assistants review their Job Description with an emphasis on the facility Fall Program and the importance of implementation of interventions to prevent resident injury and decline.
4. Beginning 11/18/2024, the MDS Department and/or designee will conduct quarterly chart reviews to ensure the fall care plan is updated with any necessary fall prevention interventions.

5. Beginning 11/18/2024, the Director of Nursing and/or designee will review the care plan of any resident who experiences a fall to ensure there is an escalation of interventions to promote safety and minimize any associated injuries or declines.

6. Beginning 10/21/2024, the Director of Staff Development and/or designee will conduct at least 5 random staff interviews to ensure staff can validate where to find the amount of assistance required with ADLs with an emphasis on bed weekly x1 month then twice monthly x 2 months then monthly until no further discrepancies are identified.

Measure(s) that will be implemented to monitor continued effectiveness of the corrective action(s) taken to ensure that this deficiency has been corrected and will not recur:

1. The Director of Nursing and the Director of Staff Development will be responsible for the implementation of this plan.

2. The Director of Staff Development and/or designee will report any occurrences of care plan interventions not implemented to the Director of Nursing daily and as needed.

3. The Director of Nursing and/or designee will report the total number of falls and the number of occurrences of care plan interventions not implemented at the monthly QA Meeting.

Corrective action(s) to be completed on:

11/22/2024