#38108 and #36924 review and accepted
2/26/24

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FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055344	A. BUILDING _____ B. WING _____	C 01/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDENVIEW HEALTHCARE & WELLNESS CENTRE, LP	590 S. INDIAN HILL BLVD. CLAREMONT, CA 91711

(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 during the investigation of three facility reported incidents. Facility reported incident numbers: CA00878902, CA00878168, and CA00879599. Representing the Department: HFEN #38108 and #36924 The inspection was limited to the specific facility reported incidents investigated and does not represent the findings of a full inspection of the facility. One deficiency was written for facility reported incident # CA00878168. One deficiency was written for facility reported incident # CA00879599. No deficiency was written for facility reported incident #CA00878902.	F 000	Country Villa Claremont Healthcare Center submits this response and plan of correction as part of the requirements under the state and federal law. The Plan of Correction is submitted in accordance with specific regulatory requirements. It shall not be construed as admission of any alleged deficiency cited or any liability. The provider submits this plan of correction with the intention that it is inadmissible by any third party in any civil, criminal action or proceedings against the provider or its employee, agents, officers, director, or shareholders. The provider reserves the right to challenge the cited findings if at any time the provider determines that the disputed findings are relied upon in a manner adverse to the interests of the provider either by the governmental agencies or third party. The facility desires that this plan of correction be considered the facility's allegation of compliance. "Preparation, submission and/or execution of this Plan of Correction does not constitute admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction is prepared, submitted and/or executed solely because it is required by the provision of federal and state law."	
F 557 SS=D	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by:	F 557	**F557 Respect, Dignity/ Right to have Personal Property** **How corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice:**	2/12/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: DON — (X8) DATE: 2/12/24

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

DON 3/12/24

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 557	Continued From page 1 Based on interview and record review, the facility failed to ensure two of three sampled residents (Resident 7 and Resident 8) were treated with respect and dignity by failing to answer call lights (a visual cue that a patient needs assistance) in a timely manner. a. On 1/18/24, Resident 7 waited one hour to get Resident 7's soiled adult brief changed. b. On 1/18/24, Resident 8 waited one hour to get Resident 8's soiled adult brief changed. These failures resulted with Resident 7 to feel forgotten and like no one cared about Resident 7 and Resident 8 to feel very angry and upset. Findings: a. During a review of Resident 7's "Admission Record (AR)", the "AR," indicated Resident 7 was admitted to the facility on 12/18/23 with diagnoses that included fracture (partial or complete break of the bone) of the left hip joint, difficulty walking, and general muscle weakness. During a review of Resident 7's "History and Physical Reports (H&P)", dated 12/28/23, the H&P indicated Resident 7 had the capacity to understand and make decisions. During a review of Resident 7's "Minimum Data Set" (MDS, a resident assessment and care-screening tool) dated 2/22/23, the "MDS" indicated Resident 7 was cognitively (ability to understand and process information) intact, Resident 7 had clear speech, the ability to be understood (clear comprehension), and made self-understood. The MDS indicated Resident 7	F 557	On 2/5/2024 SSD conducted a psychosocial visit to Resident 7 and Resident 8. On 2/5/2024 DON/Designee provided re-education to facility staff on Policy and Procedure titled "Communication Call System" and "Resident's Rights-Accommodations of needs" with an emphasis on answering call lights in a timely manner. On 2/5/2024 DON/Designee provided a one: one to CNA #5 on Policy and Procedure titled "Communication Call System" and "Residents Rights-Accommodation of needs" with an emphasis on answering call lights in a timely manner. **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:** On 2/6/2024 the DON/Designee conducted a visual observation and interview of 5 random residents regarding prompt response to call light; no other residents were affected by the same deficient practice. **What measures will be put in place or what systemic changes will you make**	

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F 557	Continued From page 2 was dependent (helper does all effort) with toilet hygiene (maintain hygiene before and after voiding or bowel movement) and lower body dressing. During a review of Resident 7's "Change in Condition" (COC, sudden clinically deviation from a patient's baseline) dated 1/18/24, the "COC" indicated Resident 7 was diagnosed with a urinary tract infection (UTI, an infection in any part of the urinary system: kidneys, bladder, or urethra [tube through which the urine leaves the body]). During a review of Resident 7's care plan (CP), titled "Activity of Daily Living (ADL, term used to describe the skills required to independently care for oneself) self-care performance deficit related to impaired balance, limited mobility (impacts a person's ability to move around freely, easily, and without pain)," dated 12/31/23, the CP's interventions indicated to encourage Resident 7 to use [the] bell to call for assistance. During a review of Resident 7's CP, titled "UTI per Urine analysis (urine test to confirm a UTI), dated 1/18/24, indicated to perform proper perineal (an area lower in the body located between the thighs) care assistance as part of the facilities intervention. During an interview with Resident 7 in Resident 7's room on 1/19/24 at 11:30 am, Resident 7 stated on "last night" (1/18/24, unknown time) Resident 7 waited for one hour to have Resident 7's soiled adult brief changed. Resident 7 stated "I don't like to stay in a soiled diaper [brief] at all, let alone one hour. It just makes me feel forgotten and that no one cares."	F 557	**to ensure that the deficient practice does not recur:** On 2/5/2024 DON/Designee provided re-education to facility staff on Policy and Procedure titled "Communication Call System" and "Residents Rights-Accommodation of needs" with an emphasis on answering call lights in a timely manner. On 2/5/2024 DON/Designee provided a one: one to CNA #5 on Policy and Procedure titled "Communication Call System" and "Residents Rights-Accommodation of needs" with an emphasis on answering call lights in a timely manner. DON/designed and Social Services Director/designee will do random visual observation and resident interviews weekly for 4 weeks, then monthly for 3 months to ensure call lights are being answered in a timely manner. Identified concerns will be addressed immediately and reported to the Administrator and DON for further follow-up as warranted. An audit tool was created and started on 2/12/2024 **How facility plans to monitor its performance to make sure the**	

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F 557	Continued From page 3 b. During a review of Resident 8's "Admission Record (AR)," the "AR" indicated Resident 8 was admitted to the facility on 12/27/23 with diagnoses that included fracture of the lower left leg and general muscle weakness. During a review of a "H&P", dated 12/28/23, the "H&P" indicated Resident 8 had the capacity to understand and make decisions. During a review of a "MDS," dated 1/3/24, the "MDS" indicated Resident 18 was cognitively intact, had clear speech, had the ability to be understood (clear comprehension) and make-self understood. The MDS indicated Resident 8 was dependent (helper does all effort) with toilet hygiene (maintain hygiene before and after voiding or bowel movement) and lower body dressing. During a review of Resident 8's CP, titled "Activity of Daily Living (ADL, term used to describe the skills required to independently care for oneself) self-care performance deficit related to functional abilities impaired, need assist for ADL," dated 1/10/24, the CP's interventions indicated to encourage Resident 8 to use bell to call for assistance. During an interview with Resident 8 in Resident 8's room on 1/19/24 at 11:46 am, Resident 8 stated Resident 8 would wait 30 minutes to one hour for someone [staff] to respond to Resident 8's call light. Resident 8 stated Resident 8 waited up to two hours after calling for assistance to have Resident 8's soiled brief changed. Resident 8 stated on 1/18/24 at around 10 pm, Resident 8 waited an hour to be changed and that made Resident 8 very angry and upset.	F 557	**solutions are sustained and to ensure deficient practice will not recur:** The DON/designee will report on finding of weekly visual observation during Stand-up meeting. Identified concerns will be reported to the administrator for further follow-up as warranted. The DON will present the results of the above audits to the Quality Assurance and Performance Improvement Committee for monthly review and recommendations for 3 months or until substantial compliance of at least 90% is achieved.	

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F 557	Continued From page 4	F 557		

During an interview with Certified Nurse Assistant 5 (CNA 5), on 1/19/24 at 2:37 pm, CNA 5 stated 1/18/24 was [a] very busy [night]. CNA 5 stated CNA 5 attempted to help the residents assigned to CNA 5, but CNA 5 only had two hands. CNA 5 stated residents assigned to CNA 5 waited up to one hour to receive care. CNA 5 stated CNA 5 only had two hands and did the best CNA 5 could to assist residents (in general) and change resident's soiled [adult briefs].

During a review of the facility's "Assignment Sheet (AS)" for the evening shift (3 pm to 11 pm), the "AS" indicated CNA 5 cared for Residents 7 and Resident 8 on 1/18/24.

During an interview with the Director of Nursing (DON) on 1/19/24 at 3:24 pm, the DON stated call lights should be answered with in 15 minutes. The DON stated call lights should be answered by all staff. The DON stated residents waiting 1, 2, or 3 hours to have a soiled diaper (briefs) changed was unacceptable because [there was a] risk of skin breakdown, contracting a UTI, and a risk of possible falls. The DON stated dignity also played a factor and there was a potential to affect resident's psychosocial health.

During a review of the facility's policy and procedure (P&P), titled "Resident Rights - Quality of Life," revised on 3/2017, indicated to ensure that each resident receives the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. Each resident shall be cared for in a manner that promotes and enhances the quality of life, dignity,

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F 557	Continued From page 5 respect, individuality and receives services in a person-centered manner, as well as those that support the resident in attaining or maintaining his/her highest practicable well-being. During a review of the facility's (P&P), titled "Resident Rights - Accommodation of Needs," revised 1/2012, the P&P indicated to ensure that the facility provided an environment and services that met resident individual needs. During a review of the facility's (P&P), titled Communication - Call System, revised 1/1/2012, the P&P's purpose indicated, to provide a mechanism for residents to promptly communicate with Nursing Staff. The P&P indicated; the facility would provide a call system to enable residents to alert the nursing staff from resident rooms. Call cords (call lights) will be placed within the resident's reach in the resident's room and Nursing Staff will answer call bells promptly, in a courteous manner.	F 557	**F689 Free of Accidents/Supervision/Devices** **How corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice:** On 1/19/2024 Resident #2's bed was placed in the lowest position.	2/12/2024
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 observation, interview, and record review, the facility failed to ensure a safe and accident-free environment for one of three	F 689	On 2/5/2024 DON/Designee provided re-education to facility staff on Policy and Procedure titled "Fall Prevention and management program" with the emphasis on providing a safe environment that minimized complications associated with falls- by making sure low beds used for fall prevention are in the lowest position On 2/12/24 DON/Designee provided re-education to LVN 1 on Policy and Procedure titled "Fall Prevention and management program" with the emphasis on providing a safe environment that minimized complications associated with	

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F 689	Continued From page 6 sample residents (Resident 2). This failure had the potential to result in a fall and injury to Resident 2. Findings: During a review of Resident 2's "Admission Record (AR)," the "AR" indicated Resident 2 was admitted to the facility on 11/14/23 with diagnoses that included left-sided hemiplegia/hemiparesis (paralysis [complete or partial loss of muscle function] on one side of the body), heart failure (the heart doesn't pump as well as it should), and difficulty walking. During a review of Resident 2's "History & Physical (H&P)," dated 11/15/23, the "H&P," indicated Resident 2 had muscle weakness, unsteadiness of feet, lack of coordination, and Resident 2 had the capacity to understand and make decisions. During a review of Resident 2's "Minimum Data Set (MDS, a resident assessment and care screening tool)" dated 11/22/23, the "MDS," indicated Resident 2 had moderate cognitive impairment (a term referring to an individual's ability to process thoughts and the ability of an individual to perform the various mental activities), impairment on one side of the body, and Resident 2 required substantial/maximum assistance with chair to bed to chair transfers (moving a resident from one flat surface to another). During an observation on 1/19/24, at 11:35 a.m., Resident 2's bed was observed raised to and between surveyor's hip and knee area. Resident	F 689	falls. by making sure low beds used for fall prevention are in the lowest position **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:** On 2/6/2024 the DON/Designee conducted a visual audit of 5 random residents who are high fall risk to make sure beds were in the lowest position; no other residents were affected by the same deficient practice. **What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur:** On 2/5/2024 DON/Designee provided re-education to facility staff on Policy and Procedure titled "Fall Prevention and management program" with the emphasis on providing a safe environment that minimized complications associated with falls- by making sure low beds used for fall prevention are in the lowest position On 2/12/24 DON/ Designee provided re-education to LVN 1 on Policy and Procedure titled "Fall Prevention and management program" with the emphasis on providing a safe environment that minimized complications associated with	

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F 689	Continued From page 7 2's bed was not in the lowest position and Resident 2 was lying in bed. During a concurrent observation and interview, on 1/19/24, at 11:38 a.m., with Licensed Vocational Nurse (LVN 1) LVN 1 in Resident 2's room. LVN 1 stated Resident 2 was a Red Star fall risk. LVN 1 stated fall precaution actions included checking residents (in general) every two hours, pad alarms for some residents to alert staff when residents were moving, floormats at the bedside, and low beds [beds at lowest position]. LVN 1 stated Resident 2's bed was not in the lowest position. LVN 1 lowered Resident 2's bed to the lowest position. LVN 1 stated it was important for the bed to stay in the lowest position, for a risk for fall resident [Resident 2], to minimize falls to Resident 2 [that can occur] from a [bed being in a] high position. During an interview, on 1/19/24, at 3:40 p.m., with the Director of Nursing (DON), the DON stated [when residents were] a Red Star fall risk, this indicated they [residents] had fallen within the last three months. The DON stated Resident 2 was a Red Star fall risk and Resident 2's bed should be in the lowest position when Resident 2 was lying in bed. During a review of the facility's Policy & Procedure (P&P), dated 8/2014, titled, "Fall Prevention and Management Program," The P&P indicated [the facility was] to provide a safe environment that minimized complications associated with falls.	F 689	falls. by making sure low beds used for fall prevention are in the lowest position The DON/ Designee will conduct visual rounds at least weekly x 1 month, then at random thereafter, of residents who have indication for fall precautions, specifically residents on a low bed, to ensure precautions are in place and/or beds are in the lowest position. Identified concerns will be addressed immediately and reported to the Administrator and DON for further follow-up as warranted. An audit tool was created and started on 2/12/2024 **How facility plans to monitor its performance to make sure the solutions are sustained and to ensure deficient practice will not recur:** The DON/designee will report findings of weekly visual audit during monthly fall meeting, any identified concerns will be addressed immediately and reported to Administrator and DON for further follow- up as warranted. DON will present the results of the above audits to the Quality Assurance and Performance Improvement Committee for monthly review and recommendations for 3 months or until substantial compliance is reached.	