| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055047 | A. Building<br>B. Wing | 07/30/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Palms Care Center | 1010 Ventura Avenue<br>Chowchilla, CA 93610 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38961<br><br>Based on observation, interview, and record review, the facility failed to ensure adequate supervision and monitoring for one of six sampled residents (Resident 1) when Resident 1 had a history of aggressive behavior towards other residents and staff did not implement interventions to protect other residents. On 7/12/24 Resident 1 was left unattended in the dining room. Resident 1 hit Resident 2 with a closed fist to his left hand. Resident 1 had a care plan intervention for one on one (1:1-constant observation for safety of residents) supervision.<br><br>This failure resulted in Resident 1 not being supervised in the dining room and striking Resident 2 on his left hand, causing injuries to Resident 2 ' s left hand that required treatment for a skin tear (a wound that is caused by direct contact between the skin and another object) and bleeding to his left hand.<br><br>Finding:<br><br>During a review of Resident 1 ' s Admission Record (AR), dated 7/30/24, the AR indicated, Resident 1 was admitted on [DATE] with diagnoses that included, Dementia (loss of cognitive functioning, thinking remembering, and reasoning), and Type 2 Diabetes Mellitus (body has trouble controlling blood sugar).<br><br>During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool used to identify resident cognitive (mental process) and physical function) assessment dated [DATE], the MDS indicated, Resident 1's Brief Interview for Mental Status (BIMS -assessment of memory and judgment) assessment score was 99 (unable to complete) (a score of 13-15 indicates cognitively intact, 8-12 indicates moderately impaired, 0-7 indicates severe impairment).<br><br>During a review of Resident 2 ' s Admission Record (AR), dated 7/30/24, the AR indicated, Resident 1 was admitted on [DATE] with diagnoses that included, Congestive Heart Failure (heart is unable to pump blood efficiently), and anemia (not enough healthy red blood cells).<br><br>During a review of Resident 2's MDS assessment dated [DATE], the MDS indicated, Resident 1's BIMS assessment score was 4. The BIMS assessment indicated Resident 2 had severe cognitive impairment.<br><br>(continued on next page) |



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

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During a concurrent observation and interview on 7/30/24 at 08:35 a.m. with Certified Nurse Assistant (CNA) CNA 1 in Resident 1 ' s room, Resident 1 was sitting in his wheelchair by the bed, dressed. CNA 1 stated, she was assigned to a 1:1 with Resident 1 from 08:30 a.m. to 09:00 a.m. CNA 1 stated, Resident 1 was on a 1:1 because of his aggressive behaviors to other residents. CNA 1 stated, Resident 1 should be 1:1 continuously for the safety of other residents. CNA 1 stated, all residents including Resident 1 had the right to be free from physical abuse.<br><br>During a concurrent interview and record review on 7/30/24 at 9:20 a.m. with Licensed Vocational Nurse (LVN) LVN 1. Resident 1 ' s (AM SHIFT) document dated 7/12/24 1:1 document was reviewed. LVN 1 stated, Resident 1 liked to go up to other residents and shake their hand. LVN 1 stated, Resident 1 has had altercations with other residents. LVN 1 stated, we were in charge of assigning CNAs to a 1:1 daily, for Resident 1 starting at 6:00 a.m. to 10:00p.m. in 30- minute increments. LVN 1 stated Resident 1 was on a 1:1 due to his multiple altercations with other residents. LVN 1 stated, Resident 1 was a danger to other residents. LVN 1 stated, Residents have the right to be free from physical abuse from other residents. LVN 1 stated, Resident 1 and Resident 2 had an altercation in the large dining room on 7/12/24 at 2:30 p.m. LVN 1 stated, Resident 2 had a skin tear and was bleeding from his left hand. LVN 1 stated Resident 1 hit Resident 2 with a closed fist. LVN 1 stated 1:1 document dated 7/12/24 showed Resident 1 was on 1:1 on 7/12/24 at 6:00 am till 10:00 pm. LVN 1 stated the assignment sheet indicates at 2:00 p.m. to 2:30 p.m. and 2:30 p.m. to 3:00 p.m. a CNA was not assigned to provide 1:1 for Resident 1. LVN stated, because of the missing assignments on 7/12/24 placed other residents in danger.<br><br>During a record review of Resident 1 ' s Care Plan (CP) undated, the CP indicated, .Focus .resident will be free of being involved in any resident to resident altercation .goal .resident will be free of physical altercation . intervention .one on one .CNA .date initiated 7/12/2024 .<br><br>During an interview on 7/30/24 at 10:25 a.m. with LVN 2, LVN 2 stated, Resident 1 was on a 1:1 on 7/12/24 from 6:00 am to 10:00 pm. LVN 2 stated, Resident 1 was not on a 1:1 at the time of the incident. LVN 2 stated, the altercation took place on 7/12/24 at 2:30 p.m. in the dining room. LVN 2 stated, LVNs were responsible to complete the 1:1 log sheet for CNA assignments daily. LVN 2 stated LVN ' s were responsible to monitor and observe CNAs were providing the 1:1. LVN 2 stated, Resident 1 was on a 1:1 due to his behavior and aggression towards other residents. LVN 2 stated, Resident 1 was a danger to others because his aggression could escalate quickly, and he would become verbally and physically aggressive. LVN 2 stated, residents had the right to be free from physical abuse by other residents.<br><br>During an interview on 7/30/24 at 10:40 a.m. with CNA 2, CNA 2 stated, she was assigned to Resident 1 to provide 1:1 from 6:00 a.m. to 12:00 p.m. on 7/12/24. CNA 2 stated, Resident 1 was on a 1:1 due to his aggression, especially towards other male residents. CNA 2 stated, residents had the right to be free from abuse from other residents. CNA 2 stated, Resident 1 was danger to other residents.<br><br>During an observation on 7/30/24 at 11:00 a.m. in the patio, Resident 2 was sitting in his wheelchair. Resident 2 had a large bandage to the back of his left hand. Resident 2 was unable to recall how or what happened to his hand.<br><br>During a review of Resident 4 ' s Admission Record (AR), dated 7/30/24, the AR indicated, Resident 4 was admitted on [DATE] with diagnoses that included, Schizophrenia (a disorder that affects a person ' s ability to think, feel, and behave) and muscle weakness.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During a review of Resident 4's MDS assessment dated [DATE], indicated Resident 4's BIMS assessment score was 15. The BIMS assessment indicated Resident 4 was cognitively intact.<br><br>During an interview on 7/30/24 at 11:15 a.m. with LVN 1, LVN 1 stated, a CNA did not witness the altercation. LVN 1 stated, if Resident 1 was on a 1:1 at the time of the incident, the assigned CNA would be the witness. LVN 1 stated, Resident 4 witnessed the incident.<br><br>During an interview on 7/30/24 at 11:30 a.m. with Resident 4, Resident 4 stated, he was in the dining room watching a movie when he saw Resident 1 hit Resident 2 on his left hand several times with a closed fist.<br><br>During a concurrent interview and record review on 7/30/24 at 1:00 p.m. with Director of Nursing (DON), Resident 1 ' s 1:1 document dated 7/12/24 was reviewed. The DON stated, the incident happened on 7/12/24 at 2:30 pm in the dining room. The DON stated, Resident 1 was on a 1:1 due to his physical aggression towards other residents. The DON stated the 1:1 log dated 7/12/24 indicated there were no CNAs assigned to Resident 1 on 7/12/24 from 2:00 p.m. to 3:00 p.m. The DON stated, because Resident 1 was not on the 1:1, the incident took place. The DON stated, Resident 1 should be on 1:1 always. The DON stated, if Resident 1 had been on 1:1 the CNA assigned would be a witness. The DON stated, there was no documentation of a CNA as a witness. The DON stated residents in the facility had the right to be free from physical harm from other residents. The [NAME] stated any injury to another resident from a resident-to-resident altercation was considered harm. The DON stated, Resident 2 sustained injuries to his left hand. The DON stated it was the facilities responsibility to keep residents safe.<br><br>During an interview on 7/30/24 at 1:35 p.m. with CNA 3, CNA 3 stated, she was familiar with Resident 1 who could be aggressive with other residents. CNA 3 stated Resident 1 is currently on a 1:1 due to his behavior and is a danger to other residents. CNA 3 stated all residents had the right to be free from physical abuse from other residents.<br><br>During a concurrent interview and record review on 7/30/24 at 1:55 p.m. with the DON, the facility Policy and Procedure (P&P) titled Abuse, Neglect and Exploitation dated 2024 was reviewed. The P&P indicated, .It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property . The DON stated, We did not follow our P&P. The DON stated we failed to protect Resident 2 from a resident who we knew was a danger to others in the facility.<br><br>During a telephone interview on 07/31/24 at 10:52 a.m. with Administrator (ADM), The ADM stated the facility was responsible for the safety of all of their residents. The ADM stated Resident 1 was on a 1:1 because of his aggressive behavior and was danger to other residents. The ADM stated all residents had the right to be free from abuse per the facility P&P.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During a review of the facility ' s P&P titled Abuse, Neglect and Exploitation dated 2024, the P&P indicated .It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property .abuse means the willful infliction of injury .resulting in physical harm or mental anguish .Instances of abuse of all residents .cause physical harm, pain, or mental anguish It includes verbal abuse, physical abuse .the facility will implement policies and procedures to prevent and prohibit all types of abuse .the facility will make efforts to ensure all residents are protected from physical harm .increased supervision of .residents . |