

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055116	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/07/2024
NAME OF PROVIDER OR SUPPLIER Linda Mar Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 751 San Pedro Terrace Road Pacifica, CA 94044	

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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43913</p> <p>Based on interviews and record reviews, the facility failed to ensure the allegation of accidents, was promptly reported to the State Agency (SA, which is the California Department of Public Health, CDPH) in accordance with facility ' s policy and procedure for one of two three sampled residents (Resident 1).</p> <p>This failure to report fall with injury has potential for further accidents to happen not being reported.</p> <p>Findings:</p> <p>During a review on 5/7/24 at 10 AM, of Admission Record, dated 5/7/24, indicated, admitted to facility on 4/26/23 with diagnoses including: Congestive Heart Failure (a condition in which the heart does not pump as it should), Atrial Fibrillation (an irregular heartbeat that causes heart to beat too quickly), Abnormalities with Gait and Mobility(abnormal walking and movement).Resident discharged to acute 5/10/23.</p> <p>During an interview on 5/7/24 at 10:48 AM, with CNA, per CNA who have worked at facility for [AGE] years, to prevent falls, put bed on low position, mattress on the floor, read the fall sticker or dot on the patient ' s bed or wheelchair, that indicates patient is fall risk. Meeting everyday at 11 am, they talk about Fall risks patients, involves activities. If patient falls, do not touch the patient till assessed by Licensed Nurse and tells us what to do next.</p> <p>During an interview on 5/7/24 at 11:43AM, with Director of Nursing (DON), per DON, the patient had a fall, unwitnessed fall in the room and nurse found him on the floor at change of shift. Patient admitted on [DATE], had been here before, alert and oriented, more debilitated from last time. admitted for short term rehab, plans to go back to group home. Daughter is emergency contact #1. Per DON, when asked for the report to state agency and Ombudsman, per DON, not reportable, it ' s a minor injury only a laceration. Will know the extent when patient is seen in the hospital. Patient was sent toER on [DATE]. Per DON, the daughter called her and told her that her dad was sent home from ER with Home Health. Per DON daughter upset with facility for sending him to ER, concerned about ambulance bill. Hearing aid is kept in the medication cart for safe keeping, since it was early, 911 came already, patient left without the hearing aid. No documentation found of reporting incident to state agency and Ombudsman.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of PT Evaluation and Plan of Treatment dated 4/27/23, Start of Care is 4/27/23, total dependence with bed mobility and transfers. PT discharge Summary, indicated, Total dependence with bed mobility and transfers.</p> <p>Review of OT Evaluation and Plan of Treatment, indicated, start of care is 4/28/23.</p> <p>Review of SLP Evaluation and Plan of Care indicated, start of care is 5/1/23.</p> <p>During an interview on 5/7/24 at 12:30PM, with Licensed Vocational Nurse (LVN), per LVN, she remembers patient, she was a new nurse. CNA reported that he turned patient to the side to change his diaper, hit the bedside table, rolled out of bed. Patient was alert and verbally responsive, no behavior. Walked in and assess the body, took Vital Signs, he is on blood thinner, was bleeding in the forehead, in the middle. Patient was not unresponsive, no loss of consciousness, I called 911. Protocol to call the DON on every fall. After assessment, patient put back to bed using Hoyer lift, usually two people but don ' t remember how many people were there. DON called the family.</p> <p>During a review of MD orders, MD order indicated, Eliquis Oral tab 2.5 mg give 1 tablet every 12 hours related to Paroxysmal Atrial Fibrillation. Hold if SBP below 100 or Pulse below 60.</p> <p>Review of Untitled Progress notes, dated 5/10/23 at 8:30 AM, indicated, Resident with incident of rolling off bed during incontinent care with CNA. CNA stated, while providing care to resident, resident was turned on is side with minimal assistance .while retrieving linen from bedside table, resident begun moving further towards edge of opposite side of bed and rolled over the edge before he could reach him. CNA stated prior to incident, resident was noted to have increased confusion .he stayed with resident student nurses came to the room and reported incident to charge nurse. After nurse assessment, resident was transferred back to bed and 911 was called. CNA educated going forward when providing care to resident to have stuff secondary to resident ' s impulsiveness.</p> <p>CNA involves not available per DON. Out of the country from 4/30/24 to 6/1/24. Unable to interview.</p> <p>Review of MDS Section C- dated 5/3/23, indicated, BIMS Score - 13, no cognitive impairment.</p> <p>Review of MDS Section G- Functional Status, dated 5/3/23, indicated, 3= extensive assist for bed mobility, transfers, walk, locomotion, eating and toilet use. Support= 2, means one person physical assist.</p> <p>Review of facility document, Unusual Occurrence Reporting, dated 2/24, indicated, Policy Statement, As required by federal or state regulations, our facility reports unusual occurrences or other reportable events which affects the health, safety, or welfare of our residents . 1. Our facility will report the following events to appropriate agencies: g. Allegations of Abuse, neglect, and misappropriation of resident property; and resident elopement. 2. Unusual occurrences shall be reported via telephone and later in writing to appropriate agencies as required by current law and /or regulations within twenty four (24) hours of such incident or as otherwise required by federal and state regulations.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43913</p> <p>Based on interview and record review, the facility failed to provide adequate supervision and interventions for one of three residents (Resident 1) when:</p> <p>Resident 1, extensive assist with bed mobility per MDS section G, rolled out of bed during incontinent care.</p> <p>This failure resulted in Resident 1 hitting the side of the table and sustained laceration on the forehead.</p> <p>Findings:</p> <p>During a review on 5/7/24 at 10 AM, of Admission Record, dated 5/7/24, indicated, admitted to facility on 4/26/23 with diagnoses including: Congestive Heart Failure (a condition in which the heart does not pump as it should), Atrial Fibrillation (an irregular heartbeat that causes heart to beat too quickly), Abnormalities with Gait and Mobility(abnormal walking and movement).Resident discharged to acute 5/10/23.</p> <p>During an interview on 5/7/24 at 10:48 AM, with CNA, per CNA who have worked at facility for [AGE] years, to prevent falls, put bed on low position, mattress on the floor, read the fall sticker or dot on the patient ' s bed or wheelchair, that indicates patient l s fall risk. Meeting every day at 11 am, they talk about Fall risks patients .involve activities. If patient falls, do not touch the patient till assessed by Licensed Nurse and tells us what to do next.</p> <p>During an interview on 5/7/24 at 11:43AM, with Director of Nursing (DON), per DON, the patient had a fall, unwitnessed fall in the room and nurse found him on the floor at change of shift. Patient admitted on [DATE], had been here before, alert and oriented, more debilitated from last time. admitted for short term rehab, plans to go back to group home. Daughter is emergency contact #1. Per DON, when asked for the report to state agency and Ombudsman, per DON, not reportable, it ' s a minor injury only a laceration. Will know the extent when patient is seen in the hospital. Patient was sent toER on [DATE]. Per DON, the daughter called her and told her that her dad was sent home from ER with Home Health. Per DON daughter upset with facility for sending him to ER, concerned about ambulance bill. Hearing aid is kept in the medication cart for safe keeping, since it was early, 911 came already, patient left without the hearing aid. No documentation found of reporting incident to state agency and Ombudsman.</p> <p>Review of PT Evaluation and Plan of Treatment dated 4/27/23, Start of Care is 4/27/23, total dependence with bed mobility and transfers. PT discharge Summary, indicated, Total dependence with bed mobility and transfers.</p> <p>Review of OT Evaluation and Plan of Treatment, indicated, start of care is 4/28/23. Reason for referral/Current Illness: Patient referred to OT due to new onset of compromised physical exertion level during activity, decreased functional mobility and functional limitation with self-care. Vision: patient wears glasses 24 hrs (needs glasses replaced by VA).</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of SLP Evaluation and Plan of Care indicated, start of care is 5/1/23. Cognition: Alertness = Intact, Oriented to person, place, time, purpose and caregivers.</p> <p>Problem Solving: Mild, Memory: mild.</p> <p>During an interview on 5/7/24 at 12:30PM, with Licensed Vocational Nurse (LVN), per LVN, she remembers patient, she was a new nurse. CNA reported that he turned patient to the side to change his diaper, hit the bedside table, rolled out of bed. Patient was alert and verbally responsive, no behavior. Walked in and assess the body, took Vital Signs, he is on blood thinner, was bleeding in the forehead, in the middle. Patient was not unresponsive, no loss of consciousness, I called 911. Protocol to call the DON on every fall. After assessment, patient put back to bed using Hoyer lift, usually two people but don ' t remember how many people were there. DON called the family.</p> <p>During a review of MD orders, MD order indicated, Eliquis Oral tab 2.5 mg give 1 tablet every 12 hours related to Paroxysmal Atrial Fibrillation. Hold if SBP below 100 or Pulse below 60.</p> <p>Review of Untitled Progress notes, dated 5/10/23 at 8:30 AM, indicated, Resident with incident of rolling off bed during incontinent care with CNA. CNA stated, while providing care to resident, resident was turned on his side with minimal assistance .while retrieving linen from bedside table, resident begun moving further towards edge of opposite side of bed and rolled over the edge before he could reach him. CNA stated prior to incident, resident was noted to have increased confusion .he stayed with resident student nurses came to the room and reported incident to charge nurse. After nurse assessment, resident was transferred back to bed and 911 was called. CNA educated going forward when providing care to resident to have stuff secondary to resident ' s impulsiveness.</p> <p>CNA involved not available per DON. Out of the country from 4/30/24 to 6/1/24. Unable to interview.</p> <p>Review of MDS Section C- dated 5/3/23, indicated, BIMS Score - 13, no cognitive impairment.</p> <p>Review of MDS Section G- Functional Status, dated 5/3/23, indicated, 3= extensive assist for bed mobility, transfers, walk, locomotion, eating and toilet use. Support= 2, means one person physical assist.</p> <p>Review of facility document, Fall Risk Assessment, dated 4/26/23, Score- 16. High Risk.</p> <p>Review of facility document. Care Plan, dated 4/26/23, At risk for falls and injuries due to decline in function, impaired mobility .Intervention: Identify resident ' s needs . staff anticipates and attends to needs. Keep environment hazard free. Fall Risk care plan does not address visual deficit.</p> <p>Review of undated facility Policy and Procedure, Accidents and Incidents, indicated. All accidents or incidents involving residents, employees, visitors, vendors, etc. occurring on our premises shall be investigated and reported to the Administrator. 1. The Nurse Supervisor/Charge Nurse and /or the department director or designee shall promptly initiate and document investigation of the accident or incident</p> <p>No Investigation Summary found/sent to State agency office.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of facility Policy and Procedure, Falls and Fall Risk, Managing, dated 3/2019, indicated,</p> <p>Based on previous evaluations and current data, 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. Fall Risk Factors: 2. Residents conditions that may contribute to the risk of falls may include: 1. Visual deficits . Resident-Centered Approaches to Managing Falls and Fall Risk: 1. The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with history of falls.</p>		