

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055222	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/26/2024
NAME OF PROVIDER OR SUPPLIER  Springs Road Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE  1527 Springs Road Vallejo, CA 94591	

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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40214</b></p> <p>Based on interviews and record reviews, the facility failed to ensure the physician ' s order were followed to properly manage one out of two sampled resident's (Resident 1) pain. This failure resulted in inadequate pain management for Resident 1.</p> <p>Findings:</p> <p>A review of Resident 1 ' s face sheet (demographics) indicated an admitted [DATE] to the facility. Resident 1 ' s diagnoses included Muscle Weakness, Chronic Pain (persistent pain that last for more than 3 months) and Hemiplegia (paralysis on one side of the body). Resident 1 ' s Minimum Data Set (MDS, an assessment tool) dated 11/10/24 indicated intact cognition.</p> <p>A review of Resident 1 ' s pain monitoring on the electronic medical record (EMAR, an electronic health record that keeps track of when medications are given to the residents) for 11/2024 indicated Resident 1 complained of pain 26 out of 27 days since his admission on 11/3/24. Resident 1 ' s EMAR for 11/2024 indicated an order for oxycodone (narcotic, analgesic) 5 milligram (mg, unit of measure) 1 tablet every 6 hours as needed (PRN) for severe pain.</p> <p>A review of Resident 1 ' s pain monitoring on the EMAR for 12/2024 indicated Resident 1 complained of pain 24 out of 26 days from 12/1/24 up to 12/26/24. Resident 1 ' s EMAR for 12/2024 indicated an order for oxycodone 5 mg half (1/2) tablet every 6 hours PRN-start date of 11/29/24 and discontinued date of 12/13/24, for moderate pain. Resident 1 ' s EMAR for 12/2024 also indicated an order for oxycodone 5 mg 1/2 tablet every 4 hours PRN -start date of 12/13/24 for moderate pain.</p> <p>During an interview on 12/26/24 at 1:10 p.m., Resident 1 stated staff did not know how to adequately manage his pain. Resident 1 stated he knew he was undermedicated for pain. Resident 1 stated nurses were not following the doctor ' s order for pain management, or they just don ' t bother to read the order. Resident 1 stated due to staff not following the physician order for his pain management, his pain was not adequately controlled.</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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and EMAR record review for 11/2024 and 12/2024 on 12/26/24 at 2:46 p.m., the Director of Nursing (DON) stated the facility uses a numeric rating scale (NRS, consist of a series of numbers rating pain intensity, typically from 0 to 10) when identifying pain intensity. The DON stated the facility interprets a pain level (PL) of 1 to 3 to indicate mild pain, a PL of 4 to 6 to indicate moderate pain and PL of 7 to 10 indicate severe pain. The DON stated pain medications were administered based on severity parameters as ordered by the physician. The DON stated it was important to follow the physician ' s orders for pain management so resident could achieve optimal pain relief. The DON stated this was important to improve residents ' quality of life.</p> <p>A concurrent interview and 12/2024 EMAR record review with the DON indicated on 12/26/24 at 2:46 p.m. indicated oxycodone 5 mg 1/2 tablet by mouth every 6 hours PRN for moderate pain (start date of 11/29/24 and dc date of 12/13/24) was given to the resident on 12/7/24 for a PL 7, 12/11/24 for a PL 8, 12/12/24 for a PL 8, 12/13/24 for a PL 9. The DON verified MD ordered was not followed since Resident 1 was complaining of severe pain and not moderate pain.</p> <p>A review of 12/2024 EMAR with the DON indicated oxycodone 5 mg 1/2 tablet by mouth every 4 hours PRN for moderate pain, start date of 12/13/24, was administered to Resident 1 on 12/14/24 two times when he complained of PL 7 and 8, on 12/17/24 for a PL 9, on 12/21/24 for a PL 7 and on 12/24/24 for PL 2. The DON verified staff did not the follow the physician ' s order.</p> <p>A review of the numeric rating scale adopted from [NAME], [NAME] et al. 1989 indicated 1-3 as mild pain, 4-6 as moderate pain, and 7-10 as severe pain.</p> <p>A review of the facility ' s policy and procedure (P&amp;P) titled Pain Assessment and Management, revised 3/2020, the P&amp;P indicated, . the pain management program is based on a facility wide commitment to appropriate assessment and treatment of pain, based on professional standards of practice, the comprehensive care plan, and the resident choices related to pain management .</p> <p>A review of the facility ' s P&amp;P titled Administering Medications, revised 4/2019, the P&amp;P indicated, . medications are administered in accordance with prescriber orders .</p> <p>Based on interviews and record reviews, the facility failed to ensure the physician's order were followed to properly manage one out of two sampled resident's (Resident 1) pain. This failure resulted in inadequate pain management for Resident 1.</p> <p>Findings:</p> <p>A review of Resident 1's face sheet (demographics) indicated an admitted [DATE] to the facility. Resident 1's diagnoses included Muscle Weakness, Chronic Pain (persistent pain that last for more than 3 months) and Hemiplegia (paralysis on one side of the body). Resident 1's Minimum Data Set (MDS, an assessment tool) dated 11/10/24 indicated intact cognition.</p> <p>A review of Resident 1's pain monitoring on the electronic medical record (EMAR, an electronic health record that keeps track of when medications are given to the residents) for 11/2024 indicated Resident 1 complained of pain 26 out of 27 days since his admission on 11/3/24. Resident 1's EMAR for 11/2024 indicated an order for oxycodone (narcotic, analgesic) 5 milligram (mg, unit of measure) 1 tablet every 6 hours as needed (PRN) for severe pain.</p> <p>(continued on next page)</p>		

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<p>F 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Plan the resident's discharge to meet the resident's goals and needs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 40214</p> <p>Based on interviews and record reviews, the facility failed to ensure there was an updated discharge plan for one out of two sampled residents (Resident 1) when:</p> <ol style="list-style-type: none"> <li>1. There were no regular re-evaluation of Resident 1 to identify changes that require the modification his discharge plan. The discharge plan was not updated, as needed, to reflect these changes.</li> <li>2. Resident 1 was not involved in the development of the discharge plan and was not informed of the final discharge plan.</li> <li>3. There was no documentation that Resident 1 has been asked about his plans in returning to the community after he completed skilled services on 12/15/24.</li> </ol> <p>These failures to fully prepare Resident 1 be discharged for discharge from the facility could result to safety issues, prevent Resident 1 to be an active partner to effectively transition him to post-discharge care to prevent potential readmissions.</p> <p>Findings:</p> <p>A review of Resident 1 ' s face sheet (demographics) indicated an admitted [DATE] to the facility. Resident 1 ' s diagnoses included Muscle Weakness, Chronic Pain (persistent pain that last for more than 3 months) and Hemiplegia (paralysis on one side of the body). A review of Resident 1 ' s Minimum Data Set (MDS, a health status screening and assessment tool used for all residents of long-term care nursing facilities) assessment dated [DATE] indicated he had intact cognition. Resident 1 ' s MDS also indicated he needed maximal assistance (staff provides more than half of the effort) when it comes to transfers.</p> <p>During an interview on 12/26/24 at 1:10 p.m., Resident 1 stated he wished to be discharged from the facility as soon as possible. Resident 1 stated staff did not talk to him about his discharge plan and his preference to go home with his cousin. Resident 1 stated no one from the facility talked to him about being discharged from the facility and what the current plan was. Resident 1 stated for now all he knew was he can ' t be discharged from the facility. Resident 1 stated the facility nurses, and the social services knew he wished to be discharged from the facility.</p> <p>During a concurrent interview and Social Services Initial assessment dated [DATE] record review on 12/26/24 at 4:37 p.m., the Director of Nursing (DON) stated she was aware Resident 1 wished to be discharged from the facility. The DON verified Resident 1 ' s previous discharged plan was to go home; however, it was now changed since Resident 1 had no one to care for him and has limited funding. The DON stated Resident 1 was custodial (non-medical care provided by non-licensed staff and does not require the constant attention of trained medical professional) as of 12/15/24. The DON stated she was aware of Resident 1 ' s desire to be discharged from the facility. The DON was unsure on whether anyone from her team had spoken to Resident 1 about Resident 1 ' s plan to be discharged to his cousin ' s care. The DON was unable to provide documentation about a new DC plan in place for Resident 1.</p> <p>(continued on next page)</p>		

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<p>F 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and Social Service Director (SSD) note dated 11/8/24 record review on 12/26/24 4:43 p.m., the Minimum Data Set Coordinator (MDSC) verified there were no plans yet on when to discharge Resident 1 from the facility and there was no note to indicate a new plan to discharge Resident 1 from the facility had been initiated at this time. The MDSC stated it was Resident 1 ' s right to be discharged from the facility if he so wished and it was the facility ' s responsibility to ensure safe discharge from the facility.</p> <p>A review of the facility ' s policy and procedure (P&amp;P) titled Transfer or Discharge- Resident Initiated dated 10/2022, the P&amp;P indicated, Resident Initiated Transfer or Discharge means the resident, or the responsible party had provided written or verbal notice of intent to leave the facility .documentation: written or verbal notice of intent to leave the facility, a discharge plan, documented discussion with the resident, or if appropriate, with his/her representative containing details of discharge planning and arrangements .</p> <p>46132</p> <p>Based on interviews and record reviews, the facility failed to ensure there was an updated discharge plan for one out of two sampled residents (Resident 1) when:</p> <ol style="list-style-type: none"> <li>1. There were no regular re-evaluation of Resident 1 to identify changes that require the modification his discharge plan. The discharge plan was not updated, as needed, to reflect these changes.</li> <li>2. Resident 1 was not involved in the development of the discharge plan and was not informed of the final discharge plan.</li> <li>3. There was no documentation that Resident 1 has been asked about his plans in returning to the community after he completed skilled services on 12/15/24.</li> </ol> <p>These failures to fully prepare Resident 1 be discharged for discharge from the facility could result to safety issues, prevent Resident 1 to be an active partner to effectively transition him to post-discharge care to prevent potential readmissions.</p> <p>Findings:</p> <p>A review of Resident 1's face sheet (demographics) indicated an admitted [DATE] to the facility. Resident 1's diagnoses included Muscle Weakness, Chronic Pain (persistent pain that last for more than 3 months) and Hemiplegia (paralysis on one side of the body). A review of Resident 1's Minimum Data Set (MDS, a health status screening and assessment tool used for all residents of long-term care nursing facilities) assessment dated [DATE] indicated he had intact cognition. Resident 1's MDS also indicated he needed maximal assistance (staff provides more than half of the effort) when it comes to transfers.</p> <p>During an interview on 12/26/24 at 1:10 p.m., Resident 1 stated he wished to be discharged from the facility as soon as possible. Resident 1 stated staff did not talk to him about his discharge plan and his preference to go home with his cousin. Resident 1 stated no one from the facility talked to him about being discharged from the facility and what the current plan was. Resident 1 stated for now all he knew was he can't be discharged from the facility. Resident 1 stated the facility nurses, and the social services knew he wished to be discharged from the facility.</p> <p>(continued on next page)</p>

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<p>F 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and Social Services Initial assessment dated [DATE] record review on 12/26/24 at 4:37 p.m., the Director of Nursing (DON) stated she was aware Resident 1 wished to be discharged from the facility. The DON verified Resident 1's previous discharged plan was to go home; however, it was now changed since Resident 1 had no one to care for him and has limited funding. The DON stated Resident 1 was custodial (non-medical care provided by non-licensed staff and does not require the constant attention of trained medical professional) as of 12/15/24. The DON stated she was aware of Resident 1's desire to be discharged from the facility. The DON was unsure on whether anyone from her team had spoken to Resident 1 about Resident 1's plan to be discharged to his cousin's care. The DON was unable to provide documentation about a new DC plan in place for Resident 1.</p> <p>During a concurrent interview and Social Service Director (SSD) note dated 11/8/24 record review on 12/26/24 4:43 p.m., the Minimum Data Set Coordinator (MDSC) verified there were no plans yet on when to discharge Resident 1 from the facility and there was no note to indicate a new plan to discharge Resident 1 from the facility had been initiated at this time. The MDSC stated it was Resident 1's right to be discharged from the facility if he so wished and it was the facility's responsibility to ensure safe discharge from the facility.</p> <p>A review of the facility's policy and procedure (P&amp;P) titled Transfer or Discharge- Resident Initiated dated 10/2022, the P&amp;P indicated, Resident Initiated Transfer or Discharge means the resident, or the responsible party had provided written or verbal notice of intent to leave the facility .documentation: written or verbal notice of intent to leave the facility, a discharge plan, documented discussion with the resident, or if appropriate, with his/her representative containing details of discharge planning and arrangements .</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 40214</p> <p>Based on interviews and record reviews, the facility failed to ensure one out of two sampled residents (Resident 1) was safe during transfer when four certified nursing students were allowed to assist a staff member to transfer Resident 1 from his bed to the shower chair. This failure resulted to Resident 1 to fall on 11/15/24.</p> <p>Findings:</p> <p>A review of Resident 1 ' s face sheet (demographics) indicated an admitted [DATE] to the facility. Resident 1 ' s diagnoses included Muscle Weakness, Chronic Pain (persistent pain that last for more than 3 months) and Hemiplegia (paralysis on one side of the body). Resident 1 ' s Brief Interview for Mental Status (BIMS, a screening tool used to assess a person's cognitive functioning) dated 11/10/24 score was 15 indicating intact cognition. A review of Resident 1 ' s Minimum Data Set (MDS, a health status screening and assessment tool used for all residents of long term care nursing facilities) assessment dated [DATE] indicated he had intact cognition and he needed maximal assistance (when a helper/staff member provides more than half of the effort to help a resident complete an activity) when it comes to transfers.</p> <p>A review of the Interdisciplinary Team (IDT, a group of health care professionals from different disciplines who work together to provide care for patients) note dated 11/18/24 indicated during transfer from bed to the shower chair Resident 1 fell while being transferred by the certified nursing assistant (CNA) with the assistance of 4 students.</p> <p>During an interview on 12/26/24 at 12:36 p.m., Licensed Staff (LS) B stated Resident 1 required an assistance of 2 staff during transfers. LS B stated students were not allowed to assist staff with transfers because they were only at the facility to observe.</p> <p>During an interview on 12/26/24 at 1:10 p.m., Resident 1 stated he fell while a staff member and 4 students attempted to transfer him from bed to the shower chair. Resident 1 stated the students did not know what they were doing. Resident 1 stated there was no coordination and he felt the students yanking him from different directions. Resident 1 stated he knew students should not be assisting with his transfers. Resident 1 stated he fell because instead of 2 staff assisting him during transfers, there was only 1 staff who assisted him and 4 students. Resident 1 stated this compromised his safety. Resident 1 stated the facility did not follow the protocol.</p> <p>During a concurrent interview and IDT note dated 11/18/24 record review on 12/26/24 at 1:16 p.m., the Director of Nursing (DON) verified the IDT note indicated Resident 1 fell during transfer to shower chair while being assisted by a staff and 4 students. The DON stated Resident 1 required the assistance of 2 staff during transfers. When asked if students were allowed to assist CNAs to transfer residents, the DON stated no.</p> <p>A review of the facility ' s policy and procedure (P&amp;P) titled Falls and Fall Risks, Managing revised 3/2018, the P&amp;P indicated, . staff will identify interventions related to residents specific risk and causes to try to prevent the resident from falling .</p> <p>(continued on next page)</p>

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