STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055241	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willow Pass Healthcare Center	3318 Willow Pass Road Concord, CA 94519

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 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50013 Based on observation, interview and record review, the facility failed to supervise one of three residents (Resident 1) with a history of falls when, Resident 1 was not supervised and assisted to the bathroom. This failure resulted in Resident 1 sustaining a left hip fracture (broken bone), experiencing pain, and transferring to Acute Care Hospital 1 (ACH 1) for follow up care. Findings: During a record review of Resident 1's Admission Record, printed on 4/25/24, the record indicated Resident 1 was admitted to the facility on [DATE], with dementia (memory loss), muscle weakness, abnormalities of gait (a person's manner of walking) and mobility, and abnormal posture. During a record review of Resident 1's Annual Minimum Data Set (MDS, a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan.) assessment, dated 2/21/24, the MDS assessment indicated Resident 1 used a walker for mobility. The assessment also indicated Resident 1's need for supervision during activities of daily living (Activities of daily living are those needed for self-care and mobility and include activities such as bathing, dressing, grooming, oral care, ambulation (walk, move about), toileting, eating, transferring, and communicating.) and mobilization. The record indicated Resident 1's Brief Interview of Mental Status (BIMS, is a scoring system used to determine the resident's cognitive status regarding attention, orientation, and ability to register and recall information. A BIMS score of thirteen to fifteen is an indication of intact cognitive status.) score was nine (9) out of 15, indicating moderately impaired mental status. The BIMS indicated Resident 1 was unable to recall the correct year and day of the week and was able to recall recent information with cueing. During a concurrent observation and interview on 4/25/24, at 9:55 a.m., with Resident 1, Resident 1 was lying in bed and stated the bathroom in her room had an out of order sign, and she fell while trying to use the bathroom. Resident 1 stated she did not know how she fell . Resident 1 then stated she did not remember if she fell and denied pain/discomfort. During a record review of Resident 1's Physician Order, dated 5/25/23, the Physician Order indicated to monitor the resident for wandering [become lost or confused about their location]/ambulation without assistance . redirect as needed every shift for fall precautions. (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a record review of Resident 1's Fall Risk Care Plan, initiated on 3/23/23, the Fall Risk Care Plan indicated, The resident is at risk for falls [related to] psychoactive drugs (drugs that change the function of the nervous system and results in alterations of perception, mood, cognition and behavior) use ., staff was to Anticipate and meet the resident's needs ., and The resident needs prompt response to all requests for assistance. During a record review of Resident 1's Morse Fall Scale (a tool which determines the residents' likelihood of falling), dated 12/15/23, the record indicated Resident 1's fall risk score was 70 (scores greater than 45 indicated a high risk for falls (Morse, J.M 1997)). Resident 1's scoring elements included history of falling, use of an ambulatory aid such as a crutch, cane or walker, and when asked, Are you able to go to the bathroom alone, or do you need assistance? , Resident 1 overestimated or forgot limits. During an interview on 4/25/24, at 10:30 a.m., with Certified Nursing Assistant 1 (CNA 1), outside Resident 1's room, CNA 1 stated, on 4/18/24 around 7:10 a.m., he observed Resident 1 walking in the hall without a walker. CNA 1 stated Resident 1 appeared frail and expressed need for bathroom because her bathroom was out of order. CNA 1 stated his back was towards Resident 1 when Resident 1 was in the hallway. CNA 1 stated he heard a loud thump sound, turned around, and saw Resident 1 on the floor in the hallway. During an interview on 4/25/24, at 10:00 a.m., with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated around 9:00 a.m. on 4/18/24, Resident 1 was screaming in pain. LVN 1 stated she assessed and noted Resident 1's left hip was deformed. LVN 1 stated Resident 1 complained of pain to left thigh and groaned when touched. LVN 1 further stated she called 911 at 9:30 a.m. and Resident 1 was transported to ACH 1. During a concurrent interview and record review on 4/25/24, at 10:20 a.m., with Director of Nursing (DON), Resident 1's Progress Notes and SBAR (Situation, Background, Assessment, Recommendation- a technique that can be used to facilitate prompt and appropriate communication) communication form, dated 4/18/24 at 9:34 a.m., was reviewed. The progress notes indicated, LVN 1 found Resident 1 in distress with a skin tear on Resident 1's left elbow with significant bleeding and Resident 1 stated is hurting really bad to her [left] side of the hip and inner thigh. The progress notes further indicated, upon assessment, Resident 1's left hip was deformed, Resident 1 had severe pain to touch, and Resident 1 was unable to sit or move their extremity while lying in bed. Resident 1's SBAR indicated Resident 1 had a fall, sustained a laceration (cut) to her left arm, and complained of new pain at a level of 6 out of 10 (10 being worse experienced pain). During a record review of Resident 1's ACH 1 Hospital Discharge Summary, dated 4/18/24, the record indicated Resident 1 had a fall with left hip fracture (broken bone) and underwent subliminary nailing (type of surgery for hip fracture repair) procedure.

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F 0918 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide a bathroom in or located near each resident’s room. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50013 Based on observation, interview and record review, the facility failed to provide one of one sampled resident (Resident 1) a functioning toilet that can be accessed quickly, when Resident 1 needed to use the toilet, but her bathroom was Out-of-Order and she did not have a bedside commode. This failure potentially resulted in Resident 1 sustaining a fall while looking for an alternate bathroom, resulting in left hip fracture (broken bone), pain, and transfer to Acute Care Hospital (ACH 1) for follow up care. (Cross reference F689) Findings: During a record review of Resident 1's Admission Record printed on 4/25/24, the record indicated Resident 1 was admitted to the facility on [DATE], with dementia (memory loss), muscle weakness, abnormalities of gait (a person's manner of walking) and mobility, and abnormal posture. During a record review of Resident 1's Annual Minimum Data Set (MDS, a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan.) assessment, dated 2/21/24, the MDS indicated Resident 1 was occasionally incontinent with bladder. The MDS further indicated Resident 1's Brief Interview of Mental Status (BIMS, is a scoring system used to determine the resident's cognitive status regarding attention, orientation, and ability to register and recall information. A BIMS score of thirteen to fifteen is an indication of intact cognitive status.) score was nine (9) out of 15, and indicated moderately impaired mental status. The MDS indicated Resident 1 was unable to recall the correct year and day of the week and was able to recall recent information with cueing. During a concurrent observation and interview on 4/25/24, at 9:55 a.m., with Resident 1 lying in bed, Resident 1 stated the bathroom in her room had an out-of-order sign, and she fell while trying to use the bathroom. Resident 1 stated she did not know how she fell . Resident 1 then stated she did not remember if she fell and denied pain/discomfort. During an interview on 4/25/24, at 10:30 a.m., with Certified Nursing Assistant (CNA 1), outside Resident 1's room, CNA 1 stated, on 4/18/24 around 7:10 a.m., CNA 1 observed Resident 1 walking in the hall without a walker. CNA 1 stated Resident 1 appeared frail and expressed need for bathroom because her bathroom was out-of-order. CNA 1 stated he checked Resident 1's room and found out-of-order signage on the bathroom door and there was no bed side commode in her room as an alternate for a nonfunctional bathroom. CNA 1 stated he proceeded to find an alternate bathroom for Resident 1. CNA 1 stated his back was towards Resident 1 when Resident 1 was in the hallway. CNA 1 stated he heard a loud thump sound, turned around, and saw Resident 1 on the floor in the hallway. (continued on next page)

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F 0918 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and record review on 4/25/24, 11:00 a.m., with Maintenance Supervisor (MS 1), Maintenance log binder was reviewed. MS 1 stated he learned Resident 1's bathroom was out of order during a meeting on 4/18/24 at approximately 9:30 am. MS 1 stated there was no report of Resident 1's bathroom issue in the maintenance log. MS 1 stated Resident 1's toilet was clogged with toilet wipes and was not flushable. During an interview on 4/25/24, at 11:30 a.m., with the Director of Nursing (DON), the DON stated if residents' bathroom was not functional, a bed side commode could be offered, and staff should check on residents more often and ask them if they needed to go to the bathroom. The DON further stated staff should consider fall risk factors such as resident's mental state, slippery floors, syncope (fainting, or a sudden temporary loss of consciousness), balance disturbances, and were expected to meet and anticipate residents' needs to prevent falls.