

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055271	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER LA Sierra Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2424 M Street Merced, CA 95340	

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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47254</p> <p>Based on interview and record review the facility failed to follow facility's policies and procedures that meet professional standards of quality when:</p> <p>1.) One of three sampled Residents (Resident 1) did not have nursing documentation in the progress notes for 346 times that he was found on the floor and head-to-toe assessments were not complete.</p> <p>This failure result in no head-to-toe assessments completed and had the potential for delay in care of for Resident 1 and missed opportunity for updating his care plan.</p> <p>2.) Two of five Certified Nursing Assistant ' s (CNA) working during the afternoon shift were not wearing any identification badges identifying themselves as staff.</p> <p>This failure had the potential for facility residents to not know who was providing care to them, and if they worked in the facility.</p> <p>Findings:</p> <p>1. During a review of Resident 1's Admission Record (AR) (document containing resident demographic information and medical diagnosis), dated 3/24/2025, the AR indicated Resident 1 was originally admitted to the facility on [DATE]. Resident 1's diagnosis included but are not limited to .PARKINSONISM (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements) . PERSISTENT MOOD [AFFECTIVE] DISORDER (disorder that causes them to lose interest in everyday activities, lack productivity, experience low self-esteem, feel hopeless, and feel inadequate) .OTHER MUSCLE SPASM (occur when your muscle involuntarily and forcibly contracts uncontrollably and can't relax) . DIFFICULTY IN WALKING (inability to walk properly due to abnormal and uncontrollable walking patterns) . LACK OF COORDINATION (a problem with movement, balance, or coordination) .</p> <p>During a review of Resident 1's Admission MDS assessment, dated 3/6/2025, the Admission MDS assessment indicated, Resident 1's Brief Interview for Mental Status (BIMS -an evaluation of attention, orientation, and memory recall) score of 13 (0-7 severe cognitive impairment, 8-12 moderate cognitive impairment, 13-15 no cognitive impairment), indicating Resident 1 had no cognitive impairment.</p> <p>During a record review of Resident 1's Medication Administration Record, dated 3/1/2025 -3/31/2025, the Medication Administration Record indicated, Resident 1 had 354 episodes of Resident 1 placing himself on the floor.</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 record review of Resident 1 ' s Progress Notes, dated 3/1/2025 - 3/31/2025, the Progress Notes indicated, licensed nursing staff documented eight of 354 episodes of Resident 1 placing himself on the floor.</p> <p>During an interview on 3/24/2025 at 5:50 p.m., with Resident 1, Residents 1 stated he falls and places himself on the floor multiple times a day. Resident 1 stated when he falls or places himself on the floor, he will remain on the floor until staff assist back into bed or a chair. Resident 1 stated there are times when staff will not come check on him immediately, so he remains on the floor until they come into the room.</p> <p>During an interview on 3/24/2025 at 6:37 p.m., with the Director of Nurses (DON), the DON stated the facility did not consider that when Resident 1 was found on the floor as a fall. The DON stated Resident 1 ' s placed himself on the floor, so they were not considered unwitnessed falls by her, but she considered them resident behaviors.</p> <p>During a concurrent interview and record review on 4/3/2025 at 1:45 p.m., with the Administrator (ADM), the facilities policy and procedure (P&P) Assessing Falls and Their Causes dated December 2021 was reviewed. The ADM stated per P&P, falls should be documented, and residents assessed, whether witnessed or unwitnessed by licensed nursing staff. Nursing staff is expected to follow proper fall protocols to ensure resident safety and to assess potential injuries. ADM stated his expectations would have been for Resident 1 to be assessed, placed under observation, care plans should have been updated, neuro checks should be completed, and proper communication should be provided to primary physician if a fall were to occur. ADM stated nursing staff did not document assessment of incidents for falls indicated on behavior monitoring.</p> <p>During a concurrent interview and record review on 4/3/2025 at 2:10 p.m., with Licensed Vocational Nurse (LVN) 1, Resident 1 ' s electronic medical records (EMR) dated 3/1/2025-3/30/2025 was reviewed. LVN 1 stated Resident 1 had multiple instances of being found on the floor from 3/1/2025 to 3/31/2025. LVN 1 stated documentation of the resident being found on the floor are charted in the medication administration monitoring, the nurses failed to document these same incidents in the nursing progress notes. LVN 1 stated, when Resident 1 was found on the floor should be considered falls. LVN 1 stated when Resident 1 is found on the floor, a resident assessment should have been conducted. LVN 1 stated full head to toe assessment were not conducted during 3/1/2025 to 3/31/2025 when Resident 1 was found on the floor. LVN 1 stated he did not follow fall policy and procedure, head to toe assessments and physician notification were not completed. LVN 1 stated there is a potential risk for injury to Resident 1 because a head-to-toe assessment is not completed after Resident 1 is found on the floor.</p> <p>During a concurrent interview and record review on 4/3/2025 at 2:18 p.m., with LVN 1, facility P&P Assessing Falls and Their Cause, dated December 2021 was reviewed. LVN 1 stated P&P indicated P&P indicates when a resident falls, documentation in the resident medical record should indicated information that includes head to toe assessment, condition of the resident, notification of responsible parties including physician and appropriate interventions. LVN 1 stated facility staff are not following fall policies for Resident 1.</p> <p>(continued on next page)</p>		

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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 record review on 4/3/2025 at 2:24 p.m., with LVN 2, facility P&P Assessing Falls and Their Cause, dated December 2021 was reviewed. LVN 2 stated on the P&P for falls, facility nursing staff were not following protocols for his witnessed or unwitnessed falls as no assessment or communication were conducted to primary physician for each occurrence as indicated in P&P. LVN 2 stated, resident falls a lot, approximately five to six times a day so he would constantly be under charting. LVN 2 stated on normal occasions those falls would be documented each time with full head to toe assessment, neuro (an evaluation of a person's nervous system) checks, interventions updated, and resident placed under observation for 72 hours with communication to responsible personnel. LVN 2 stated resident is falling multiple times a day and they are unwitnessed most the times so proper documentation should be conducted by nursing staff.</p> <p>During an interview on 4/10/2025 at 12:00 p.m., with Certified Nursing Assistant (CNA 1), CNA 1 stated Resident 1 has difficulties with his Parkinson ' s which contributes to Resident 1 falling a lot. CNA 1 stated he could not tell if Resident 1 is placing himself on the floor purposefully or it ' s related to his diagnosis because there are times when he will be on the floor when he enters the room and Resident 1 will does not explain why he is on the floor. CNA 1 stated when he finds Resident 1 on the floor, he notifies licensed nursing staff when resident is on the floor. CNA 1 stated he does not document his notification to licensed staff anywhere.</p> <p>A review of the facility policy and procedure, titled, Accidents and Incidents- Investigation and Reporting, dated July 2017, indicated .The Nursing Supervisor/Charge Nurse and /or the department director or supervisor shall promptly initiate and document investigation of the accident or incident .date and time incident took place .nature of injury .e.g. bruise, fall .circumstances surrounding incident .time attending physician was notified .</p> <p>A review of the facility policy and procedure, titled, Assessing Falls and Their Causes, dated December 2021, indicated .Procedure guidelines for assessing a resident after a fall and to assist staff in identifying causes of the fall .falling may be related to underlying clinical or medical conditions .if a resident had just fallen, or is found on the floor without a witness to the event, evaluate injuries to the head, neck, spine and extremities . obtain and record vital signs . provide appropriate first aid and/or obtain medical treatment . notify the residents attending physician . in an appropriate time frame .observe for delayed complications of a fall .document any observed signs or symptoms of pain, swelling, bruising, deformity and/or decreased mobility .complete incident report for resident falls no later than 24 hours after the fall occurs .evaluate chain of events . time of fall .what was resident doing .whether the resident was among other persons or alone . environmental risk factors . pattern of falls .resident falls should be recorded in the medical record .condition in which the resident was found .assessment data .interventions .notification of the physician . completion of post fall assessment .</p> <p>(continued on next page)</p>		

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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>A review of the facility policy and procedure, titled, Behavior Assessment, Intervention and Monitoring, dated March 2019, indicated .As part of the comprehensive assessment, staff will evaluate, based on input from the resident, family and caregivers, review of medical record and general observations . the resident usually patterns of cognition, mood and behavior . the resident ' s usually method of communicating . The nursing staff will identify, document and inform the physician about specific details regarding changes in an individual mental status, behavior and cognition . onset, duration, intensity, and frequently of behavioral symptoms . the interdisciplinary team will thoroughly evaluate .underlying causes and address any modifiable factors that may have contributed to the resident change in condition .the IDT will seek and document any improvements or worsening in the individuals behavior, mood and function . the IDT will monitor the progress of the individuals . interventions will be adjusted based on the impact on behavior and other symptoms .</p> <p>2. During a review of facility policy and procedures, titled, Identification Name Badges, dated January 2008, indicated .In order to promote safety and security measures established by our facility, each employee must wear his/her identification name badge at all times while on duty . an identification name tag or badge must be clearly visible and contain the employees first name initial, last name and job title . employees will be responsible for maintaining their identification tags or badge and wearing them to work . employees must report lost identification tags or badges to their supervisors so that replacement tags/badges can be issued .</p> <p>During an observation and interview on 3/24/2025 at 5:37 p.m., with Certified Nursing Assistant (cna) 2, CNA 2 stated she knows she is supposed to be wearing her identification (ID) badge, but she forgot it at home. CNA 2 stated she does have an ID badge she just doesn ' t have it with her today. CNA 2 stated residents already know she works at the facility but understands staff are supposed to be wearing proper identification in order for others to identify staff when needed.</p> <p>During an observation and interview on 3/24/2025 at 5:44 p.m., with CNA 3, CNA 3 was observed not wearing her identification badge while in the facility. CNA 3 stated her ID badge was left at home, and she understands it is important to wear their badge daily in order for families and residents to identify staff when assistance is required. CNA 3 stated it is part of facility policies to wear a badge at all times and currently she is not abiding by that policy if she is missing her ID badge. She stated all staff receive ID badge on the first day of employment and if they lose or are missing their ID badge, they are to notify leadership to obtain replacement. CNA 3 stated in the meantime, temporary ID badge can be made indicating name and title in order for proper identification.</p> <p>During an interview on 3/24/25 at 7:20 p.m., with the DON, the DON stated proper identification of staff is necessary and important in order to be properly identified in the facility in order to provide the appropriate care needs of the resident. Identification is important in order for family to identify staff during a resident ' s time in need. DON confirmed the two missing ID badges on staff is an issue and it could potentially cause a delay in resident care if a family member or resident is unable to identify staff who are not wearing the appropriate name tags. All staff members should be wearing name tags at all times while working in the facility according to facility protocols.</p>		