

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055298	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/29/2024
NAME OF PROVIDER OR SUPPLIER  Fallbrook Skilled Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE  325 Potter Street Fallbrook, CA 92028	

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 0555</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to choose his or her attending physician.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46982</b></p> <p>Based on interview and record review, the facility failed to honor a resident ' s preference for their personal physician for one of three residents (Resident 1) when reviewed. This failure ignored the resident ' s right to choose a physician and caused Resident 1 to feel ignored and depressed.</p> <p>Findings:</p> <p>Resident 1 was admitted to the facility on [DATE] with diagnosis that included: recurrent enterocolitis (stomach inflammation, causing pain or diarrhea or constipation); heart disease; major depressive disorder; anxiety. Resident 1 has the capacity (ability) to make her own health care decisions.</p> <p>On 9/17/24 at 11:35 A.M. Resident 1 was interviewed. Resident 1 stated she had made an appointment to see her regular doctor outside of the facility. Resident 1 said when her daughter called the facility to ask about transportation arrangements related to the doctor appointment, her daughter was told the facility staff cancelled the appointment and explained (Res 1) must see our doctor. Resident 1 said she was upset about not seeing her own doctor and goes to bed crying most nights and has been so depressed she is having meals in her room.</p> <p>On 9/19/24 at 11:25 the Progress Note, dated 9/13/24 and signed by the Director of Social Services (SSD), was reviewed. The progress note reflected Resident 1 came to the SSD office and asked to see her own doctor. SSD explained to (Resident 1) that since she is in a nursing home now her doctor now is (name of doctor) .Resident got very agitated, saying she can do whatever she wants.we (SSD and DON) explained to (Resident 1) if she fires (name of doctor) she won ' t have a doctor and can ' t stay here without a doctor.</p> <p>On 10/29/24 at 10:15 A.M. an interview was conducted with the SSD and the Director of Nurses (DON). The SSD stated Resident 1 ' s doctor appointment was cancelled because she was concerned one of the doctors (the facility ' s doctor and Resident 1 ' s choice of doctor) would not get paid. The DSS stated she believed that Resident 1 wanted both the facility doctor and her own doctor. SSD also stated she had not confirmed with Resident 1 her wishes on making changes to the doctor assigned to her. SSD had not checked with Resident 1 ' s insurance to see if coverage was available for medical transportation, or what, if any, costs would be involved for Resident 1 to see her own doctor outside of the facility. The SSD stated Resident 1 would be required to see the doctor monthly. The DON stated that if a resident was stable, a doctor visit was required every three months.</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 0555</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The DON stated Resident 1 has the right to choose her own doctor. The DON stated, normally the facility transports residents to their medical appointments, but she recalls the bus was broken when Resident 1 had her first medical appointment. The DON stated because the facility did not know if Resident 1 ' s transportation to medical appointments was covered she would follow up to ensure the insurance questions were answered, and then advise Resident 1.</p> <p>On 10/29/24 the facility ' s policy titled Resident Rights was reviewed. Per the policy, 1.f. communication with and access to people and services, both inside and outside the facility .h.be supported by the facility in exercising his or her rights .s. choose an attending physician and participate in decision-making regarding his or her care.</p>		