STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055435	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villas at Saratoga Skilled Nsg & Assisted Lvg	20400 Saratoga-Los Gatos Rd Saratoga, CA 95070

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** 48590 Based on interview and record review, the facility failed to provide free of accident hazard during transfer for one of three residents (Resident 1) when the facility failed to complete a fall risk evaluation for Resident 1 upon admission, Certified nursing assistant A (CNA A) did not follow the Hoyer (an assistive device that allows patients to be transferred between a bed and a chair or other similar resting places, by the use of electrical or hydraulic power) lift's user instruction manual when CNA A did not check the sling which suitable for the particular resident, the correct size, and CNA A did not follow the policy and procedure about using a mechanical lifting machine to gently support the resident as she moved. These failures resulted in Resident 1's fall and send to acute hospital that caused Resident 1 small left sub-insular (a lobe in the brain) white matter and post-central gyrus (region of the brain that perceives various sensations from the body including touch, pressure, temperature, and pain) intracranial hemorrhage (bleeding in the brain). Findings: During a review of Resident 1's clinical record, indicated she was admitted on [DATE] and had the diagnoses including hemiplegia (loss of strength in the arm, leg, and sometimes face on one side of the body) and hemiparesis (a loss of strength in the arm, leg, and sometimes face on one side of the body) following cerebral infarction (stroke; a result of disrupted blood flow to the brain) affecting right dominant side, aphasia (loss of ability to understand or express speech caused by brain damage), unspecified abnormalities of gait and mobility, and dysphagia (difficulty swallowing). Resident 1's weight was 104.2 pounds (lbs., unit of measurement) and height of 55 inches (in., unit of measurement). During a record review on 3/25/24, Resident 1's Fall Risk Evaluation, dated 12/16/23, the fall risk evaluation was not completed on admission on 12/16/23. During a review of Resident 1's Minimum Data Set (MDS, an admission assessment tool), dated 12/22/23, indicated chair/bed-to-chair transfer required assistance of two or more persons to complete the activity. The MDS also indicated the brief interview for mental status (BIMS, an assessment tool) had score of 0, which means Resident 1 rarely/never understood. (continued on next page)

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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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review on 5/28/24 at 10:40 a.m., with the Director of Nursing (DON), the DON reviewed Resident 1's N Adv - Fall Risk Evaluation and confirmed that the fall risk evaluation was not completed on admission to prevent fall. During a concurrent interview and record review titled, N ADV - Fall Risk Evaluation, on 5/28/24 at 11:22 a.m. , with Minimum Date Set Coordinator (MDSC), MDSC confirmed the fall risk evaluation was not completed on admission. MDSC stated it should have been completed. During a review of the facility's policy and procedure titled, Admission Assessment and Follow Up: Role of the Nurse, dated 9/2012, indicated 9. Conduct supplemental assessment (following facility forms and protocol) including the Fall risk assessment . During a review of Resident 1's limited physical mobility care plan related to stroke, revised on 12/19/23, indicated the intervention was to provide assistance in activities of daily living (ADL, tasks of everyday life include eating, dressing, getting in and out of bed or chair)) as needed and use Hoyer lift when transferring Resident 1 from bed to wheelchair. During a review of the physical therapy treatment encounter notes, dated 12/21/23 at 9:30 p.m., indicated bed mobility and wheelchair transfers for Resident 1 required total dependence of two people assist. During a record review of Resident 1's nursing progress notes, dated 12/22/23 at 3:34 p.m., indicated, Resident 1 during the Hoyer lift transfer was moving and immediately slide down the sling. The progress notes further indicated the facility sent Resident 1 to acute hospital for evaluation. During an interview on 3/25/24 at 2:29 p.m., with CNA A, CNA A stated Resident 1's family member (FM) asked her to transfer Resident 1 to the wheelchair on 12/22/23. CNA A stated she told the resident's FM that she needs another staff to help with the transfer. CNA A stated there were no other CNA available to help. CNA A asked the therapist who was assigned to Resident 1. Registered Occupational Therapist (ROT) was the assigned therapist. CNA A stated she placed a small-sized sling under the resident and hooked the sling to the Hoyer lift. CNA A stated she was operating the Hoyer lift. ROT will place the wheelchair under the resident during the transfer. CNA A stated she raised the sling with the resident on it and pulled the Hoyer lift away from the bed. CNA A then started to turn the Hoyer lift to the right when Resident 1 started to move backward and fell to the floor. During an interview on 3/27/24 at 1:17 p.m., with ROT, the ROT stated CNA A asked him for assistance to help transfer Resident 1 from bed to wheelchair using the Hoyer lift. When ROT got to Resident 1's room, the Hoyer lift was in the room and the sling was already underneath the resident. ROT and CNA A attached the sling to the lift. ROT stated he was standing in between the resident and the wheelchair next to the bed. ROT stated CNA A was operating the Hoyer lift. ROT stated he was at beside the bed holding the wheelchair while Resident 1 was being lifted off the bed. ROT stated during the transfer Resident 1 fell . ROT stated he did not see how Resident 1 fell . ROT stated the resident probably slipped through the bottom of the sling. ROT stated Resident 1 fell butt first then hit her head on the floor. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 5/28/24 at 10:07 a.m., with Licensed Vocational Nurse (LVN) B, LVN B stated she heard a loud noise coming from Resident 1's room. LVN B stated she found Resident 1 was on the floor when she entered the room. LVN B stated she was told by the ROT that the resident slipped through the bottom part of the sling during the transfer and fell on the floor. During a concurrent interview and record review on 5/28/24 at 11:51 a.m., with the Director of Rehab and Physical Therapy (DRPT), the DRPT reviewed Resident 1's PT Evaluation & Plan of Treatment dated 12/18/23 and OT Evaluation & Plan of Treatment dated 12/17/23 and stated there was no documentation that Resident 1 was evaluated for the use of the Hoyer lift. DRPT stated rehab staff does not evaluate the residents for the use of mechanical lifting device because it was not considered a skilled transfer. DRPT stated the CNA used the mechanical lifting device based on discharge orders from acute hospital and their training for the use of the Hoyer lift. During an interview on 6/19/23 at 10:36 a.m., with DSD, DSD stated CNA A had the return demonstration with the use of Hoyer lift on 11/5/23 and ROT on 8/24/23 . DSD stated whole body sling was supposed to be used for Resident 1 to prevent fall. DSD stated the recommendation for this resident was whole body sling. DSD stated certified nursing assistants assessed by looking at the resident's size and weight to determine what size of sling to be used. DSD stated they do not use any measuring device to determine the size and weight of the resident . During a review of Resident 1's post fall evaluation, dated 12/22/23, indicated, fall occurred while being transferred and resulted in hospitalization . During an interview on 5/28/24 at 8:57 a.m., with CNA A, she stated that the sling was not appropriate to use for Hoyer transfer to a chair. CNA A stated she was operating the Hoyer lift, and the ROT was holding the wheelchair to be placed under the resident. CNA A stated no one was holding and supporting the sling during Resident 1's transfer from bed to the wheelchair. CNA A stated the sling should have been supported and guided during Resident 1's transfer on 12/22/23. During an interview on 5/28/24 at 9:05 a.m., with the ROT, ROT stated the sling used during the transfer was not the usual sling that the facility used for transfer. The ROT stated no one was supporting the sling while Resident 1 was being transferred from bed to the wheelchair. During an interview on 5/28/24 at 10:03 a.m., with the DSD, the DSD stated the sling used on Resident 1 was the U-shaped sling and not the full body sling which was not appropriate. The DSD stated the sling should have been guided and supported during Resident 1's transfer on 12/22/23. Review of Resident 1's acute hospital record titled Neurocritical Care (NCC)- Primary Service ICU History and Physical dated 12/22/2023, indicated, admitted : 12/22/2023 . Today, the patient presented from SNF (Skilled Nursing Facility) s/p (status post, means after) witnessed ground level fall (one that begins when a person has his or her feet on the ground) at facility with head strike at mental status baseline. Initial CTH (CT -Head, computed tomography scan - a non-invasive diagnostic imaging procedure using X-Rays to create detailed pictures of the inside of the Head) with concern for possible hemorrhagic conversion of recent ischemic stroke . (a process which involves the bleeding of brain tissue that has been affected by the stroke). admitted to NCC for stability and neuro checks. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of Resident 1's CT Head Cervical Spine without contrast (substance taken by mouth or injected into an intravenous line that causes the particular organ or tissue under study to be seen more clearly) imaging, dated 12/22/23, indicated .demonstrates extensive cortical lamellar necrosis (a permanent brain injury that occurs due to lack of oxygen) with small areas of hemorrhagic transformation (a process which involves the bleeding of brain tissue that has been affected by the stroke) in the subinsular white matter (a lobe in the brain) and post central gyrus (region of the brain that perceives various sensations from the body including touch, pressure, temperature, and pain). Review of Resident 1's acute hospital Stroke Discharge Summary indicated, admitted [DATE], discharge date [DATE], Resident 1's discharge diagnosis, indicated, small left subinsular white matter, post-central gyrus, and intracranial hemorrhage. Resident 1 was discharge from acute hospital on 12/31/23. Resident 1 did not return to the facility. Review of the facility's training lesson plan titled, Patient Lifts Safety Guide, undated, indicated 3. Check patient's condition before using a patient lift, check .patient's medical condition .make sure you have correct lift and sling for patient's condition .4. Select patient's sling size: assess patient's size, weight, hip measurement, and choosing correct sling size is critical for safe patient transfer. Review of an in-service sign-in sheet, dated 11/5/23, indicated the facility conducted a training titled, Hoyer Lift Transfer, the training course content indicated, Staff must understand to hold and support the patient while in the sling. Review of the facility's policy and procedure, titled Using a Mechanical Lifting Machine, revised 7/2017, indicated Measure the resident for proper sling size and purpose, according to manufacturer's instructions. Gently support the resident as he or she is moved. A review of the Hoyer lift's user instruction manual Safety Precautions indicated, Always check the sling is suitable for the particular patient and is of the correct size and capacity. Always fit the sling according to the instructions provided (user instructions). For the safety of the patient and carer, before using a sling a full risk assessment must be conducted to ensure that the correct sling choice, method of positioning in the sling and procedure for transfer has been determined for the patient.