

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055758	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/10/2025
NAME OF PROVIDER OR SUPPLIER  Cottage Crest Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  12350 Rosecrans Norwalk, CA 90650	

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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45981</b></p> <p>Based on observation, interview and record review, the facility failed to ensure one of four sampled resident (Resident 2) touch pad call light (enables residents with limited movement to call for help) and telephone were within Resident 2 ' s reach.</p> <p>This failure had Resident 2 to feel frustrated, useless and had the potential for her needs not met which could result to delay of care and services.</p> <p>Findings:</p> <p>During a review of Resident 2 ' s Admission Record, the Admission Record indicated Resident 2 was admitted to the facility on [DATE], with diagnoses including transient ischemic attack ([TIA] a brief interruption of blood flow to the brain that causes stroke-like symptoms) and cognitive (ability to think, understand, learn, and remember) communication deficit (having trouble communicating due to problems with thinking skills like memory, attention, reasoning, or organization, often caused by a brain injury).</p> <p>During a review of Resident 2 ' s History and Physical (H&amp;P), dated 2/22/24, the H&amp;P indicated, Resident 2 was unable to make his or her own medical decisions at this time.</p> <p>During a review of Resident 2 ' s Minimum Data Set ([MDS], a resident assessment tool), dated 1/2/25, The MDS indicated, Resident 2 required partial/moderate assistance (helper does less than half the effort) with toileting, and utilized a manual wheelchair and walker for mobility.</p> <p>During an observation on 2/10/25 at 9:35 a.m. in station 1 hallway, observed Resident 2 was lying in bed. Resident 2 was yelling help me, my phone is ringing. Resident 2 ' s telephone was ringing and Resident 2 ' s touch pad call light was lying on the left side of her underneath the back of her left arm. Resident 2 ' s telephone was hanging over her walker that was positioned at the head of her bed on the left side which made it impossible for Resident 2 to use the touch pad call light and not able to answer her telephone.</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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/10/25 at 9:40 a.m. with Resident 2, Resident 2 stated the facility always keeps her call light and telephone out of her reach making it difficult for her to call for help and impossible for her to communicate with her family. Resident 2 stated she does not get out of the bed and requires assistance from the staff, so when she cannot call for help due to the touch pad call light and telephone not being within in her reach it makes her feel sad, frustrated, helpless, and useless. Resident 2 stated when she does call for assistance the staff will take up to one hour before they come to assist her. Resident 2 stated sometimes she feels that the facility staff does not care about her.</p> <p>During a concurrent observation and interview on 2/10/25 at 9:45 a.m. with Certified Nurse Assistant (CNA 1), CNA 1 stated that she was responsible for ensuring all the residents call lights and telephones were within their reach to allow the residents a way to communicate with the staff and their families. CNA 1 stated Resident 2 ' s call light and telephone were not within her reach. CNA 1 stated by Resident 2 ' s call light not being within her reach she could not call for assistance, and she could try to get out of the bed and break a bone. CNA 1 stated residents use their telephones to communicate with their families, staff, and friends. CNA 1 stated if Resident 2 ' s telephone was not within her reach Resident 2 cannot communicate with her family and that could make Resident 2 feel sad and frustrated. CNA 1 stated that the residents call lights and telephones should be always within their reach.</p> <p>During an interview on 2/10/25 at 10:37 a.m. with CNA 3, CNA 3 stated that the residents call lights and telephones should be within their reach. CNA 3 stated, if the residents have difficulty with weakness on a particular side the call light and telephone should be placed on the stronger side. CNA 3 stated it is the CNA ' s responsibility to ensure that the call lights and telephones are within the resident ' s reach. CNA 3 stated if the call lights and telephones are not within the resident ' s reach, they could try to get up out of the bed, fall and hurt themselves.</p> <p>During a concurrent interview and record review on 2/10/25 at 10:40 a.m. with License Vocational Nurse (LVN 1), reviewed Resident 1 ' s Fall Risk Assessment, dated February 2024. The Fall Risk Assessment indicated, on 2/16/24 Resident 2 was at risk for falls. LVN 1 stated that the fall risk assessment is imperative because it determines the residents that are high risk for falls, therefore the facility can implement goals and interventions for the residents to decrease the likelihood of the residents falling. LVN 1 stated that all staff are responsible for ensuring that the residents call lights and telephones are within their reach to prevent the residents from becoming frustrated and trying to get out of the bed and possibly injuring themselves. LVN 1 stated Resident 2 is at risk for falls and all her personal items such as the call light and telephone should be within her reach.</p> <p>During a review of Resident 2 ' s care plan on Risk for falls dated 3/11/2024, the care plan indicated Resident 2 was at risk for falls related to impaired mobility (ability to move purposefully through one ' s daily life). The care plan interventions stated. Place the resident ' s call light within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/10/25 at 10:56 a.m. with Director of Staff Development (DSD), DSD stated the residents call lights and telephones should be always within their reach. DSD stated that the call lights and telephones are sources of communication outside of the room for the residents. DSD stated that the residents could have an emergency and would not be able to communicate with anyone if the call light and telephone were not within their reach. DSD stated that residents could feel emotionally distraught, frustrated, and sad if they are not able to have access to their personal items, call light, and telephone. DSD stated the residents call lights and telephones should be always within their reach, because it decreases the chances of residents trying to get out of the bed and hurting themselves.</p> <p>During an interview on 2/10/25 at 2:22 p.m. the Director of Nursing (DON), the DON stated the residents call lights and telephones should be always within their reach, because it makes it easier for them to call the staff for help and they can communicate with their families and staff. The DON stated that it is a safety issues for residents when their personal items are not within their reach, because they could become frustrated and attempt to get out of the bed possibly falling and sustaining a broken bone. The DON stated that all staff are responsible for ensuring that the residents call lights and telephones are within their reach.</p> <p>During a review of the facility ' s policy and procedure (P&amp;P) titled, Accommodation of Needs, dated 2022, the P&amp;P indicated, Based on individual needs and preferences, the facility will assist the resident as much as possible in maintaining and/or achieving independent functioning, dignity, and well being to the extent possible.</p> <p>During a review of the facility ' s policy and procedure (P&amp;P) titled, Call Lights: Accessibility and Timely Response, dated 2022, the P&amp;P indicated, Staff will ensure the call light is within reach of resident and secured, as needed.</p>		