STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055839	A. Building B. Wing	05/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Luis Care Center	709 N Street Newman, CA 95360

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41119 Based on observation, interview and record review, the facility failed to implement a resident-centered comprehensive care plan for one of three sampled residents (Resident 1), when Resident 1 with known behavior of physical aggression was left unsupervised on 4/23/24. This failure resulted in Resident 1 punching Resident 2. Findings: During a review of Resident 1's Admission Record (document containing resident demographic information and medical diagnosis) undated, the admission record indicated Resident 1 was admitted to the facility on [DATE]. Resident 1's diagnosis included Alzheimer ' s (affects memory, thinking and behavior), major depression and anxiety. During a concurrent observation and interview on 5/6/24 at 10:00 a.m. with Resident 1, in Resident 1's room, Resident 1 was lying on his bed. Resident 1 did not recall the altercation on 4/23/24. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool used to identify resident cognitive and physical function) assessment dated [DATE], it indicated Resident 1's Brief Interview for Mental Status (BIMS -assessment of memory and judgment) assessment score was 0 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, 00-07 indicates severe impairment, 99 severely impaired). The BIMS assessment indicated Resident 1 had severe cognitive impairment. During a telephone interview on 5/6/24 at 11:31 a.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated Resident 1 had a history of aggression and required supervision while he was in his wheelchair. CNA 1 stated she was busy performing another residents care when Resident 1 and Resident 2's altercation took place. CNA 1 stated the altercation could have been avoided if Resident 1 was supervised per his care plan. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's Progress Notes (PN), dated 4/23/24 was reviewed. The PN indicated, . The writer was coming out of the bathroom when .nurse reported that the resident had a resident-to-resident altercation with resident [Resident 2] . The writer immediately went to assess the residents [Resident 2] . stated that [Resident 1] . was trying to pass by him and [Resident 1] . became upset and started punching him on the back and . [Resident 2] retaliated and started punching him back on the arms . During a review of Resident 1's PN, dated 4/23/24 was reviewed. The PN indicated, . nurse stated she was doing patient care in room . with CNA, then walked out to the hallway when she heard yelling, 'they are fighting'. She stated she immediately ran towards the nurse's station and noted resident [Resident 2] and Resident 1 were swinging at one another but no visible contacted punches were noted. The residents were separated immediately. The . nurse reported incident to the writer and the writer took over care During a telephone interview on 5/6/24 at 11:40 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated she was exiting the restroom when another LVN informed her of the altercation between Resident 1 and Resident 2. LVN 1 stated care planned interventions should be implemented to ensure resident safety. LVN 1 stated unless Resident 1 was one on one observation it was difficult to supervise him since assigned staff had additional residents they had to care for. During a concurrent interview and record review on 5/6/24 at 12:34 p.m. with the Director of Nursing (DON, Resident 1 ' s Care Plan (CP) dated 2/21/24 was reviewed. The CP indicated, .[Resident 1] has potential to be physically aggressive [related to] extreme agitation and being combative . Maintain visual supervision at all times especially when he was ambulating in the wheelchair. When seen close to another resident in the wheelchair. Make sure keep his path clear to avoid bumping on other residents .Staff will maintain visual supervision at all times with [Resident 1], especially when he was ambulating in the wheelchair . The DON stated the care planned interventions should be implemented. The DON stated per the care plan Resident 1 required visual supervision at all times when in wheelchair. During a review of the facility policy and procedure (P&P) titled Comprehensive Care Plans dated 11/2017 was reviewed. The policy indicated, .The facility Interdisciplinary Team (IDT) will develop and implement a comprehensive, person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident ' s medical, nursing, physical, mental, and psychosocial needs .Interventions identified by the comprehensive care plan will be provided by qualified, competent persons .Resident care needs and care plan interventions will be communicated to direct care staff .