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	08/08/2024

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38517 Based on interview, record review, and facility policy review, the facility failed to provide three of three residents (Resident (R)41, R47 and R62) reviewed for hospital transfers out of a total sample of 36 residents' notification to the ombudsman when R41, R47 and R62 transferred to the hospital. This failure placed the resident and their representative at risk of having incomplete information, misunderstanding the reason of transfer/discharge, and the discharge appeal process. Findings include: Review of the facility's policy titled Admission, Transfer and Discharge Notice Requirements Before Transfer/discharge date d 07/2018, read in part .10. Notifications to the Office of the State LTC [Long Term Care] Ombudsman will occur before or as close as possible to the actual time of a facility-initiated transfer/discharge. 1.Review of R41's undated Face sheet located in the resident's electronic medical record (EMR) under the Profile tab revealed the resident was admitted to the facility on [DATE]. Review of R41's Notice of Purposed Transfer/Discharge, revealed R41 was transferred to hospital on 02/10/24. 2. Review of R47's undated Face sheet located in the resident's electronic medical record (EMR) under the Profile tab revealed the resident was admitted to the facility on [DATE]. Review of R47's Notice of Purposed Transfer/Discharge, revealed R47 was transferred to hospital on 03/24/24. Review of R47's Notice of Purposed Transfer/Discharge, revealed R47 was transferred to hospital on 04/14/24. Review of R47's Notice of Purposed Transfer/Discharge, revealed R47 was transferred to hospital on 06/20/24. 2. Review of R62's undated Face sheet located in the resident's electronic medical record (EMR) under the Profile tab revealed the resident was admitted to the facility on [DATE]. (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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R62's Skilled Nursing Facility to Hospital form revealed R62 was transferred to hospital on 06/20/24. During an interview on 08/06/24 at 1:43 PM, Social Services (SS) confirmed the facility failed to provide the written notice of transfer/discharge form to the ombudsman for R41, R47 and R61 after they were transferred to the hospital. The SS confirmed was sending the notifications to a fax number they believed belonged to the local ombudsman. SS confirmed they spoke with the ombudsman who confirmed they had not received any transfer notifications from SS. SS stated the ombudsman provided their email and all transfers will be emailed and confirmed receipt from ombudsman going forward. SS stated they thought the ombudsman was receiving the notifications through fax but confirmed they never received any confirmations forms.

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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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38517 Based on interview, record review, and facility policy review, the facility failed to provide two of three residents (Resident (R)47 and R62) or their responsible party, reviewed for hospital transfers out of a total sample of 36 residents a written bed hold when R47 and R62 was transferred to the hospital. This failure had the potential to cause confusion or distress regarding return to the same room after hospitalization . Findings include: Review of facility's policy titled Admission, Transfer and Discharge Notice of Bed Hold Policy Before/Upon Transfer revision date 11/2018 indicated, .The facility will provide written information to the resident or resident representative specifying the duration of the state bed-hold policy, if any, during which time the resident is permitted to return and resume residence in the facility.This information will be provided to the resident and the resident representative before a transfer or therapeutic leave and at the time of transfer of a resident for hospitalization or therapeutic leave. 1. Review of R47's undated Face sheet located in the resident's electronic medical record (EMR) under the Profile tab revealed the resident was admitted to the facility on [DATE]. Review of R47's Notice of Purposed Transfer/Discharge, revealed R47 was transferred to hospital on 03/24/24. The EMR lacked evidence that the facility provided R47 or the resident representative a copy of the facility's bed hold policy upon transfer to the hospital. Review of R47's Notice of Purposed Transfer/Discharge, revealed R47 was transferred to the hospital on 04/14/24. Review of R47's California Bed Hold Policy, dated 04/14/24, revealed R47s representative was contacted via phone on 04/15/24. The EMR lacked evidence that the facility provided R47 or the resident representative a copy of the facility's bed hold policy upon transfer to the hospital. 2. Review of R62's undated Face sheet located in the resident's EMR under the Profile tab revealed the resident was admitted to the facility on [DATE]. Review of R62's Skilled Nursing Facility to Hospital form revealed R62 was transferred to hospital on 06/20/24. The EMR lacked evidence that the facility provided R62 or the resident representative a copy of the facility's bed hold policy upon transfer to the hospital. Interview with the Business Office Manager (BOM) on 08/08/24 at 10:49 AM, the BOM stated they do consent for bed holds over the phone and she will sign. BOM stated they had residents and/or residents representative sign the bed hold policy upon admission but not upon transfer. BOM stated they did not document or confirm when or if a resident or representative was provided a written bed hold. BOM confirmed R62 was not provided a bed hold upon transfer to the hospital.

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38517 Based on observation, interview, and record review, the facility failed to revise the care plan to include refusals for weekly weights for one resident (Resident (R)41) out of a sample of 36 residents. Refer to F692. Findings include: Review of R41's Admission Record from the electronic medical record (EMR) Profile tab showed a facility admitted [DATE] with medical diagnoses that included Hydronephrosis with Renal and Ureteral Calculous Obstruction, Dysphagia, Anemia and Muscle Weakness. Review of R41's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/18/24, located in the resident's EMR under the MDS tab indicated the facility assessed R41 to have a Brief Interview for Mental Status (BIMS) score was 12 out of 15, indicating R41 was cognitively alert. Review of R41's Care Plan, located in the resident's EMR section titled Care Plans, revealed the resident had a care plan with revision date of 08/01/24. The care plan identified the resident had focus for R41 was at risk for altered nutrition/hydration status and/or weight fluctuations. Supplements: health shakes three times a day and multivitamins with minerals. Review of care plan did not have any indication of R41 refusing weekly weights. Interview on 08/08/24 at 11:40 AM with Licensed Vocational Nurse (LVN) 2 revealed they have weekly meetings with the Registered Dietician to discuss any nutrition concerns. LVN2 stated R41's last nutrition review was 05/31/24 and RD recommended multi vitamins, health shake and continue weekly weights. LVN2 stated they are responsible for ensuring R41's care plan was updated with all dietician recommendations. LVN2 stated R41 sometimes refuses weights but confirmed there was only one note from May 2024 through July 2024 indicating R41 refused to be weighed. LVN2 stated they were responsible for ensuring R41's care plan was updated with interventions for refusing weekly weights. Interview on 08/08/24 at 12:04 PM with Director of Nursing (DON), revealed LVN2 was responsible for initiating R41's weekly weights and other nutrition interventions are implemented and entered on their comprehensive care plan. DON stated if a resident is refusing interventions and still triggering for weight loss then staff are to let the RD and Physician know so they can attempt to go over the risk verse benefits with resident.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25490 Based on interviews, observations, and a review of the facility policies, the facility failed to ensure one resident (Resident (R)25) in a total sample of 30, received a range of motion care and treatment. Specifically, the facility failed to provide restorative aide care per R25's care planned intervention to prevent further contractures of her right hand. Findings included: Review of the facility's policy titled, Restorative Nursing Program, undated revealed, .The Restorative Nursing Program (RNP) is designed to assist the facility team help residents to achieve and maintain their highest functional level . the RNP has two general purposes (a). the program may be used to help residents restore function . (b). to assist residents to maintain function or prevent, to the extent possible, or minimize functional declines .RNPs do not require a physician order .RNP activities may be provided by designated RNAs (Restorative Nursing Assistants, Certified Nursing Assistants (CNAs) .If the resident or representative refuses the RNP, the RNP Coordinator will document the education that was provided to include the risk and benefits . Review of the Admission Record located in the Profile tab of the electronic medical record (EMR) revealed R25 was admitted to the facility on [DATE] and had diagnoses that included but were not limited to Parkinson's, weakness, contracture of muscle, left ankle, and foot, and cognitive communication deficit. Review of R25's Care Plan, located in the EMR under the Care Plan tab, initiated on 05/08/24, revealed, . R25 has, an ADL [activities of daily living] self-care performance deficit r/t [related to] limited mobility, weakness, Parkinson's, cognitive impairment, autonomic neuropathy, left ankle contracture .Certified Nurse Aide (CNA): Splint/Brace Program: Gentle prolonged stretches with shoulders down, gentle prolonged stretches to fingers, all joints in preparation for washcloth placement to right hand to prevent further contracture of fingers 5 times a week for 12 weeks . Review of the quarterly Minimum Data Set (MDS) located in the MDS tab of the EMR with an Assessment Reference Date (ARD) of 01/26/23 revealed a Brief Interview of Mental Status (BIMS) score of three out of a three which indicated she was severely impaired in cognition. Further review of the MDS revealed rhe resident was not coded for having a contracture or using a splint. Review of an Occupational Therapy Note dated 05/03/24 provided by the facility revealed, .rolled washcloth, especially under the third finger . Review of a CNA Task for Splint, dated from 07/08/24 until 08/06/24, located in the EMR under the Task tab revealed, R25 had refused the placement of the rolled washcloth . Review of a Progress Note dated for July and August 2024 located in the Progress Notes tab of the electronic medical records (EMR) revealed there were no nursing notes to indicate that R25 had refused restorative aide care (RA). (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 08/05/24 at 12:07 PM, R25 was observed in her room lying on a low bed, an observation was made of R25's right hand which was closed tightly in a fist. During the same observation, an interview was conducted. The surveyor asked R25 to open her right hand. R25 used her left hand and fingers to attempt to open her right hand with great difficulty. During an observation on 08/06/24 at 9:11 AM, revealed R25 resting peacefully in her room. R25's right hand was closed tightly in a fist. No rolled towel was observed in R25's hand. During an interview on 08/06/24 at 10:31AM with the CNA1, revealed, she was familiar with R25 and acknowledged the right-hand contracture. The surveyor asked CNA1 was there any intervention in place to prevent further damage to the resident's hand. CNA1 stated, Yes, to place a rolled towel in the right hand. This surveyor informed CNA1 that several observations were made of R25, and no gauze or towel was placed in the right hand. CNA1 stated she did not place the towel in the resident hand per care plan. This surveyor asked CNA1 what was facility policy when a resident refused care. CNA1 stated, to document on the Task form located in the EMR and to notify the charge nurse. CNA1 did document in EMR, however, she did not inform the charge nurse that the towel was not placed. During an interview on 08/06/24 at 11:00 AM with the facility Infection Preventionist (IP) revealed, R25 is care planned for RA. The IP continued to share that the facility no longer has an RA department, so the responsibility has transitioned to the CNAs to complete. The IP further stated, if a resident refuses RA care the CNA is to document in the EMR under the task tab along with informing the charge nurse. Once the charge nurse has been notified, the nurse will document in the EMR that the resident has refused care, and when the resident refuses care multiple times, the RA will be discontinued, or the resident will be reassessed by the therapy department. The IP informed this surveyor that CNA1 did not follow proper facility policies. During an interview on 08/06/24 at 3:33 PM the Administrator revealed that the purpose of notifying the nursing staff of any care refusal is to ensure that nursing staff are aware of any care issues residents are not receiving along with monitoring CNAs are following through with their duties and responsibilities. The Administrator further stated that her expectation of all staff is that they follow facility policies and procedures when it comes to refusal of care. During an interview on 08/08/24 at 11:39 AM, the Director of Nursing (DON) revealed nursing competencies are done annually and as needed. The DON stated for all refusals of care, CNAs are to document in the EMR along with informing the nursing staff of the refusal. Once the nursing staff is notified, the nurse will document in the EMR that a resident has refused care. The DON continued to share that the purpose of notifying nursing staff of refusals is to monitor and track care and to ensure that staff are performing their responsibilities and duties.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38517 Based on interview, medical record review, and policy review, the facility failed to ensure one of five residents (Resident (R) 41) reviewed for nutrition had weekly weights obtained after a significant weight loss. This failure had the potential for residents to lose a significant amount of weight without interventions which could have adverse health effects. Findings include: Review of R41's Admission Record from the electronic medical record (EMR) Profile tab showed a facility admitted [DATE] with medical diagnoses that included Hydronephrosis with Renal and Ureteral Calculous Obstruction, Dysphagia, Anemia and Muscle Weakness. Review of the NSG Skin and Nutrition Review, located under the Evaluations tab of the EMR, dated 05/31/24stated the reason for the review was significant/grad weight loss/gain. Comments section stated R41 weight history: 05/22/24: 136 lbs (-5#/-3.7% x 1 week, not sig), 5/10/24:145 lbs and 4/27/24: 148 lbs (-17#/-11.5% x 1 mon, sig) Significant weight loss noted in the past 1 month likely related to poor intake secondary to food consistency. PO intake is 25-100% with 1-2 meals refusal daily. Further weight loss is not encouraged due to advanced age. No edema noted at this time Recommend Health shake 120mL three times a day. Recommend Multivitamin with minerals and continue weekly weight monitoring. Review of R41's weights form the Vitals/Weights tab indicated: 05/10/24 145 lbs. 05/22/24 136 lbs. 05/31/24 131 pounds (lbs.) No June or July 2024 weight Revie of R41's Nursing Progress Note, located under the progress notes tan, dated 07/29/24 documented, R41 refused to be weighed this week for weekly review. The Medical Director notified of R41's refusal with no new orders, continue to encourage residents to allow weight. Further review of R41's EMR revealed there was no other documentation of R41 refusing to be weighed. Interview on 08/08/24 at 11:40 AM with Licensed Vocational Nurse (LVN) 2, LVN2 revealed they have weekly meeting with the Registered Dietician to discuss any nutrition concerns. LVN2 stated R41's last nutrition review was 05/31/24 and RD recommended multi vitamins, health shake and continue weekly weights. LVN2 stated they are responsible for ensuring R41 was put on weekly weights and LVN2 confirmed R41 was not placed on weekly weights. LVN2 stated R41 sometimes refuses weights but confirmed there was only one note from May 2024 through July 2024 indicating R41 refused to be weighed. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/08/24 at 12:04 PM with Director of Nursing (DON), DON stated LVN 2 was responsible for initiating R41's weekly weights and other nutrition interventions are implemented. DON stated if a resident is refusing interventions and still triggering for weight loss then staff are to let the RD and Physician know.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25490 Based on record review, observation, interview, and review of the facility policies., the facility failed to ensure staff followed enhanced barrier precautions and standard nursing precautions while providing wound care for one of one resident (Resident (R)19) out of a sample size of 30. Specifically, facility staff failed to follow personal protective equipment (PPE) guidelines properly and did not use a clean barrier surface for wound care supplies when providing bilateral wound care to R19. This facility failure had the potential to cause further infection to the resident's wounds. Findings include: Review of the facility's policy titled, Infection Control Enhanced Barrier Precautions, not dated, revealed, Enhanced Barrier Precautions (EBP) are an infection control intervention used to reduce transmission of multi drug-resistant organisms . EBP is an extension of standard precautions utilized for resident . Review of the facility undated policy titled, Infection Prevention and Control Program, revealed, .facility staff will use standard precautions during resident care activities, .staff will use PPE as indicated by the identified precautions . Review of R19 Face Sheet located in the electronic medical record (EMR) under the Profile tab revealed, that R19 was originally admitted to the facility on [DATE] with the following diagnoses but not limited to, type 2 diabetes, contracture of muscle, venous insufficiency, and anemia. Review of R19's Physicians Order, located in the EMR under the Oorders tab, dated 08/06/24 revealed, .on Enhanced Barrier Precautions [EBP] . Review of R19's Physicians Order, located in the EMR under the Oorders tab revealed, Treatment of bilateral lower extremities: Cleanse with soap and water, apply non-adherent dressing and wrap with Kerlix . Observation on 08/05/24 at 11:13 AM revealed Licensed Vocational Nurse (LVN)1 was already in the room providing wound care to R19 with gloves, and a mask but no yellow gown per doctor orders and EPB sign located on the outside of R19's room. LVN1 was observed spraying R19's lower right and left legs with a cleaning solution and wiping with a white 2-inch by 2-inch gauze which was located on the resident's bedside table resting on R19's breakfast tray. There was no clean barrier cloth on the resident tray to prevent cross-contamination. LVN1 then proceeded to call a Certified Nurse Aide (CNA) into the room to assist with holding the HELIX stick with a blue tip (a HELIX stick is used to measure wounds) to obtain photos of R19 lower extremities wounds. CNA1 walked into the room with only a mask and gloves, CNA1 did not wear a yellow gown. Once CNA1 was at the bedside to assist LVN1. LVN1 retrieved the HELIX stick, which was resting on a black IPAD, the IPAD was resting on a dresser drawer located against the wall. LVN1 handed the HELIX stick to CNA1. CNA1 placed the HELEX stick directly on R19's leg and LVN1 preceded to take images. Observation of R19's door revealed Everyone must: clean their hands before entering and leaving ., Providers and staff must also: Wear gloves and gown for the following high contact resident care .dressing, bathing, transferring, wound care . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/06/24 at 11:03 AM the Infection Preventionist (IP) revealed, that when providing wound care or any care and supplies are used a clean barrier (drop cloth) is placed on the bedside table or at the foot of the resident's bed. At no time are supplies to be placed on the resident's food tray or any uncleaned surfaces. The IP further stated that for any residents on e EBP precautions, staff must wear their masks, gloves, and yellow gowns. During an interview on 08/06/24 at 10:41 AM, CNA1 recalled assisting LVN1 with R19's wound care. The CNA1 was asked to share the proper procedures for providing care for a resident on EBP. CNA1 stated, You wear a mask, gloves, and a yellow gown. T. CNA1 stated, No we [she and LVN1] were not [wearing yellow gowns]. The CNA1 was asked did she recall where the supplies were placed. CNA1 stated, On the bedside table. The CNA1 was asked did she recall the supplies being placed on a clean surface barrier. CNA1 stated, No they were not. During an interview on 08/06/24 at 12:07 PM, LVN1 revealed, that when providing wound care all supplies should be placed on a clean barrier. LVN1 acknowledged he did not place R19's supplies on a clean barrier nor did he wear a yellow gown while performing care. LVN1 continued to share that by not wearing his yellow gown and placing R19's supplies on a clean barrier he did not follow proper infection control policies and procedures. During an interview on 08/06/24 at 3:38 PM, the Administrator revealed she expects all nursing staff providing care should follow standard precautions of care to prevent any infection control breaks. During an interview on 08/08/24 at 11:39 AM, the Director of Nursing (DON) revealed nursing competencies are done annually and as needed, this surveyor informed the DON of the infection-control break which was observed. The DON stated, That is nursing 101 and I expect all staff to follow proper standard precautions of care at all times.