

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055917	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/21/2024
NAME OF PROVIDER OR SUPPLIER Harvest Crossing Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 469 East North Street Manteca, CA 95336	

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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50161</p> <p>Based on interview and record review, the facility failed to ensure 1 of 24 sampled residents (Resident 6) received treatment in accordance with quality care when, Resident 6 had left knee swelling, and exhibited signs of pain via facial grimacing and screaming during care provided to her by staff and,</p> <p>a. Nursing staff did not adequately assess Resident 6's source of pain and provide pain management based on Resident 6's level of pain; and,</p> <p>b. There was a delay in obtaining an x-ray result of Resident 6's left knee, ordered to provide information as to the source of Resident 6's pain.</p> <p>These failures had the potential for Resident 6 to experience prolonged pain and suffering and may have resulted in a delay of treatment and other complications related to her fractured femur (thigh bone) and dislocated left knee.</p> <p>Findings:</p> <p>Review of Resident 6's ADMISSION RECORD, indicated Resident 6 was admitted to the facility during the summer of 2024, with diagnoses including dementia (progressive loss of intellectual functioning, affecting memory and thinking), fracture of lumbar vertebra (break in bones of the lower back), osteoarthritis (cartilage and bone in joints break down over time), muscle weakness, and difficulty walking.</p> <p>Review of Resident's 6's care plan, Chronic Pain dated 6/12/24, indicated, .The resident has chronic pain r/t [related to] arthritis, Fracture [lower back location], Limited mobility .The resident will display a decrease in behaviors of inadequate pain control (irritability, restlessness, grimacing, groaning, crying) .Administer analgesia [pain medication] as per orders .respond immediately to any complaint of pain .Assess /record/report to Nurse any s/sx [signs/symptoms] of non-verbal pain .Mood/behaviors (changes, more irritable, restless) .Evaluate the effectiveness of pain interventions .</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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 6's BIMS Evaluation Nursing Note [BIMS is a brief screener and aids in detecting cognitive impairment], dated 9/13/24, indicated, .Resident is disoriented and confused. Resident had a Dx [diagnosis] of Dementia .BIMS Summary Score: 3 [BIMS assessment uses a points system that ranges from 0 to 15 points. 0 to 7 points suggests severe cognitive impairment, 8 to 12 points suggests moderate cognitive impairment, and 13 to 15 points suggests that cognition is intact] .</p> <p>Review of Resident 6's clinical record, Physician Progress Notes, dated 11/12/24, written by a physician, (MD) 3, indicated, .Patient is not in acute distress, continue with close follow-up, she was evaluated as she has baseline dementia and has multiple medical issues .Patient remains high risk as she is unable to identify her care needs .no signs of acute decline or distress .</p> <p>Review of Resident 6's clinical record, SBAR [Situation, Background, Assessment, Recommendation- a communication between members of the health care team and the physician]</p> <p>dated 11/16/24, at 8:41 p.m., written by Licensed Nurse (LN) 14 indicated, .Resident noted with left knee swollen. No redness noted. Pain when resident move leg. MD notified. New order for x-ray for left knee . Prednisone [medication used for inflammation or swelling] .daily for five days .</p> <p>Review of Resident 6's clinical record, Order Details, dated 11/16/24, at 9:30 p.m., indicated, .x-ray left knee . communication method .phone .Ordered . [MD 1] .</p> <p>Review of Resident 6's clinical record, Health Status Note, dated 11/16/24 at 9:45 p.m., written by LN 14, indicated, .Called X ray mobile spoke with [name redacted] for x ray needed ASAP [as soon as possible] .</p> <p>Review of Resident 6's clinical record, Radiology Interpretation, dated 11/17/24 at 10:36 a.m., signed by the Radiologist (MD) 2, indicated, .PAIN IN LEFT KNEE, SWELLING .SIGNIFICANT FINDINGS .distal femur supracondylar fracture [fracture of leg bone near the knee] .Lateral dislocation of femoral condyle prosthesis [dislocation of left knee joint] .</p> <p>Review of Resident 6's clinical record, Health Status Note, dated 11/17/24 at 6:30 p.m., written by LN 14, indicated, .Received X ray results of left knee. Notified MD. Received order to send patient to ER [emergency room] Due to abnormal X ray result of left knee for further evaluation and treatments as indicated. Called [Emergency Medical Services] to transfer patient to hospital. Resident Transferred to [hospital name] @ [at] 1845 [6:45 p.m.] .</p> <p>Review of Resident 6's clinical record, Interdisciplinary Notes, dated 11/18/24, written by the Director of Nurses (DON), indicated, .Resident is a [AGE] year old female .history is significant for left hip osteoarthritis, multiple fractures, osteoporosis [weakened bones] and dementia. Her BIMS is 3. She required assistance with ADL's [activities of daily living for personal care] and is a hooyer lift [electronically operated patient lift for the safe lifting of patients] for transfers. On 11/17/24 a left knee X-ray was done due to new onset pain and swelling. The X-ray showed a dislocation of the lateral femoral condyle prosthesis [dislocation of the artificial knee joint and leg bone]. The resident was sent to the hospital for further treatment per md [medical doctor] orders .</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a phone interview on 11/19/24, 12:18 p.m., with Family Member (FM) 2 and FM 3, FM 3 stated she received a phone call from the facility on 11/16/24 to notify of the x-ray needed, and on 11/17/24 the facility called to inform her Resident 6 had a knee dislocation and was being sent to the hospital. FM 3 stated the hospital also found Resident 6 to have a hip fracture, and her hemoglobin was found to be 8.5 (hemoglobin is a protein in red blood cells, and for women, a normal level ranges between 12.3 gm/dL and 15.3 gm/dL) on 11/17/24 and went down to 7.5 on 11/18/24. FM 3 stated Resident 6 needed to be transferred to a different hospital on 11/18/24 due to her low hemoglobin. FM 3 stated Resident 6 was medically unstable at this time for surgery and was in a splint. FM 3 stated Resident 6 was experiencing a lot of pain and kept saying it hurts.</p> <p>During an interview on 11/20/24, at 1:36 p.m., CNA 4 stated she worked with Resident 6 on 11/15/24. CNA 4 stated while performing her care, every time she touched Resident 6, her face looked like she was in pain, and when she turned her, she would scream. CNA 4 stated she told LN 9 about the pain and notified her she was not going put Resident 6 in the reclining chair. CNA 4 stated on Saturday, 11/16/24, Resident 6 started vomiting, and she was still in pain, and explained she did not put her in the chair that day either, and stated she still did not look good, and would scream when they turned her.</p> <p>During an interview on 11/21/24, at 8:22 a.m., CNA 4 stated, on Friday, 11/15/24, she informed LN 18 of Resident 6's pain first thing in the morning, and explained she noticed her pain when she was changing her after breakfast, which was around 9 a.m. CNA 4 stated she told LN 18 Resident 6 was screaming and she could not touch her because she was in a lot of pain. CNA 4 stated on Saturday, 11/16/24, she told LN 16 who was Resident 6's nurse, she did not look good, and she was nauseous. CNA 4 stated LN 16 told her maybe she was constipated. CNA 4 stated she was familiar with Resident 6 and knew something was wrong with her.</p> <p>During an interview on 11/21/24, at 8:33 a.m., LN 18 stated she was Resident 6's nurse on Friday, 11/15/24 during the day shift. LN 18 stated Resident 6 had an ongoing change of condition, as she was having nausea and vomiting. LN 18 stated she watched the CNA do her oral care after breakfast while she was preparing her medications. LN 18 stated she heard Resident 6 stating it hurts to the CNA, and when the CNA asked her what hurt, Resident 6 did not say anything. LN 18 stated she did not see any swelling in her left knee, and Resident 6 did not show any evidence of pain such as grimacing. When asked if LN 18 moved or touched Resident 6 to assess her pain, LN 18 stated she did not, and stated she did not give her medication for pain at that time.</p> <p>During an interview on 11/21/24, at 10:24 a.m., LN 14 stated on Saturday, 11/16/24, during the evening shift, CNA 9 informed her Resident 6's left leg was swollen. LN 14 stated at around 6 p.m., she assessed Resident 6 and stated her left knee was swollen and when she touched her, she would move, and appeared to be in pain, so she gave her acetaminophen and called the physician. LN 14 stated she told the physician Resident 6's knee was swollen, and it was painful to the touch, and stated the physician wanted an x-ray, and ordered prednisone (medication used for inflammation). LN 14 stated she asked the x-ray company to come as soon as possible and was hoping they would come that night because Resident 6 was in pain. LN 14 stated on 11/17/24 the x-ray company called her because they were not able to fax the results to the facility, so LN 14 stated she contacted the DON, who was off, and asked her for help retrieving the x-ray results.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 6's clinical record, Medication Administration Record (MAR, a document listing all medications and tests carried out by nursing staff), for November 2024, indicated Resident 6 had the following orders for pain management:</p> <p>.325 MG [milligram, a unit of weight] acetaminophen .Give 2 tablet by mouth every 6 hours as needed for mild pain .</p> <p>. Tramadol 50 MG [an opioid pain medication] .Take 1 tablet by mouth every 6 hours as needed for Moderate to severe pain .</p> <p>Review of the MAR for November 2024 indicated Resident 6 received the following for pain:</p> <p>Acetaminophen 2 tablets on 11/16/24 at 8:50 p.m., for a pain level of 3 (a scale used to describe pain, 1-3 is mild, 4-6 is moderate, and 7-10 is severe) administered by LN 14</p> <p>Acetaminophen 2 tablets on 11/17/24, at 4 am, for a pain level of 3, administered by LN 19.</p> <p>The record indicated Resident 6 did not receive the Tramadol medication during the month of November 2024.</p> <p>In an interview on 11/21/24, 9:17 a.m., the DON stated LN 14 called her on Sunday, 11/17/24, during her PM shift because she was looking for the x-ray results for Resident 6. The DON stated the results were emailed to her, but she was off, so she sent them to LN 14.</p> <p>During a concurrent interview and record review on 11/21/24, at 1:15 p.m., the DON stated she expected the LN would assess the resident for pain, including using facial grimacing as an indicator. The DON stated the expectation was for the nurse use touch in their assessment of pain and explained it was important because the resident might not be able to verbalize where the pain was. The DON stated the expectation was for the LN to do a head-to-toe assessment and look over the entire body. The DON stated Resident 6's x-ray results were ready on 11/17/24 at 10:36 a.m., and not received until 11/17/24 at 6:23 p.m. The DON confirmed Resident 6 was given two doses of acetaminophen between 11/16/24, when the change of condition was reported to the MD, and the evening of 11/17/24, when Resident 6 was sent to the hospital.</p> <p>During an interview on 11/21/24, at 2:17 p.m., MD 1 stated he was the physician covering for the facility's medical director over the weekend of 11/16/24 to 11/17/24. MD 1 stated Resident 6 had dementia and this condition made determining the cause of her pain more difficult, requiring prompt follow up. MD 1 stated if the x-ray or result was delayed, his expectation was staff should notify the physician, and he would have sent the patient out to the hospital. MD 1 stated a patient waiting twenty hours for x-ray results was too long, and this would place the patient at risk for further complications.</p> <p>During a review of a facility policy and procedure (P&P) titled Dementia, revised 11/2018, indicated, . The staff and physician will determine any relationship between the resident's level of pain and cognitive loss . The staff will monitor the individual with dementia for changes in condition and decline in function and will report the findings to the physician .</p>		