

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>49823</p> <p>Based on observation, interview, and record review, the facility failed to ensure one resident (Resident 26) in a sample of 24 was treated with dignity and respect when staff stood over Resident 26 while assisting with breakfast on 11/19/24.</p> <p>This failure had the potential to negatively impact Resident 26's psychosocial well-being.</p> <p>Findings:</p> <p>A review of Resident 26's Admission Record, indicated Resident 26 was admitted to the facility with diagnoses which included alzheimer's disease (a gradual decline in memory, thinking, behavior, and social skills), and dementia (a decline in memory and other thinking skills severe enough to reduce a person's ability to perform daily activities).</p> <p>During a concurrent observation and interview on 11/19/24, at 7:45 a.m., Certified Nursing Assistant (CNA) 1 assisted Resident 26 with breakfast while standing over her at her bedside. Resident 26's breakfast tray was noted on the bedside table next to her bed. CNA 1 held a spoon with food up to Resident 26's mouth in one hand, and a carton of milk containing a straw in her other hand. Resident 26 pushed the carton of milk away and shouted, No! CNA 1 stated that she was assisting Resident 26 with breakfast and confirmed she stood while assisting Resident 26 with breakfast. CNA 1 stated that staff should sit at the resident's bedside when assisting residents with meals. CNA 1 further stated she did not know why staff should not stand when residents were assisted with meals.</p> <p>During an interview on 11/20/24, at 11:30 a.m., with the Director of Nursing (DON), the DON stated the expectation for staff assisting residents with meals would be to sit beside the resident at eye level. The DON further stated the risk of staff standing up and over the resident while assisting the resident with their meals was a loss of dignity and respect for the resident. The DON confirmed the facility procedure was not followed.</p> <p>During a review of a facility policy and procedure (P&P) titled, Resident Rights, revised February 2021, indicated, .Employees shall treat all residents with kindness, respect, and dignity .1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a. a dignified existence b. be treated with respect, kindness, and dignity .</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
---	-------	-----------

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 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>50018</p> <p>Based on observation, interview, and record review, the facility failed to ensure 1 of 24 sampled residents (Resident 31) needs were accommodated when Resident 31 did not have a working call light (a device used by residents to call for assistance).</p> <p>This failure increased the risk for psychosocial and/or physical harm if Resident 31 was unable to contact staff for her needs.</p> <p>Findings:</p> <p>A review of Resident 31's clinical record titled, Admission Record, indicated Resident 31 was admitted to the facility with diagnoses including osteoarthritis of hip (causes pain and stiffness of the hips) retention of urine (inability to empty the bladder completely), and stress incontinence (when movement or activity puts pressure on the bladder, causing urine to leak).</p> <p>During a concurrent observation and interview on 11/18/24, at 10:42 AM, the call light system in Resident 31's room was noted not to be working, confirmed by certified nursing assistant (CNA) 8. CNA 8 confirmed Resident 31 did not have a bell (a bell used to summon an attendant or give an alarm or notice) in her room. CNA 8 stated that Resident 31 could just scream out for help and the staff would assist her.</p> <p>During an interview on 11/19/24, at 3:35 PM, the Maintenance Director (MD) confirmed the call light system in Resident 31's room was not working.</p> <p>During an interview on 11/20/24, at 10:07 AM, Licensed Nurse (LN) 12 stated the staff would not know if the residents needed help if the call light system was not working. LN 12 further stated that residents screaming for help would not be the best way for residents to get the help they need.</p> <p>During an interview on 11/20/24, at 4:12 PM, the Director of Staff Development (DSD) stated she expected the call light system to be working and functioning. The DSD stated the risks of having a malfunctioning call light system would be the resident's needs not being met and could contribute to falls. The DSD further stated the facility should have a working call light system to prevent those risks. The DSD added she did not want the residents to be screaming for help.</p> <p>During an interview on 11/20/24, at 11:56 AM, the Director of Nursing (DON) stated residents should have bells in the event the call light was not working. The DON stated the nurses and CNAs were aware that they could provide bells to residents in the event that the call light system was not functioning. The DON stated the call light system should be functioning and working at all times. The DON further stated she did not want residents to scream out for help.</p> <p>(continued on next page)</p>		

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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 31's clinical record titled, Care Plan, dated 12/28/2021, indicated .Focus: The resident is at risk for falls .she sometimes forgets to take her walker with her when she attempts to use the restroom . The interventions include: Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance, the resident needs a safe environment .a working and reachable call light .</p> <p>During a review of the facility's Policy and Procedure (P&P) titled, Call System, Resident, dated 9/2022, the P&P indicated, .Each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor .The resident call system remains functional at all times. If audible communication is used, the volume is maintained at an audible level that can be easily heard. If visual communication is used, the lights remain functional .The resident call system is routinely maintained and tested by the maintenance department .</p> <p>During a review of the P&P titled, Accommodation of Needs, revised 3/2021, the P&P indicated, .The residents individual needs and preferences, including the need for adaptive devices and modifications to the physical environment, are evaluated upon admission and reviewed on an ongoing basis .In order to accommodate individual needs and preferences, staff attitudes and behaviors are directed towards assisting the residents in maintaining independence, dignity and well-being to the extent possible and in accordance with the resident's wishes. For example . interacting with the residents in ways that accommodate the physical or sensory limitations of the residents, promote communication, and maintain dignity .</p>		

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 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>50598</p> <p>Based on observation, interview, and record review, the facility failed to maintain residents' right to privacy of personal information, when resident meal tickets were discarded in the facility kitchen garbage bin for a census of 87.</p> <p>This failure increased the risk of unauthorized access of residents' personal and medical records.</p> <p>Findings:</p> <p>During a concurrent observation and interview on 11/20/24 at 8:50 PM with Dietary Aide (DA) 1 in the dishwashing area, DA 1 was observed throwing residents' meal tickets left on the meal trays into the garbage bin. DA 1 confirmed the observation.</p> <p>During an interview on 11/20/24 at 8:52 AM with the Interim Certified Dietary Manager (ICDM) in the dishwashing area, the ICDM confirmed DA 1 threw the residents' meal tickets into the garbage bin. The ICDM also confirmed that multiple residents' meal tickets were returned with their meal trays to the kitchen. The ICDM stated they used to shred the tickets but somehow, they reverted to throwing them back in the garbage bin.</p> <p>A review of a resident meal ticket indicated the meal ticket contained information such as the resident's complete name, identification number, where the resident usually ate their meal, room, and bed number, diet order, allergies, food notes and alerts, likes and dislikes, the date, and type of meal.</p> <p>During an interview on 11/21/24 at 12:16 PM, with the Registered Dietician (RD), the RD stated she was aware of this practice and stated throwing the tray cards in the garbage did not meet her expectations. The RD stated the residents' meal tickets should have been shredded after the resident finished eating to avoid violating HIPPA (Health Insurance Portability and Accountability Act- a federal law that requires the creation of national standards to protect sensitive patient health information from being disclosed), and if the meal ticket was returned in the kitchen, the kitchen staff should shred them. The RD further stated there had been several meetings with the dietary and the nursing department about the proper disposal of the tray meal tickets.</p> <p>A review of the policy titled Confidentiality of Information and Personal Privacy Policy, dated October 2017, indicated, The facility will safeguard the personal privacy and confidentiality of all resident personal and medical records.</p>		

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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>50018</p> <p>Based on observation, interview, and record review, the facility failed to maintain a safe, clean, and comfortable living environment for 2 of 24 sampled residents (Resident 340 and Resident 31), when Resident 340's and Resident 31's floor vents (provides cold and warm air) were full of dust and debris.</p> <p>This failure had the potential to negatively impact Resident 340's and Resident 31's homelike environment and their health.</p> <p>Findings:</p> <p>1. A review of Resident 340's clinical record titled, ADMISSION RECORD, indicated Resident 340 was admitted to the facility with diagnoses including pleural effusion (fluid build up between the lungs and the chest) and other symptoms of the heart and lungs.</p> <p>A review of Resident 31's clinical record titled, ADMISSION RECORD, indicated Resident 31 was admitted to the facility with diagnoses including cough and a history of contracting Covid-19.</p> <p>During a concurrent observation and interview on 11/18/24 at 3:28 PM with the Maintenance Director (MD), the MD confirmed the floor vents were dirty in Resident 340's and Resident 31's room. The vents were observed to have gray dust particles and debris inside of them. The MD stated the floor vents were active and in use. The MD stated the housekeeping staff were supposed to clean the vents weekly. The MD further stated that the residents could be at risk for respiratory problems due to the dirty vents.</p> <p>During an interview on 11/19/24 at 8:43 AM, with the Housekeeping Supervisor (HKS), the HKS stated it was the responsibility of the housekeeping department to clean the floor vents. The HKS also stated the housekeeping department does not clean the floor vents weekly, only if it was noticed during a spot check.</p> <p>During an interview on 11/20/24 at 12:57 PM with Resident 340, Resident 340 stated she wanted the vents in her room to be kept clean. Resident 340 stated she was afraid she was going to inhale the vent particles. Resident 340 further stated she was scared to look at the vents in her room.</p> <p>During an interview on 11/20/24 at 1:10 PM with Licensed Nurse (LN) 11, LN 11 stated the staff members knew it was not good for the residents to have dirty vents in their rooms. LN 11 stated it was not very homelike to have dirty vents because it can trigger resident allergies. LN 11 further stated respiratory issues could occur because of the dirty vents.</p> <p>During an interview on 11/20/24 at 11:59 AM with the Director of Nursing (DON), the DON stated she wanted the resident rooms to be clean and clutter free. The DON also stated the vents in the resident rooms should not be dusty and dirty.</p> <p>(continued on next page)</p>		

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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's document titled, Homelike Environment, revised 2/2021, the Policy and Procedure indicated, .The facility staff and management maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: a clean, sanitary, and orderly environment .</p>

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 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</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 accurately complete, and ensure the completion of, a Pre-Admission Screening and Resident Review (PASRR, a required assessment for individuals with mental illness, intellectual or developmental disabilities, or related conditions, so that a determination of need, appropriate setting, and a set of recommendations for services to be included in the individual's plan of care is provided) for two of twenty-four sampled residents (Resident 60 and Resident 72), when,</p> <ol style="list-style-type: none"> 1. Resident 72's level I PASRR did not reflect his diagnosis of autism (a disorder that affects how people interact with others, communicate, learn, and behave) or his use of psychotropic medications (drugs that treat symptoms of psychosis, such as hallucinations, delusions, and thought disorders) which resulted in a level II PASRR (mental health screening for additional services) never being completed; and, 2. Resident 60 had a positive level I PASRR screening and the required level II PASRR screening was not completed due to Resident 60 being in transmission-based precautions (TBP, isolation precautions implemented to prevent or control the spread of germs) in August 2022 for a medical illness. <p>These failures had the potential to affect the provision of appropriate treatment and specialized services for Resident 60 and Resident 72 and increased their risk of having unmet behavioral health needs.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of Resident 72's ADMISSION RECORD, indicated, Resident 72 was admitted to the facility with diagnoses including autistic disorder, anxiety disorder (frequently have intense, excessive and persistent worry and fear about everyday situations, adult failure to thrive (describes a state of decline to include weight loss, decreased appetite, poor nutrition, and inactivity), cognitive communication deficit (difficulty paying attention to a conversation), depression (depressed mood or loss of pleasure or interest in activities), and dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life). <p>Review of Resident 72's Physician Progress Note, dated 10/4/24, written by the Psychiatric Nurse Practitioner (NP, a nurse who specializes in the diagnosis, prevention, treatment of mental disorders) 2, indicated, .Per staff, patient with periods of mood lability [rapid and unpredictable shifts in mood] behaviors and with periods of intentionally crawling on floor, and yelling/screaming. Psychotic (psychotropic) medications reviewed. Patient is currently on Depakote [used to treat mood disorders/seizures], Remeron [used to treat depression/appetite stimulant], and on PRN [as needed] Lorazepam [used to treat anxiety]. Goal is to minimize use of benzodiazepine [class of depressant drugs such as Lorazepam] in elderly as much as possible . The report indicated a treatment plan to include, .consider social support, continue nonpharmacological measures [behavioral interventions without using medication], psychiatric follow up within 4 weeks or PRN [as needed] .</p> <p>(continued on next page)</p>		

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 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 72's Preadmission Screening and Resident Review (PASRR) Level 1 Screening, dated 9/10/23, indicated under the section .Intellectual or Developmental Disability (ID /(DD) or Related Condition . the answer was marked no to the question of .The individual has .disabilities that originated before the age of 18 .includes .autism . Under the section .Specify type/Diagnosis . the answer was marked no to the question of .The individual has a history of substantial disability prior to the age of 22 . Under the section .Describe the services . the answer was marked no to the question of .Because of ID/DD, the individual experiences functional limitations .mobility, self-care, delf-direction, learning/understanding/using language, capacity for living independently . Under the section .Serious Mental Illness . the answer was marked yes with depression listed as a diagnosis. Resident 72's other diagnoses that were not listed by staff included his anxiety disorder and/or mood disturbance. Under the same section, the answer was marked no to the question .The individual has been prescribed psychotropic medication for mental illness . Under the section Categorical Determination the answer was marked yes to the statement .The individual could not benefit from specialized (mental health) services because there is a severe physical condition . with dementia being listed as to why Resident 72 would not benefit from specialized (mental health) services.</p> <p>A Review of Resident 72's Department of Health Care Services Letter, dated 9/10/23, indicated, .UNABLE TO COMPLETE LEVEL II EVALUATION .After reviewing Positive Level 1 Screening .a Level II Mental Health Evaluation was not scheduled for the following reason .The individual has no serious mental illness . The case is now closed .To reopen, please submit a new level I screening .</p> <p>During an interview on 11/18/24, at 10:24 a.m., the Speech Language Pathologist (SLP) stated Resident 72, prior to coming to the facility, had been found by police because he was wandering the streets without any clothes on. The SLP stated he has been living in the facility for two years and stated Resident 72 was autistic and had other medical issues.</p> <p>During an interview on 11/20/24, at 8:57 a.m., LN 9 stated Resident 72 was alert and knows what was going on around him. LN 9 stated Resident 72 does have behaviors including crawling on the floor. LN 9 stated staff try to assist Resident 72, but he will get anxious, and this was usually related to his communication issues, and he will get upset and start crying loudly.</p> <p>During a concurrent interview and record review on 11/21/24, at 10:46 a.m., the DON reviewed Resident 72's Department of Health Care Services Letter dated, 9/10/23, which indicated Resident 72, . has no serious mental illness (SMI) . case is now closed.</p> <p>(continued on next page)</p>		

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 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During review of Resident 72's Preadmission Screening, dated 9/10/23, the document indicated, .the individual has or suspected of having . autism . [marked no] . The DON stated this question was answered incorrectly and it should have been marked yes due to Resident 72's autism diagnosis. The DON stated this inaccurate information was used by the evaluator of the PASSR II and stated Resident 72 could have qualified for outside services related to his autism diagnosis if the Preadmission Screening had been filled out accurately. The DON stated the facility had filled out the PASRR Level 1 screening, dated 9/10/23 inaccurately and this impacted Resident 72's ability to qualify for a PASSR II. The DON stated had Resident 72 been found eligible under the PASSR II he would have qualified for programs related to his behaviors and diagnosis of autism. The DON stated the potential harm for Resident 72 was for behavioral disturbances since he was experiencing a delay of services which impact behavior. The DON stated that although the LN's are temporarily calming Resident 72 with medications, his behaviors would continue. The DON stated the expectation was the PASSR was completed on admission and if it triggers for a Level II PASSR evaluation, then it should be completed within two to four days. The DON stated if the resident qualifies for services based on the PASSR II, then services start immediately, and the facility should start referring and connecting the resident for outside services. The DON stated if this process was not followed then the patient would be at risk for inappropriate management.</p> <p>49823</p> <p>2. A review of Resident 60's Admission Record, indicated that Resident 60 was admitted with diagnoses which included, but were not limited to, bipolar disorder (a mental illness associated with episodes of mood swings from severe depression to manic highs), major depressive disorder (a persistent feeling of sadness and loss of interest that can interfere with activities of daily living), and anxiety disorder (a nervous disorder characterized by a state of excessive uneasiness and apprehension that interferes with daily living).</p> <p>During a review of Resident 60's Electronic Medical Record (EMR), the EMR indicated a PASRR Level I screen was completed on 8/3/22, the PASRR Level I screen indicated that a PASRR Level II screening was required. Resident 60's EMR further indicated that a PASRR Level II screening was attempted on 8/10/22 but was not completed as Resident 60 was in TBP isolation for a medical illness.</p> <p>During an interview and concurrent record review on 11/19/24 at 9:50 a.m. with the facility Admissions Coordinator (AC), the AC confirmed that Resident 60's PASRR II was not completed. The AC stated that nursing staff were responsible for requesting a new PASRR screen after Resident 60's medical condition had improved.</p> <p>During an interview on 11/19/24 at 11:45 a.m. with the DON, the DON confirmed that Resident 60's PASRR Level II screen was not done. The DON confirmed that the facility policy was not followed.</p> <p>A review of a facility policy and procedure (P&P) titled, Admission Criteria, revised March 2019, the P&P indicated, . All new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID) or related disorders (RD) per the Medicaid Pre-Admission Screening and Resident Review (PASARR) process .a. The facility conducts a Level I PASARR screen for all potential admissions .b. If the level I screen indicates that the individual may meet the criteria for a MD, ID, or RD, he or she is referred to the state PASARR representative for the level II (evaluation and determination) screening process .</p> <p>(continued on next page)</p>		

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 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of a facility policy and procedure (P&P) titled, Admission Criteria, revised March 2019, indicated, .9. All new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID) or related disorders (RD) per the Medicaid Pre-Admission Screening and Resident Review (PASARR) process .</p> <p>a. The facility conducts a Level I PASARR screen for all potential admissions .b. If the level I screen indicates that the individual may meet the criteria for a MD, ID, or RD, he or she is referred to the state PASARR representative for the level II (evaluation and determination) screening process .</p> <p>During a review of a facility policy and procedure (P&P) titled Behavioral Assessment, Intervention and Monitoring , revised 3/2019, the document indicated, . The facility will provide and residents will receive behavioral health services as needed to attain or maintain the highest practical physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care . Behavioral health services will be provided by qualified staff who have the competencies and skills necessary to provide appropriate services to the residents .Residents will have minimal complications associated with the management of altered or impaired behavior . As part of the initial assessment, the nursing staff and Attending Physician will identify individuals with a history of impaired cognition, altered behavior . or mental disorder . All residents will receive a level 1 PASARR screen prior to admission . If the level 1 screen indicates that the individual may meet criteria for a mental disorder, intellectual disability or related condition here she will be referred to the state space PASARR representative for the level II (evaluation and determination) screening process . New onset or changes in behavior or possible serious mental disorder, intellectual disability, or related disorder will be referred for a PASARR Level II evaluation</p> <p>Review of https://www.medicaid.gov/medicaid/long-term-services-supports/institutional-long-term-care/preadmission-screening-and-resident-review/index.html, accessed on 11/27/24, indicated .PASRR is an important tool for states to use in rebalancing services away from institutions and towards supporting people in their homes, and to comply with the Supreme Court decision, [NAME] vs L.C. (1999), under the Americans with Disabilities Act, individuals with disabilities cannot be required to be institutionalized to receive public benefits that could be furnished in community-based settings. PASRR can also advance person-centered care planning by assuring that psychological, psychiatric, and functional needs are considered along with personal goals and preferences in planning long-term care .In brief, the PASRR process requires that all applicants to Medicaid-certified nursing facilities be given a preliminary assessment to determine whether they might have SMI or ID. This is called a Level I screen. Those individuals who test positive at Level I are then evaluated in depth, called Level II PASRR. The results of this evaluation result in a determination of need, determination of appropriate setting, and a set of recommendations for services to inform the individual's plan of care .</p>		

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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49823</p> <p>Based on observation, interview, and record review, the facility failed to provide services which met professional standards of quality for diabetic (inability to regulate sugar levels in the body) residents in a census of 87 when the quality control solution (QC, used to verify the product meets specific standards) for the East Unit's glucometer (used to measure a resident's blood sugar) was expired.</p> <p>This failure had the potential to cause an inaccurate blood sugar test which could have resulted in diabetic residents receiving the wrong dose of a blood sugar reducing medication called insulin endangering their health and well-being.</p> <p>Findings:</p> <p>During an observation and concurrent interview of the East Unit medication cart #2 on [DATE] at 3:25 p.m. with Licensed Nurse (LN) 2 and LN 6, LN 2 confirmed the QC solution had an open date of [DATE] and an expiration date of [DATE]. LN 2 confirmed the QC solution was expired.</p> <p>During an interview on [DATE] at 11:30 a.m. with the facility Director of Nursing (DON) and LN 3 in the DON's office, the DON stated the risk of using expired QC solution for the QC testing was the QC testing results may not be correct, and the blood sugar readings for the diabetic residents may not be correct. The DON confirmed the facility policy was not followed.</p> <p>A review of a facility policy and procedure (P&P) titled, Blood Glucose [sugar] Monitoring System Calibration, revised [DATE], the P&P indicated, .Procedure in Performing a Control Solution Test .Step 7: Remove the test strip .Make sure that the test strips and control solutions are not past expiration date. This date is shown on bottle. Date the test strip bottle and control solution bottle once opened. Discard control solution 90 days after bottle is opened .</p>		

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 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>49823</p> <p>Based on interview and record review, the facility failed to ensure one resident on fluid restriction (Resident 7), out of 24 sampled residents, physician was notified when Resident 7's fluid intake exceeded the restricted amount specified by the physician.</p> <p>This failure had the potential to result in a decline in Resident 7's health and well-being.</p> <p>Findings:</p> <p>A review of Resident 7's Admission Record indicated that Resident 7 was admitted with diagnoses which included chronic obstructive pulmonary disease (COPD, a lung disease), chronic congestive heart failure (the heart does not pump blood as well as it should), and chronic respiratory failure (difficulty breathing).</p> <p>During an interview with Resident 7 in her room on 11/18/24 at 11:40 a.m., Resident 7 stated she was on fluid restriction. Resident 7 stated she purchased drinks which she stored in her room and did not drink the fluids that came on her meal tray.</p> <p>During a review of Resident 7's Physician Order Summary, dated 11/10/24, the Physician Order Summary indicated, .monitor intake and output every shift .fluid restriction1 liter (unit of measure)/24 hours .</p> <p>During a review of Resident 7's Physician Orders Summary, dated 11/16/24, the Physician Order Summary indicated, .total intake and output every week .add total cc's (cubic centimeters-unit of measurement 1000cc=1 liter) consumed for previous 7 days and divide by 7 for weekly average intake .</p> <p>During a review of Resident 7's Medication Administration Record (MAR), the MAR indicated, 11/11/24 fluid intake 1360 cc .11/12/24 fluid intake 1320 cc .11/13/24 fluid intake 1100 cc .11/14/24 fluid intake 1280 cc . 11/15/24 fluid intake 1350 cc .11/16/24 fluid intake 1390 cc .11/17/24 fluid intake 1420 cc .total fluid consumed for previous 7 days .9730 cc . divide by 7 . total 1390 cc [average consumed per day] .</p> <p>During an interview on 11/21/24 at 7:25 a.m. with the facility Infection Preventionist (IP), the IP stated when a physician wrote an order to monitor intake and output and fluid restriction for a resident, Licensed Nurses (LNs) monitored resident fluid intake and documented the fluid intake in the resident's MAR. The IP stated if the resident's fluid intake was more than the restriction limit written by the physician, LNs called the physician and documented physician notification in a progress note in the resident's electronic medical record (EMR).</p> <p>(continued on next page)</p>		

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 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview and concurrent record review of Resident 7's MAR and Progress Notes on 11/21/24 at 9:30 a.m. with the Director of Nursing (DON), the DON stated that the expectation was that LNs would monitor intake and output for a resident on fluid restriction and notify the physician if the intake was above the fluid restriction amount. The DON stated the expectation was the LNs documented physician notification in the resident's EMR. The DON confirmed there was no documentation the physician was notified of Resident 7's fluid intake from 11/11/24 to 11/17/24. The DON stated the risk of not reporting Resident 7's fluid intake to the physician was Resident 7 could experience worsening heart failure from consuming too many fluids. The DON acknowledged the facility policy was not followed.</p> <p>A review of a facility policy and procedure (P&P) titled, Intake, Measuring and Recording, revised October 2010, the P&P indicated, .The purpose of this procedure is to accurately determine the amount of liquid a resident consumes in a 24-hour period .1. Verify that there is a physician's order for this procedure and/or that the procedure is being performed per facility policy .The following information should be recorded in the resident's medical record, per facility guidelines: 1. The date and time the resident's fluid intake was measured and recorded .Reporting .2. Report other information in accordance with facility policy and professional standards of practice .</p> <p>A review of a facility P&P titled, Change in a Resident's Condition or Status, revised February 2021, the P&P indicated, .Our facility promptly notifies .his or her attending physician .of changes in the resident's medical/mental condition and/or status .</p>		

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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>49823</p> <p>Based on observation, interview, and record review, the facility failed to ensure medications were labeled, stored, and disposed of according to standards of practice for a census of 87 when:</p> <ol style="list-style-type: none"> Expired (no longer usable) medications were stored in a medication cart; Opened, unlabeled vials of tuberculin purified protein derivative (PPD, used in the testing of staff and residents for the presence of tuberculosis infection) were stored in a medication room refrigerator; Staff clothing (pants) was stored in a treatment cart with medications and resident care equipment; Expired liquid narcotic medication (a drug that in moderate doses relieves pain and induces sleep but in excessive doses can cause coma) and an expired vial of tuberculin PPD were stored in a medication room refrigerator; and Expired glucose quality control solution (QC, substance used during a quality control test to verify that the device or product meets specific standards for quality and that it is free from contaminants or other impurities that may pose a health risk) was stored in a medication cart. <p>These failures had the potential to contribute to unsafe medication use and storage and could result in medication errors that could affect the well-being of residents.</p> <p>Findings:</p> <p>During an interview and concurrent observation of a medication storage room near the [NAME] Nurses station on 11/18/24 at 9:02 a.m. with Licensed Nurse (LN) 9, one expired vial of tuberculin PPD was observed in Medication Refrigerator 1 in the medication storage room. LN 9 acknowledged that the vial of tuberculin PPD was expired with an opened date of 9/21/24 and a manufacturer discard date of 30 days after opening. LN 9 confirmed there was an expired bottle of oral Lorazepam liquid (a narcotic medication used to treat anxiety) with an opened date of 7/11/24 and an expired date of 90 days after opening located in the Medication Refrigerator 2 in the medication storage room. LN 9 stated that expired narcotics are discarded by Director of Nursing (DON) and Pharmacist.</p> <p>During an interview and concurrent observation of a medication storage room near the East Nurses station on 11/18/24 at 10:30 a.m. with LN 8, LN 8 confirmed two vials of tuberculin PPD were opened but not labeled with an opened date. LN 8 stated that the vials should have been labeled when they were opened. LN 8 stated that the vials should be discarded.</p> <p>(continued on next page)</p>

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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview and concurrent observation of Medication Cart #2 on the East Unit on 11/19/24 at 3:25 p. m. with LN 2 and LN 6, LN 6 confirmed there was an expired over the counter bottle of vitamin B-6 (essential nutrient supplement) with an expiration date of 7/2024 in the top left-hand drawer. LN 2 confirmed there was an expired blood glucose quality control solution (QC) for QC testing of the glucometer (device used to measure a resident's blood sugar) with an opened date of 7/7/24 and an expired date of 10/7/24 stored in Medication Cart #2 top right-hand drawer. LN 2 stated that the expired QC solution should have been discarded.</p> <p>During an interview and concurrent observation of a Respiratory Treatment Cart on the [NAME] Unit on 11/20/24 at 8:20 a.m. with LN 5, observed Drawer 4 of the cart had respiratory inhalation medications (medications used for improving breathing), percussion treatment equipment (a method of tapping with small instruments to assess the presence of fluid in the lungs), and a pair of jean pants. LN 5 stated that the pants belonged to the Respiratory Therapist (RT). LN 5 stated that the pants should not be in the cart. LN 5 stated that the risk was infection from cross-contamination (physical movement or transfer of harmful germs from one person, object, or place to another). LN 5 removed the pants from the cart and disinfected (the process of cleaning with a chemical in order to kill germs) the cart.</p> <p>During an interview with the Director of Nursing (DON) on 11/20/24 at 11:30 a.m., the DON stated that narcotics that were expired or were for discharged residents were reconciled (to make a consistent accounting) by her and licensed nurses. The DON stated that the risk of having expired medications in medication carts and medication refrigerators in the medication storage rooms was that the expired medications were not as effective once expired. The DON confirmed that the facility policy for expired medications and expired narcotics was not followed. The DON stated that medication vials were labeled with an open date once opened, and an expiration date. The DON acknowledged that the facility policy for labeling medication vials was not followed. The DON stated that blood glucose QC solution bottles and test strips were labeled with an opened date once opened and an expiration date. The DON stated that the risk of using expired blood glucose QC solutions for QC testing was that the QC testing may not be correct, and the blood glucose readings may not be correct. The DON acknowledged that the facility policy for blood glucose QC testing was not followed. The DON stated that the risk of staff putting their pants in the Respiratory Treatment cart with respiratory inhalation medications and treatment equipment was infection by cross-contamination. The DON stated that the facility policy for medication storage was not followed.</p> <p>A review of a facility policy and procedure (P&P) titled, Storage of Medications, revised 11/20, the P&P indicated, .The facility stores all drugs and biologicals in a safe, secure, and orderly manner .The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner .Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed .</p> <p>A review of a facility P&P titled, Administering Medications, revised April 2019, the P&P indicated, .The expiration/beyond use date on the medication label is checked prior to administering. When opening a multi-dose container, the date opened is recorded on the container .</p> <p>(continued on next page)</p>		

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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of a facility P&P titled, Blood Glucose Monitoring System Calibration, revised April 2021, the P&P indicated, .Procedure in Performing a Control Solution Test .Step 7: Remove the test strip .Make sure that the test strips and control solutions are not past expiration date. This date is shown on bottle. Date the test strip bottle and control solution bottle once opened. Discard control solution 90 days after bottle is opened .</p> <p>A review of a facility P&P titled, Policies and Practices - Infection Control, revised October 2018, the P&P indicated, .This facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infections .2. The objectives of our infection control policies and practices are to .b. Maintain a safe, sanitary, and comfortable environment for personnel, residents, visitors, and the general public .</p>		

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 0790</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide routine and 24-hour emergency dental care for each resident.</p> <p>50161</p> <p>Based on observation, interview, and record review, the facility failed to assist one of twenty-four sampled residents (Resident 72) with a referral to receive outside dental services when:</p> <ol style="list-style-type: none"> 1. Resident 72 requested new dentures during a dental exam on 4/11/24; and, 2. Resident 72 was unable to tolerate dental services provided within the facility on 7/26/24, 8/27/24, and 9/6/24. <p>This failure had the potential to delay Resident 72 from receiving dental services and obtaining dentures and could have led to complications related to dental and nutritional needs for Resident 72.</p> <p>Findings:</p> <p>Review of Resident 72's ADMISSION RECORD, indicated, Resident 72 was admitted to the facility with diagnoses including autistic disorder (a brain and developmental disorder that affects how people interact with others, communicate, learn, and behave), anxiety disorder (intense, excessive and persistent worry and fear about everyday situations), adult failure to thrive (a state of decline to include weight loss, decreased appetite, poor nutrition, and inactivity), cognitive communication deficit (difficulty paying attention to a conversation), depression (depressed mood or loss of pleasure or interest in activities), and dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life).</p> <p>Review of Resident 72's SLP [speech therapist] Evaluation and Plan of Treatment, dated 8/31/23, written by the SLP at the facility, indicated, . per responsible party, patient was safely swallowing regular consistency [food] prior to admit .he does have dentures and they were noted at bedside .when attempting to place patient immediately removed dentures . Patient swallow function appears . WFL [within functional limits] .</p> <p>Review of Resident 72's Order Summary Report, (document which includes all medication, tests, and non-medication orders), indicated Resident 72 was prescribed a liquified puree texture [pudding-like texture that is smooth, blended, or pureed] diet on 8/31/23.</p> <p>Review of Resident 72's Dental Notes, dated, 4/11/24, written by the Dentist (DDS), indicated, .Cooperation / Motivation for Tx [treatment] .Good / Positive .Initial Exam .TX NOTES [treatment] .pt [patient] desires dentures .Tx RECOMMENDATION .new F2 [impressions for new dentures] .</p> <p>Review of Resident 72's Nutrition/Dietary Note, dated 4/12/24, written by the Registered Dietician (RD), indicated .Wt [weight] variance .Wt 123# [lbs] Wt hx [history] .115# [lbs] (1/19/24), 140# [lbs] (10/4/23) . Resident has had a wt [weight] loss since admit r/t [related to] a period of very poor intake .Diet is .Pureed . Staff stating resident requests soft foods such as sandwiches and would have ST [speech therapy] eval [evaluation] for safety of less restrictive texture .</p> <p>(continued on next page)</p>

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 0790</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 72's Nutritional Status Care Plan, initiated on 8/30/23 and last updated on 10/5/24, indicated, .The resident is at risk for impaired nutritional status as well as increased risk for malnutrition r/t [related to] Diet restrictions .has many behaviors affecting intake, prior wt [weight] loss of -30# [pounds, unit for weight] .Explain and reinforce to the resident the importance of maintaining the diet ordered .Encourage the resident to comply .Explain consequences of refusal .Obtain food preferences .</p> <p>Review of Resident 72's Dental Notes, dated, 7/26/24, written by the DDS, indicated, Cooperation / Motivation for Tx [treatment] .Poor / Negative .Soft Tissue Exam .WNL (within normal limits) .TX NOTES . Refused F2 imp [denture impressions] .pt doesn't wear his current Dent [dentures] .2nd attempt .</p> <p>Review of Resident 72's Dental Notes, dated, 8/27/24, written by the DDS indicated, .Cooperation / Motivation for Tx [treatment] . [not marked] .TX NOTES .pt [patient] Refused F2 imp [denture impressions] .</p> <p>Review of Resident 72's Dental Notes, dated, 9/6/24, written by the DDS indicated, .Cooperation / Motivation for Tx [treatment] . [not marked] .TX NOTES .pt Refused .</p> <p>Review of Resident 72's Ancillary Services Care Plan, dated 7/30/24, indicated, .Resident is refusing Ancillary [support such as dental] services .compounded with a dx [diagnosis] of dementia .Dental .7/26/2023 [sic, 7/26/2024], 8/27/2024, 9/6/2024 .The resident will cooperate with care through next review date . Encourage resident to be seen by ancillary services .Explain risks and benefits of being seen by the Dental . Give clear explanation of all care activities prior to an [sic] as they occur during each contact .</p> <p>Review of Resident 72's Behavioral Care Plan, dated 10/2/24, indicated, .Resident has Autistic Disorder, Dementia and Cognitive Communication Deficit .Has impairment with memory, decision making and communication .Can make simple choices when willing. When calm he can recall some long term issues. He is difficult to understand at times as he often yells/slurs his words, and will cry out loudly, but stop right away . Mood/behavior issues often impair his abilities, as he is difficult to re-direct/keep on task .</p> <p>During an interview on 11/20/24, at 12:10 p.m., the SLP stated she had worked with Resident 72 on and off for the last two years regarding his dysphagia (swallowing difficulty). The SLP stated when Resident 72 was admitted to the facility they had him on a pureed diet, but prior to living in the facility he was used to eating microwave dinners and had a regular diet, so he did not like the pureed food. The SLP stated Resident 72 was not eating so he had lost weight, which caused his dentures to not fit. The SLP stated Resident 72 wanted a mechanical soft diet, so she was seeing him for this. The SLP stated Resident 72 does currently have dentures and was not sure what happened regarding him getting new dentures.</p> <p>(continued on next page)</p>		

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 0790</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 11/21/24, at 12:47 p.m., the SSD stated she arranged dental consults for residents in the facility. During a review of Resident 72's Dental Consult, dated 4/11/24, the SSD confirmed .patient desires denture . was indicated. Review of Resident 72's dental consults dated, 7/26/24, 8/27/24, and 9/6/24, the SSD confirmed all dental consults, which took place within the facility, were unsuccessful. The SSD stated Resident 72 was unable to tolerate the impressions for dentures and stated it would have been appropriate to send him to an outside dentist who was able to provide specialized care related to his multiple diagnoses including his autism diagnosis. The SSD stated the risk to Resident 72 for not receiving specialized dental care was delay of dental services, potential weight loss, and not enjoying his food.</p> <p>During a phone interview on 11/21/24, at 12:51 p.m., the Nurse Practitioner (NP) stated autism was a spectrum disorder (characterized by a range of symptoms that can vary in type and severity, including: Social interaction challenges, Communication difficulties, Repetitive behaviors, Sensory sensitivities, and Restricted interests) and residents with autism could experience a lot of fear and this would require specialized dental services.</p> <p>During a concurrent interview and record review on 11/21/24, at 2:27 p.m., the Registered Dietician (RD) stated in the winter of last year (2023), Resident 72 quit responding to people, he would not take his ordered supplements, he quit eating, and he was screaming he was dead. Through review of Resident 72's clinical record, the RD stated his initial weight on admission was 142 pounds and he would chew his food and spit it out, so she made a recommendation for his diet to be pureed and added milkshakes. The RD stated she attempted to get food he preferred, and would have the SLP accompany her, but Resident 72's behavior was overriding the intake and assessment process, due to him covering his ears and screaming. The RD stated after her 9/23/23 assessment she changed his diet to mechanical soft but in 11/2023 he was losing weight and stated she thought it was related to the texture of his food. The RD stated she never considered Resident 72's diagnosis of autism and how the texture of his food and food preferences could have impacted his resulting weight loss.</p> <p>During a review of a facility policy and procedure titled Dental Services, revised 12/16, indicated, . routine and emergency dental services are available to meet the residents of oral health services in accordance with the resident's assessment and plan of care .dental services are provided to our residents through . community dentists or referral to other healthcare organizations that provide dental services social services representatives will assist residents with appointments transportation arrangements and for reimbursement of dental services under the state plan if dentures are damaged or lost residents will be referred for dental services within three days if the referral is not made within three days documentation will be provided regarding what is being done to ensure that the resident is able to eat and drink adequately while awaiting the dental services and the reason for the delay .</p>		

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 0801</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.</p> <p>50598</p> <p>Based on interview and record review, the facility failed to ensure qualified staff oversight of the facility's food and nutrition services according to federal and state requirements for a census of 87, when the Interim Certified Dietary Manager (ICDM) was not certified, and the Registered Dietician (RD) worked at the facility less than 35 hours per week.</p> <p>This failure had the potential to affect food safety for 87 residents eating facility prepared food.</p> <p>Findings:</p> <p>During an interview with the ICDM on 11/18/24 at 2:58 PM, the ICDM stated the regular Certified Dietary Manager (CDM) had been on medical leave since the earlier part of this year, and the ICDM was assigned all duties and tasks until the return of the CDM which was still to be determined. The ICDM indicated she was currently enrolled in school and had approximately one year remaining to earn the credentials to become a CDM. The ICDM stated thus far the only training she had completed was a ServSafe Certification (a course which provides training on basic food safety).</p> <p>During an interview with the RD on 11/18/24 at 3:04 PM, the RD stated she worked two days each week, six to eight hours a day. The RD stated the ICDM was previously a cook and the only training the ICDM received was through ServSafe.</p> <p>During a concurrent interview and record review on 11/18/24 at 3:20 PM, the RD provided a document titled ServSafe Certification dated 6/24/24, with an expiration date of 6/27/25, and listed the ICDM's name as the recipient.</p> <p>A review of the ICDM's personnel file indicated no additional training or certifications were completed.</p> <p>During an interview with the Administrator (ADM) on 11/21/24 at 4:21 PM, the ADM acknowledged the facility did not have a qualified CDM working in the facility. The ADM stated the purpose of the CDM was to assure quality of nutrition services and monitor kitchen staff.</p> <p>A review of the facility provided document titled JOB DESCRIPTION POSITION: FNS (FOOD & NUTRITION SERVICES) Director, indicated, .QUALIFICATIONS .Must meet the qualifications of a FNS Director as stated under State & Federal regulations .</p> <p>Review of the State Health & Safety Code 1265.4 requirements indicated, . A graduate of a dietetic services training program approved by the Dietary Managers Association and is a certified dietary manager credentialed by the Certifying Board of the Dietary Managers Association, must maintain this certification, as well as having received at least six hours of in-service training on the specific California dietary service requirements contained in Title 22 of the California Code of Regulations prior to assuming full-time duties as a dietetic services supervisor at the health facility .</p>		

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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>50598</p> <p>Based on observation, interview, and record review, the facility failed to provide food storage and preparation, as well as maintain kitchen equipment and food contact surfaces in accordance with professional standards for food safety for the 87 residents who ate facility prepared meals when:</p> <ol style="list-style-type: none"> 1. Spoiled produce food items were located in the walk-in refrigerator; 2. Staff personal items were kept in the refrigerator and kitchen preparation area; 3. Several various sizes of metal pans were stacked and stored wet; 4. The ice machine was not cleaned and sanitized properly per manufacturer's guidance; and, 5. Resident freezer temperatures were not being monitored. <p>These failures had the potential to put residents eating facility prepared meals at risk for foodborne illnesses.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During a concurrent observation and interview in the walk-in refrigerator on 11/18/24 at 8:29 AM, with the Interim Certified Dietary Manager (ICDM) there was a box of four yellow and two red bell peppers. One red bell pepper was noted to have black fuzzy spots scattered around it and one yellow bell pepper appeared mushy to texture. <p>During an interview with the Registered Dietician (RD) on 11/21/24 at 12:16 PM, when asked about the bell peppers with black fuzzy spots and another one mushy, the RD stated the cooks were the ones who checked the quality of the produce. The RD stated that quality of the bell peppers did not meet her expectations, was not safe for the residents to consume, and placed the residents at a risk for developing a food borne illness.</p> <p>A review of a facility document titled, STORING PRODUCE, dated 2023, indicated, .Check boxes of fruit and vegetables for rotten, spoiled items. One rotten tomato, apple, or potato in a box can cause the rest of the produce to spoil faster. Throw away all spoiled items .</p> <ol style="list-style-type: none"> 2. During an observation on 11/18/24 at 8:50 AM, with the ICDM in the kitchen, the reach in refrigerator was noted to have an insulated pink cup filled with liquid, and two eyeglass cases were located on the spice rack above the prepping station. <p>During an interview with the RD on 11/21/21 at 12:20 PM, when asked about the staff storing items in the kitchen where food was prepared and stored, the RD stated the staff storing their items in these areas placed the food at risk for contamination with the potential to harm the residents. The RD stated these actions did not meet her expectations and staff should store their items in the manager's office or in their personal lockers.</p> <p>(continued on next page)</p>		

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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the facility's policy and procedure titled EMPLOYEE MEALS, dated 2023, indicated, .Food brought by employees from outside the facility shall not be kept in the facility's refrigerator in the kitchen . Employees bringing food from outside the facility may not keep their food in the refrigerator used to store food for the residents . Personal items brought in by staff from outside will not be kept in the kitchen . Employees bringing in personal items from outside (i.e., jackets, cell phones, keys, purses, etc.) will not be kept in the kitchen area. The items will be kept in the locker or office .</p> <p>3. During a concurrent interview and observation on 11/18/24 at 8:58 AM, with the ICDM in the kitchen, there were nine flat serving trays, four tray line serving pans, and sixteen medium tray line serving trays stored wet and setting in a pool of water.</p> <p>During an interview with the RD on 11/21/21 at 12:20 PM, when asked about the cookware that was stacked and stored wet and sitting in a pool of water, the RD stated the cookware in that condition can become mildewed and placed the residents at an increased risk for foodborne illness. The RD stated this practice did not meet her expectations and that all cookware should be completely dry before storing.</p> <p>A review of the facility document titled, Cleaning and Sanitizing Dishes, Utensils, Post and Pans, indicated, . dishes are to be racked loosely without overlapping .Dishes are to be air dried in racks before stacking and storing .</p> <p>4. During a concurrent interview and observation on 11/18/24 at 9:32 AM, with the Maintenance Director (MD), the ice machine was noted to have a black fuzzy substance on the screw that sits in the middle of the reservoir. There were small black dots scattered throughout the upper interior portion of the machine. The ice machine was noted to have white substances throughout. When the ice machine was wiped with a clean paper towel, the paper towel presented a black/brownish substance. A screw located near the reservoir within the ice machine was wiped with a sterile cotton tipped applicator and presented with a slimy brown substance. The MD stated that the machine was cleaned every three months, and housekeeping cleaned the exterior portion of the machine monthly. The MD stated to clean the machine he placed 14 ounces of cleaning solution in one gallon of water. The MD stated after emptying all the ice out of the machine he used half of the solution to clean it one time and the other half to clean the machine again 90 minutes later. The MD acknowledged the black and brown substances found within the ice machine and that the ice machine was not in operable condition.</p> <p>During an interview with the Administrator (ADM) and the MD on 11/18/24 at 3:30 PM, after observing the condition of the ice machine, the ADM decided to shut down the ice machine until it was cleaned and up to standards.</p> <p>During an interview with the RD on 11/21/21 at 12:26 PM, when asked about the condition of the ice machine, the RD stated the condition the ice machine was found in was not acceptable. The RD stated the expectation was for the ice machine to be free from mildew, slime, and dirt. The RD stated the substances found in the ice machine placed the residents at risk for contracting a food borne illness.</p> <p>A review of the facility's policy and procedure titled ICE MACHINE CLEANING PROCEDURES, dated 2023 indicated, .The ice machine needs to be cleaned and sanitized monthly. The internal components cleaned monthly or per manufactures recommendations, and the date recorded when cleaned .</p> <p>(continued on next page)</p>		

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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of a facility document titled Sanitization, dated 2023, indicated, .Ice which is used in connection with food or drink shall be from a sanitary source and shall be handled and dispensed in a sanitary manner .</p> <p>Review of the ice machine manufacturer's manual, provided by the MD, indicated, .SEMIMONTHLY CLEANING The ice scoop, ice bin, water tank, ice-full detecting plate, and evaporator surface are to be cleaned semimonthly according to the interior-cleaning program . SEMIANNUAL CLEANING All components and surface exposed to water or ice (i.e., ice-storage bin, water tank, door, evaporator, water pump, silicone tube, water-dividing pipe) should be cleaned .</p> <p>5. During a concurrent interview and observation on 11/19/24, at 11:46 AM the resident freezers located at the East and [NAME] stations did not have a thermometer placed in the freezer and no temperature log was noted. The RD confirmed the freezer should have a thermometer and the temperatures should be monitored.</p> <p>During an interview with the RD on 11/21/21 at 12:33 PM, when asked about the resident freezers not having thermometers at both nursing stations, the RD stated these freezers should have a thermometer and the nursing staff should document the freezer temperature daily. The RD stated the freezers should have thermometers and did not meet her expectations.</p> <p>Review of a facility document titled Sanitization, dated 2023, indicated, .Thermometers will be used to check temperatures of refrigerators, freezers, and food storeroom .</p>		

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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>50018</p> <p>Based on observation, interview, and record review, the facility failed to practice appropriate infection prevention and control measures for a census of 87, when:</p> <ol style="list-style-type: none"> 1. Resident 30 did not have Enhanced Barrier Precautions ([EBP] an approach to the use of personal protective equipment (PPE; items such as gloves, gowns, and facemasks) to reduce transmission of Multidrug-Resistant Organisms [MDROs are bacteria that are resistant to three or more classes of antimicrobial drugs] between residents in skilled nursing facilities) signage and PPE (clothing and equipment that is worn or used in order to provide protection against hazardous substances or environments) outside the room; 2. Dirty coffee cups were placed on a coffee cart alongside clean cups; and 3. [NAME] pants were stored alongside medications and equipment in a respiratory treatment cart. <p>These failures had the potential to spread infections to residents residing in the facility, negatively impacting their health and well-being.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During a review of Resident 30's undated clinical record titled, ADMISSION RECORD, indicated Resident 30 was admitted to the facility with diagnosis of, but not limited to, severe sepsis with septic shock (sepsis occurs when the immune system has an extreme reaction to an infection), chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), and gastrostomy status (an artificial entrance to the stomach. The stomach is located in the upper left abdomen). <p>During an observation on 11/18/24 at 10:03 AM outside Resident 30's room, EBP signage was not posted by the doorway. The storage cart used to store PPE was also not located outside Resident 30's room. Respiratory Therapist (RT) 1 was observed providing care to Resident 30 without any PPE on.</p> <p>During an interview on 11/18/24 at 10:31 AM with Licensed Nurse (LN) 17, LN 17 stated that Resident 30 receives gastrostomy-tube ([g-tube] a tube inserted through the wall of the abdomen directly into the stomach. It allows air and fluid to leave the stomach and can be used to give drugs and liquids, including liquid food to the patient) feedings four times a day. LN 17 confirmed that no EBP signage or PPE storage cart was located outside of Resident 30's room. LN 17 stated she did not want staff to go inside resident rooms to provide care without PPE on. LN 17 also stated that there could be an infection control risk if no EBP signage is posted.</p> <p>During an interview on 11/18/24 at 11:14 AM with RT 1, RT 1 stated that he had been providing care for Resident 30 for roughly the past two weeks without wearing PPE. RT 1 also stated he did not wear PPE while performing respiratory care for Resident 30 because there was no EBP signage posted. RT 1 further stated that he could have spread germs to next resident without even knowing it.</p> <p>(continued on next page)</p>

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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 11/19/24 at 11:41 AM with the Infection Preventionist (IP), the IP stated Resident 30 moved into his current room on 11/12/24 and the facility missed placing the EBP signage outside Resident 30's room. The IP stated the risk to not having signage posted outside of the residents room could result in staff not wearing PPE as required and that staff could go room to room spreading infection to other residents.</p> <p>During an interview on 11/20/24 at 11:52 AM with the Director of Nursing (DON), the DON stated that a EBP sign and a PPE box should have been placed outside Resident 30's room. The DON also stated staff members should wear the PPE for EBP rooms. The DON further stated that staff doing patient care without PPE on could lead to infection control risks for staff members and residents.</p> <p>During an interview on 11/20/24 at 4:11 PM with the Director of Staff Development (DSD), the DSD stated that EBP signage and PPE supply boxes should be placed outside the room even before the resident moves into the room. The DSD also stated staff should be wearing PPE while performing direct care. The DSD further stated when PPE was not used, it could lead to an infection control issue and residents, staff, and the community could be impacted.</p> <p>During a review of Resident 30's clinical record titled, Order Summary Report, dated 11/20/24, indicated . Enteral Feed Order four times a day .Keep Resident on Enhanced Barrier Precautions due to G-Tube, every shift .</p> <p>During a review of Resident 30's care plan, dated 6/13/24, indicated .Focus: Resident on Enhanced barrier precautions due to G-Tube . The interventions included, .Enhanced barrier precautions as ordered by CDC [Center for Disease Control and Prevention] guidelines .Provide Education to staff .</p> <p>During a review of a facility Policy and Procedure (P&P) titled, Policies and Practices - Infection Control, revised 10/18, indicated, . Maintain a safe, sanitary, and comfortable environment for personnel, residents, visitors, and the general public .</p> <p>During a review of the facility's document titled, Enhanced Barrier Precautions, dated 8/22, the P&P indicated, .Enhanced barrier precautions (EBPs) are used as an infection prevention and control intervention to reduce the spread of multi-drug resistant organisms (MDROs) to residents .EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply . Gloves and gown are applied prior to performing the high contact resident care activity .Personal protective equipment (PPE) is changed before caring for another resident . Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include .device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc.) .EBPs are indicated (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devices regardless of MDRO colonization .EBPs remain in place for the duration of the resident's stay or until resolution of the wound or discontinuation of the indwelling medical device that places them at increased risk .Signs are posted in the door or wall outside the resident room indicating the type of precautions and PPE required .PPE is available outside of the resident rooms .</p> <p>During an interview on 11/19/24 at 11:41 AM, with the IP, the IP stated that the floor vents in resident rooms should be clean as possible. The IP stated the vents should be cleaned weekly. The IP also stated that respiratory issues could develop if the vents were not properly cleaned. The IP further stated the vents that circulate the dirty air could impact the residents.</p> <p>(continued on next page)</p>		

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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 11/20/24 at 11:59 AM, with the Director of Nursing (DON), the DON stated that she wanted the resident rooms to be clean and clutter free. The DON also stated that the vents in the resident rooms should not be dusty and dirty.</p> <p>During an interview on 11/20/24 at 1:10 PM, with Licensed Nurse (LN) 11, LN 11 stated the staff members know that it is not good for the residents to have dirty ac vents in their rooms. LN 11 also stated that respiratory issues could occur because of the dirty vents.</p> <p>During an interview on 11/20/24 at 4:02 PM, with the Administrator (ADM), the ADM stated that the housekeeping team should keep the vents clean. The ADM also stated the vents should be cleaned regularly and it should be a part of the deep cleaning schedule.</p> <p>During an interview on 11/20/24 at 4:11 PM, with the DSD, the DSD stated that the vents should be kept clean. The DSD also stated that there could be respiratory issues for the residents if the vents were not properly cleaned.</p> <p>49823</p> <p>2. During a concurrent observation and interview on 11/18/24 at 4:45 p.m., in the resident dining room, with Certified Nursing Assistant (CNA) 3 and the Activity Assistant (AA), CNA 3 and the AA confirmed the coffee cart had dirty cups placed on the cart next to the coffee urn (machine that keeps coffee hot and fresh) and clean cups. CNA 3 and the AA stated that the dirty cups should not be on the coffee cart with the clean cups and coffee urn. The AA stated that the risk was cross-contamination (physical movement or transfer of harmful germs from one person, object, or place to another).</p> <p>During an interview on 11/20/24 at 11:30 a.m. with the Director of Nursing (DON), the DON stated that dirty cups should not be on the same cart with clean coffee cups and coffee urn. DON stated that the risk of storing dirty cups on the cart with the clean cups and coffee urn was infection by cross-contamination.</p> <p>3. During a concurrent observation and interview on 11/20/24 at 8:20 a.m., on the [NAME] Unit, with Licensed Nurse (LN) 5, LN 5 confirmed drawer 4 of the Respiratory Treatment Cart contained respiratory inhalation medications (medications used for improving breathing), percussion treatment equipment (a method of tapping with small instruments to assess the presence of fluid in the lungs), and a pair of jean pants. LN 5 stated that the pants belonged to the Respiratory Therapist (RT). LN 5 stated that the pants should not be in the cart. LN 5 stated that the risk was infection from cross-contamination.</p> <p>During an interview on 11/20/24 at 11:30 a.m., the DON stated that clothing (pants) should not be stored in the Respiratory Treatment Cart. The DON stated that the risk of putting pants in the Respiratory Treatment Cart was infection by cross-contamination. The DON confirmed that the facility policy for infection control was not followed.</p> <p>(continued on next page)</p>		

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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of a facility P&P titled, Policies and Practices - Infection Control, revised 10/18, the P&P indicated, . This facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infections .2. The objectives of our infection control policies and practices are to .b. Maintain a safe, sanitary, and comfortable environment for personnel, residents, visitors, and the general public .</p> <p>A review of an online document published by the United States Department of Agriculture (USDA) titled, Keep Food Safe! Food Safety Basics, dated 1/5/24, indicated, .guidelines to keep food safe: clean - wash hands and surfaces often, separate - don't cross-contaminate .</p> <p>(https://www.fsis.usda.gov/food-safety/safe-food-handling-and-preparation/food-safety-basics/steps-keep-food-safe)</p>		

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 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p>50018</p> <p>Based on interview and record review, the facility failed to provide education to a resident about Pneumococcal (a serious bacterial infection that can cause respiratory illness) vaccines for one of five sampled residents (Resident 23) prior to administration.</p> <p>This deficient practice violated Resident 23's right to make an informed choice to receive or not receive the pneumococcal vaccine.</p> <p>Findings:</p> <p>During a concurrent interview and record review on 11/19/24 at 11:41 AM, with the Infection Preventionist (IP), Resident 23's Immunization Report, dated 12/19/24 was reviewed. The IP confirmed Resident 23's Immunization Report indicated that education was not provided to Resident 23 prior to administration of Pneumovax (a vaccine that can prevent pneumococcal disease) on 11/25/2021. The IP stated that residents would not understand what vaccines they were taking if education was not provided.</p> <p>During an interview on 11/20/24 at 9:19 AM, with Resident 23, Resident 23 stated she did not understand the risks and benefits of the Pneumococcal vaccine.</p> <p>During an interview on 11/20/24 at 11:52 AM, with the Director of Nursing (DON), the DON stated that all residents should be educated on the vaccines they received at the facility. The DON also stated that a resident would have the opportunity to refuse a vaccine if they were educated about the risks and benefits.</p> <p>During an interview on 11/20/24 at 4:11 PM, with the Director of Staff Development (DSD), the DSD stated that residents should receive education before they received vaccinations. The DSD also stated that the residents may not understand the side effects of the vaccines if not properly educated on them.</p> <p>During a review of the facility's Policy and Procedure titled, Pneumococcal Vaccine, revised 10/19, the Policy and Procedure indicated, .Before receiving a pneumococcal vaccine, the resident or legal representative shall receive information and education regarding the benefits and potential side effects of the pneumococcal vaccine .Provision of such education shall be documented in the resident's medical record .</p>		

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 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>51485</p> <p>Based on observation, interview, and record review, the facility failed to ensure a functioning call light system (system/device used by residents to call staff for assistance) was in place for two of twenty-four sampled residents (Resident 31 and Resident 45) when, Resident 31 and Resident 45's call lights were not working and an alterantive means to call for assistance was not provided to the residents.</p> <p>This failure had the potential to result in Resident 45 and Resident 31 being unable to call staff for help when needed and their needs not being met.</p> <p>Findings:</p> <p>1a. During a review of Resident 31's undated clinical record titled, ADMISSION RECORD, indicated Resident 31 was admitted to the facility with diagnosis of, but not limited to, bilateral primary osteoarthritis of hip (causes pain and stiffness of the hips; can make it hard to do everyday activities like bending over to tie a shoe or rising from a chair) retention of urine, and stress incontinence (happens when movement or activity puts pressure on the bladder, causing urine to leak).</p> <p>During a concurrent observation and interview on 11/18/24, at 10:42 AM, the call light system in Resident 31's room was noted not to be working. Certified Nursing Assistant (CNA) 8 confirmed the call light system in Resident 31's room was not working. CNA 8 confirmed that Resident 31 did not have a call bell (manual hand bell used to call staff for assistance) in her room.</p> <p>During an interview on 11/19/24, at 3:35 PM, the Maintenance Director (MD) confirmed the call light system in Resident 31's room was not working since 11/18/2024.</p> <p>During an interview on 11/20/24, at 10:07 AM, Licensed Nurse (LN) 12 stated the staff would not know if the residents needed help when the call light system was not working. LN 12 also stated it was not good for the residents to be screaming for help instead of pressing the call light button. LN 12 further stated that residents screaming for help would not be the best way for residents to get the help they need.</p> <p>A review of Resident 31's fall care plan, dated 12/28/21, indicated, .Focus: The resident is at risk for falls . she sometimes forgets to take her walker with her when she attempts to use the restroom . The interventions included, .Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed .The resident needs prompt response to all requests for assistance, the resident needs a safe environment .a working and reachable call light .</p> <p>A review of Resident 31's Activities of Daily Living (ADL) care plan, dated 12/28/21, indicated .Focus: The resident has an ADL self-care performance deficit r/t [related to] Confusion, Impaired balance . The interventions included, .Encourage the resident to use bell to call for assistance .</p> <p>1b. A review of the document titled, ADMISSION RECORD, indicated Resident 45 had a diagnosis of unspecified fracture of left lower leg (broken left lower leg), difficulty in walking, and unilateral primary osteoarthritis of the right hip (a degenerative joint condition that affects the right hip).</p> <p>(continued on next page)</p>		

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 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent observation and interview on 11/20/24, at 9:02 AM, with Resident 45, the call light system in Resident 45's room was noted not to be working. Resident 45 confirmed she did not have any means to contact staff for any assistance. Resident 45 stated she had to wait for staff to come and assist her when the call light was not working and there was no other way to call for help.</p> <p>During an interview on 11/20/24, at 1:33 PM, Resident 45 stated the facility did not provide her a call bell when her call light was not working.</p> <p>During an interview on 11/20/24, at 9:54 AM, the Maintenance Director (MD) confirmed the call light system in Resident 45's room was not working.</p> <p>During an interview on 11/20/24, at 1:34 PM, Certified Nurse Assistant (CNA) 7 confirmed Resident 45 was not provided a call bell when her call light was not working.</p> <p>A review of Resident 45's risk for falls care plan, dated 9/26/24, indicated, .at risk for falls related to Deconditioning, Gait/balance problems, Difficulty walking, NWB [Non weight bearing] on Left leg . interventions . anticipate and meet the resident's needs .be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed .The resident needs prompt response to all requests for assistance .follow facility fall protocol .the resident needs a safe environment .a working and reachable call light .</p> <p>A review of Resident 45's lower leg fracture care plan, dated 9/27/24, indicated .Focus: The resident has a closed fracture of the left lower leg .Interventions . Anticipate and meet needs .Be sure call light is within reach and respond promptly to all requests for assistance .</p> <p>During an interview on 11/20/24, at 4:12 PM, the Director of Staff Development (DSD) stated she expected the call light system to be working and functioning. The DSD stated the risks of having a malfunctioning call light system would be the resident's needs not being met and could cause falls. The DSD further stated, the facility should have a working call light system to prevent those risks. The DSD added she did not want the residents to be screaming for help.</p> <p>During an interview on 11/21/24, at 10:22 AM, the DSD stated without a functioning call light system, the staff would not be able to meet the resident's needs. The DSD stated the risks of a nonfunctioning call light system would lead to a delay in emergency care that could result in complications.</p> <p>During an interview on 11/20/24, at 11:56 AM, the Director of Nursing (DON) stated the nurses and CNAs should provide the call bells to the residents in the event the call light system was not functioning. The DON stated the call light system should be functioning and working at all times. The DON further stated she did not want residents to scream out for help.</p> <p>During an interview on 11/20/24, at 4:03 PM, the Administrator (ADM) stated he expected the call light system to be working. The ADM stated if the call light system was broken, then it should have been replaced or fixed.</p> <p>(continued on next page)</p>		

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 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the facility's document Policy and Procedure titled, Call System, Resident, dated 9/22, the Policy and Procedure indicated, .Each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor .The resident call system remains functional at all times. If audible communication is used, the volume is maintained at an audible level that can be easily heard. If visual communication is used, the lights remain functional .The resident call system is routinely maintained and tested by the maintenance department .</p>		

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 0949</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide behavior health training consistent with the requirements and as determined by a facility assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50161</p> <p>Based on observation, interview, and record review, the facility failed to provide staff education regarding autism (a brain and developmental disorder that affects how people interact with others, communicate, learn, and behave) to ensure quality care was delivered for one of one residents (Resident 72) with a diagnosis of autism.</p> <p>This failure resulted in facility staff being untrained in caring for a resident with autism and Resident 72 not receiving specialized care and services which recognized the signs of autism and incorporated a system of responding to his behavioral health needs, which had the potential to result in escalating behaviors for Resident 72 and psychosocial distress.</p> <p>Findings:</p> <p>Review of Resident 72's ADMISSION RECORD, indicated, Resident 72 was admitted to the facility with diagnoses including autistic disorder, anxiety disorder (frequently have intense, excessive and persistent worry and fear about everyday situations, adult failure to thrive (describes a state of decline to include weight loss, decreased appetite, poor nutrition, and inactivity), cognitive communication deficit (difficulty paying attention to a conversation), depression (depressed mood or loss of pleasure or interest in activities), and dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life).</p> <p>Review of Resident 72's Physician Progress Note, dated 10/4/24, written by the Psychiatric Nurse Practitioner (NP, a nurse who specializes in the diagnosis, prevention, treatment of mental disorders) 2, indicated, .Per staff, patient with periods of mood lability [rapid and unpredictable shifts in mood] behaviors and with periods of intentionally crawling on floor, and yelling/screaming. Psychotic medications [used to treat mood and anxiety disorders] reviewed. Patient is currently on Depakote [used to treat mood disorders/seizures], Remeron [used to treat depression/appetite stimulant], and on PRN [as needed] Lorazepam [used to treat anxiety]. Goal is to minimize use of benzodiazepine [class of depressant drugs such as Lorazepam] in elderly as much as possible . The report indicated a treatment plan to include, . consider social support, continue nonpharmacological measures [behavioral interventions without using medication], psychiatric follow up within 4 weeks or PRN [as needed] .</p> <p>Review of Resident 72's Health Status Note, dated 9/22/24, written by LN 13, indicated, . resident constantly loud yelling/screaming without obvious cause/reason and crawling on the floor, throwing items on the floor, striking out staff during care .assessed resident for pain denied any pain .constantly yells and screams, administered med [medication] for anxiety due to inability to relax .</p> <p>Review of Resident 72's Communication Problem Care Plan, dated 6/6/24, indicated, .The resident has a communication problem related to Neurological [brain] symptoms/dementia/autism such that he presents with reduced pragmatics [difficulty communicating both verbally and nonverbally in social situations] and ST [speech therapy] are warranted to address emotion regulation, social communication, and improving QOL (quality of life) in the facility by engaging in facility led activities .</p> <p>(continued on next page)</p>

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 0949</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 72's Behavioral Care Plan, dated 10/2/24, indicated, .Resident has Autistic Disorder, Dementia and Cognitive Communication Deficit .Has impairment with memory, decision making and communication .Can make simple choices when willing. When calm he can recall some long-term issues. He is difficult to understand at times as he often yells/slurs his words, and will cry out loudly, but stop right away . Mood/behavior issues often impair his abilities, as he is difficult to re-direct/keep on task .</p> <p>During an observation on 11/18/24, at 9:59 a.m., Resident 72 was observed laying on his bed crying, and was speaking unintelligible words. A staff member was observed coming into Resident 72's room and was unsuccessful in consoling Resident 72. The staff member stated Resident 72 had autism and was looking for his speech therapist.</p> <p>During an observation on 11/18/24, at 10:02 a.m., the Speech Therapist (SLP) was observed entering Resident 72's room. Resident 72 was observed crying for at least 25 minutes and during this time the SPL amongst other staff were observed assisting Resident 72 in his room.</p> <p>During an interview on 11/19/24, at 1:56 p.m., Family Member (FM) 1 stated Resident 72 could not communicate with people, and she had to be very patient with him. FM 1 further explained Resident 72 would stutter and would get overly stimulated, and then it would be hard for him to communicate. FM 1 stated Resident 72 was autistic but never received any behavioral health services.</p> <p>During an interview on 11/20/24, 8:57 a.m., LN 9 stated Resident 72 was alert and knows what was going on around him. LN 9 stated Resident 72 does have behaviors including crawling on the floor. LN 9 stated staff tried to assist Resident 72, but he would get anxious due to his communication issues, and he would get upset and start crying loudly. LN 9 stated the facility had not provided training on how to deal with Resident 72's behaviors. LN 9 explained training would be helpful so they could give him better care, and stated his behavior could be agitating to other residents and it was their home too. LN 9 stated a training for Resident 72's behavioral needs would be helpful for him too, as it could help him settle down quicker.</p> <p>During an interview on 11/20/24, at 12:10 p.m., the SLP stated since 8/2024 she had provided Resident 72 with services for his autism diagnosis. The SLP stated Resident 72 relied on a routine, and if this was disrupted, he would cry out and crawl on the floor. The SLP stated prior to working with Resident 72 she would hear about him through the LN's who were struggling to care for him. The SLP stated she would hear Resident 72 crying, so she offered to work with him. The SLP stated she does not have a background in working with the autistic population, so she researched it and felt she could have a positive impact on his quality of life. The SLP stated working with Resident 72 did require a different approach, and staff receiving formal training regarding autistic adults would be helpful in terms of Resident 72 and staff not getting frustrated. The SLP stated the risk to Resident 72 if staff were not trained on how to work with autistic adults could be an aversion to caring for him or ignoring him unless he was exhibiting behaviors. The SLP stated this could impact his quality of life. The SLP stated staff might not understand how to deescalate a situation, and instead of using behavioral intervention techniques, they would use medication to manage his behaviors. The SLP stated she did not think Resident 72 needed medication to manage his behaviors. The SLP stated she was not aware Resident 72 was medicated with Ativan on 11/18/24, since she had used behavioral methods to calm him down. The SLP stated Resident 72 had adverse behaviors every day.</p> <p>(continued on next page)</p>		

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 0949</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/20/24, at 1:29 p.m., Certified Nurse Assistant (CNA) 4 stated even if you did not touch Resident 72, he would start screaming. CNA 4 stated she tried to explain care procedures to him, but he would still scream. CNA 4 stated LN's have never told her Resident 72 was autistic. CNA 4 stated she was told he was schizophrenic (a serious mental illness that affects how a person thinks, feels, and behaves) or had dementia. CNA 4 stated she had no training on how to treat an autistic resident. CNA 4 stated it would be helpful to have training on how to interact with Resident 72.</p> <p>During an interview and record review on 11/20/24, at 3:35 p.m., the Director of Staff Development (DSD) stated she had not held staff trainings or in-services related to residents with autism because she was not aware there was a resident who was autistic in the facility until this week. The DSD stated if there was an autistic resident residing in the facility, it would be important to train the staff so they knew how to calm the resident down, how to describe procedures prior to providing care to the patient, how to redirect the patient, de-escalation of resident behaviors, how to provide good quality care, and how to make sure the resident needs are met without complications. In terms of medication used to help with Resident 72's behaviors, the DSD stated nurses should be using non-pharmacological interventions first. The DSD stated she was only aware of Resident 72's behaviors and was not aware he had an autism diagnosis. The DSD stated had she been aware of the autism diagnosis she would have created staff trainings.</p> <p>During a concurrent interview and record review on 11/21/24, at 9:46 a.m., the Social Services Director (SSD), stated she was familiar with Resident 76. The SSD stated there were outside services including adult special needs programs and adult day care for residents with autism. The SSD stated there were behavioral counselors that could come into the facility to help educate staff on how to provide better care or help stimulate Resident 76.</p> <p>During a phone interview on 11/21/24, at 12:51 p.m., the Nurse Practitioner (NP) stated for residents with autism she would have wanted them to receive limited medication to manage their behaviors. The NP stated residents with autism need [NAME] therapy (Applied behavior analysis; treatment that helps people with autism and other developmental disorders learn new skills and behaviors) and behavioral services. The NP stated residents with autism could experience a lot of fear.</p> <p>During an interview on 11/21/24, at 1:04 p.m., the DON stated she could have brought in outside resources for behavioral health to train staff regarding their resident with autism and stated the risk of not training staff included them not being able to manage Resident 76's behaviors appropriately.</p> <p>During a review of a facility policy and procedure (P&P) titled In-Service Training, All Staff, revised 8/2022, indicated, .All staff are required to participate in regular in-service education .The primary objective of the in-service training is to ensure that staff are able to interact in a manner that enhances the resident's quality of life and quality of care and can demonstrate competency in the topic areas of the training .Required training topics include . Effective communication with residents .Behavioral health .additional training may include .person-centered care .intellectual disability .mental disorders .</p> <p>(continued on next page)</p>		

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 0949</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of a facility P&P titled Behavioral Assessment, Intervention and Monitoring, revised 2/2019, indicated, .The facility will provide and residents will receive behavioral health services as needed to attain or maintain the highest practical physical, mental and psychological well-being in accordance with the comprehensive assessment and plan of care .Behavioral health services will be provided by qualified staff who have the competencies and skills necessary to provide appropriate services to the residents .Residents will have minimal complications associated with the management of altered or impaired behavior .</p>