

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056132	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/15/2024
NAME OF PROVIDER OR SUPPLIER Golden San Andreas Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 900 Mountain Ranch Road San Andreas, CA 95249	

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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>43943</p> <p>Based on observation, interview, and record review, the facility failed to ensure one of five sampled residents (Resident 1) received adequate supervision and that care plan (an individualized set of goals and interventions specific to the Resident 1's needs) interventions were implemented to prevent an injury when, Resident 1's care plan interventions of a fall mat (a soft pad at the side of the bed to soften a fall) and two person staff assist with activities of daily living (ADL's; a term used to collectively describe fundamental skills required to independently care for oneself, such as eating, bathing, and mobility) were not implemented and Resident 1 fell from the bed on 9/24/24.</p> <p>This failure led to Resident 1 sustaining multiple skin tears, pain, a broken clavicle (also called collarbone; is a long, slightly curved bone that connects your arm to your body and located in your upper chest area), and a decline in ability to feed herself.</p> <p>Findings:</p> <p>During a review of Resident 1's undated clinical record titled ADMISSION RECORD, (a document that contained Resident 1's demographic information) indicated, Resident 1's diagnosis included encephalopathy (a brain dysfunction that caused confusion, memory loss, and personality changes), muscle weakness, and Parkinson's disease (a long-term brain disorder that caused involuntary body movements, stiffness, and difficulty with balance and coordination).</p> <p>A review of Resident 1's clinical record titled, Brief Interview of Mental Status, (BIMS - an interview that assessed Resident 1's mental function), dated 6/26/24, indicated Resident 1's BIMS score was 11 (8 to 12 points suggests moderate cognitive impairment; Problems with a person's ability to think, learn, remember, use judgement, and make decisions).</p> <p>A review of Resident 1's clinical record titled, Morse Fall Scale, (an assessment tool that determined Resident 1's fall risk factors and targeted interventions to reduced fall risks), dated 1/12/24, indicated Resident 1's fall risk score was 55 (45 and higher indicated a high risk for falls). Resident 1's contributing factors for falls included a history of falls, use of a wheelchair, overestimated or forgot physical limits, and had more than one medical diagnosis.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 1 ' s clinical record titled, [FACILITY NAME] Progress Notes *New* Post Fall Evaluation, dated 9/10/24, at 4:42 p.m., by the Licensed Nurse (LN 1), indicated the Certified Nursing Assistant (CNA 1) witnessed Resident 1 fall on 9/10/24, at 4:07 p.m., in Resident 1 ' s room. At the time of the fall, CNA 1 was changing Resident 1 ' s brief (adult diaper). After the fall, Resident 1 was sent to the Emergency Department (ED) at [ACUTE CARE HOSPITAL NAME] where it was determined Resident 1 had a fractured (broken) left clavicle.</p> <p>A review of Resident 1 ' s clinical record titled, [ACUTE CARE HOSPITAL NAME] Progress Notes *New*, dated 9/10/24, at 9:06 p.m., by LN 5, indicated Resident 1 rolled out of bed and had complaints of pain scored at 10 out of 10 using the Numerical Rating Pain Scale (assessment tool 0 through 10; 0 = no pain and 10= the worst pain).</p> <p>A review of Resident 1 ' s fall risk care plan, initiated on 8/29/22, indicated Resident 1 was at risk for falls related to her diagnosis of Parkinson's disease, weakness, urinary incontinence (unable to hold urine), use of antianxiety and antidepressant medications, history of falls, and required staff assistance with transfers and toileting. Interventions included fall mats at the bedside which was initiated on 9/1/2022.</p> <p>A review of Resident 1 ' s clinical record titled, Post Fall Evaluation, dated 9/10/24, at 4:42 p.m., indicated there was no fall mat in place at the time of the fall.</p> <p>A review of Resident 1 ' s clinical record titled, Interdisciplinary Team [IDT - a group of health care providers and other staff members that work together to discuss the care of Resident 1] Post Fall Meeting, dated 9/11/24, at 9:55 a.m., by LN 1, indicated Resident 1 rolled out of bed on 9/10/24, at 4:07 p.m. and sustained a fracture to her left clavicle, skin tears to the right and left side of her wrists, skin tears to the right index (finger next to the thumb) finger, a knot (bump) to the left side of her head, and complained of severe left shoulder pain that radiated (sent out) down to the elbow. At 4:45 p.m., Resident 1 was sent to [ACUTE CARE HOSPITAL NAME] for further evaluation.</p> <p>A review of Resident 1 ' s clinical record titled, [ACUTE CARE HOSPITAL NAME] Progress Notes *New*, dated 9/11/24, at 2:12 a.m., by LN 4, indicated Resident 1 returned to the facility from [ACUTE CARE HOSPITAL NAME] on 9/11/24, at 1:31 a.m.</p> <p>During a concurrent observation and interview on 10/16/24, at 11:50 a.m., in Resident 1 ' s room, Resident 1 had skin tears on her right hand that had steri-strips (thin, sticky bandages that are applied to the skin to help small cuts or wounds stay closed as they heal) in place, and a scabbed wound (a rough surface made of dried blood that forms over a cut or broken skin while it is healing) on her left fourth finger. There was no fall mat on either side of the bed. Resident 1 stated she was unsure how she fell out of bed on 9/10/24.</p> <p>During a concurrent observation and interview on 10/16/24, at 11:57 a.m., with LN 2, LN 2 stated Resident 1 required two staff members on each side of the bed when Resident 1 was turned and/or her brief was changed because Resident 1 was very fragile. LN 2 acknowledge there was not a fall mat at the bedside and that Resident 1 required a fall mat as part of her fall precaution interventions.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The DON confirmed Resident 1 ' s ADL deficit care plan, initiated on 8/30/22, indicated Resident 1 ' s ADL interventions, also initiated on 8/30/22, included: extensive assistance by two staff members when Resident 1 was turned in bed and toileted. The DON confirmed Resident 1 ' s clinical record titled, Kardex, indicated Resident 1 required two staff members to assist Resident 1 when she was repositioned in bed, turned in bed, and with brief changes. A concurrent interview and record review with the DON continued with a review of the facility ' s document titled, Certified Nursing Assistant Job Description, indicated, . Duties and Responsibilities .review care plans daily to determine if changes in the resident ' s daily care routine have been made on the care plan The facility ' s P&P titled, Fall and Fall Risk, Managing, indicated, . the staff will identify interventions related to the resident ' s specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling . The facility ' s P&P titled, Care Plan, Comprehensive Person-Centered, indicated, . The . team . develops and implements a . person centered care plan for each resident . After reviewing Resident 1 ' s ADL deficit care plan, Resident 1 ' s Kardex, the Certified Nursing Assistant Job Description, the Fall and Fall Risk, Managing P&P, and the Care Plan, Comprehensive Person-Centered P&P, the DON stated that CNA 1 should have used a two person assist to turn Resident 1 and two persons assist to change Resident 1 ' s brief. The DON stated Resident 1 ' s care plan was created to ensure Resident 1 received safe care from the healthcare team. The DON stated her expectation was that all the staff members would have read and followed Resident 1 ' s care plan. The DON verified Resident 1 ' s care plan, the CNA Job Description, and the above listed P&Ps were not followed.</p> <p>A review of the facility ' s undated educational power point titled, Lifting and Transferring, indicated, .WHEN CHANGING A RESIDENT-TIPS AND REMINDERS . Ensure there are appropriate staff to assist. For example, if the resident requires a 2 person assist, be sure to have 2 CNAs to assist . Ensure that all supplies are within reach, so you do not have to leave the resident ' s side. Always review the Care Plan or Kardex prior to providing care to ensure proper plan of care is maintained .</p> <p>A review of the facility ' s P&P titled, Repositioning, dated 5/13, indicated, .check the care plan, . or the communication system to determine resident ' s specific positioning needs including Resident level of participation and the number of staff required to complete the procedure .</p>		