STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056238	A. Building B. Wing	04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Vallejo Nursing & Rehabilitation Center	2200 Tuolumne Street Vallejo, CA 94589

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46132 Based on interviews and record reviews, the facility failed to: 1. document and perform a root cause analysis on how one out of two sampled residents (Resident 1) sustained the bruising (an injury that doesn't break the skin but results in some discoloration) on her eye; and, 2. ensure it provided immediate notification and consult with the physician, when one out of two sampled residents (Resident 1) was noted with bruising on her eye area. These failures could result in serious outcomes, medical complications, transfer to hospital and death. Findings: A review of Resident 1's face sheet indicated she was admitted to the facility on [DATE], with diagnoses of Chronic Pain, Fracture of the left humerus (left upper arm bone) and Repeated Falls. Her Minimum Data Sheet Assessment (MDS, a federally-mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes), dated 1/29/24, Brief Interview for Mental Status (BIMS, a mandatory tool used to screen and identify the cognitive condition of residents) score was 14, indicating intact cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). Her MDS assessment also indicated there was a functional limitation on her upper and lower extremity (limb) and required moderate to maximal assistance when performing her Activities of Daily Living (ADL, activities related to personal care such as bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet). Resident 1 was totally dependent on staff when toileting and showering, with lower body dressing and putting on/taking shoes off. During an interview on 4/10/24 at 1:55 p.m., when asked if bruising around the eye area should be documented, investigated, and reported to the physician, Unlicensed Staff A stated, Yes. When asked what could happen if a bruising around the eye area was not investigated and was not reported to the physician, Unlicensed Staff A stated a resident's condition could get worse. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/10/24 at 1:59 p.m., Licensed Staff B stated bruising around the eye area should always be documented, investigated, care planned and reported to the physician. Licensed Staff B stated, not knowing where the bruising was from was a safety issue. Licensed Staff B stated, not notifying the physician about bruising could lead to delayed care and neurological issues. During an interview on 4/10/24 at 2:33 p.m., Unlicensed Staff C stated bruising around the eye area was a concern and should be investigated and reported to the physician. Unlicensed Staff C stated, if the bruising around the eye area was not monitored or investigated, it could be a safety issue and could place the resident at risk for further injury. During an interview on 4/10/24 at 2:37 p.m., the Assistant Director of Nursing (ADON) stated that based on Resident 1's admission note, dated 1/22/24, the admission note did not indicate Resident 1 had bruising on her face and eyes when she was admitted at the facility. The ADON stated she was not sure about the exact date and which eye had the discoloration. The ADON stated bruising on the eye area needed to be monitored closely and had to be reported to the physician. The ADON stated this was a change in condition and would need to have a root cause analysis (RCA, an approach for identifying the underlying causes of an incident so that the most effective solutions can be identified) and should be care planned. The ADON stated, not reporting bruising in the eye area to the physician was a safety risk because this could worsen and could result in neurological (anything that has to do with the nervous system, the brain, spinal cord, or nerves) issues. During an interview on 4/10/24 at 3:19 p.m., the Infection Preventionist stated she recalled Resident 1 had a bruise on her eye but could not recall which eye specifically. The IP stated Resident 1 did not have bruising on her eyes when she was admitted . The IP stated the bruising on her eye was after her fall. The IP stated bruising was a change of condition (COC, a change in the resident's health or functioning) and should be monitored, documented, care planned and reported to the physician. The IP stated if the bruising on the eye area was not monitored, it was a safety risk that could lead staff to miss an important neurological change. The IP stated, if the bruising on the eye was not reported to the physician right away, it could lead to missed treatment and the issue could worsen. During an interview on 4/10/24 at 3:40 p.m., Licensed Staff D stated Resident 1 did not have bruising on her eye area when she was admitted to the facility. Licensed Staff D stated bruising on the eye area should be investigated, monitored, care planned and reported to the physician. Licensed Staff D stated, if staff did not know where the bruising was from, it could lead to residents' acquiring more bruises in the future. Licensed Staff D stated it was important to monitor bruising to the eye area to catch neurological changes and to implement safety precautions. Licensed Staff D stated if the bruising was not reported to the physician, it could lead to delayed treatment and worst-case scenario, death. During a telephone interview on 4/15/24 at 2:35 p.m., Licensed Staff D verified she could not find documentation regarding Resident 1's bruising on her eye area. Licensed Staff D verified she could not find documentation Resident 1 had a bruise on her eye upon admission. Licensed Staff D verified there was also no care plan created for Resident 1's bruising on her eye. Licensed Staff D stated she could not find documentation the physician was notified of the bruising on Resident 1's eye area. Licensed Staff D stated, bruising on the eye was considered a COC and as such should be monitored, assessed, documented, care planned and reported to the physician. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 4/15/24 at 2:40 p.m., the ADON verified there was no documentation regarding Resident 1's bruising on her eye. The ADON stated the bruising on her eye was not care planned, as well. The ADON stated, bruising on the eye was a COC and should be monitored, assessed, care planned and reported to the physician. The ADON stated there was no documentation to indicate the physician was notified of the bruising on Resident 1's eye area. The ADON stated, not monitoring bruising on the eye area could lead to missed neurological symptoms that could put residents ' safety at risk. During a telephone interview on 4/17/24 at 11:37 a.m., the DON stated the facility did not have a policy and procedure specific for bruising. The DON stated the facility used the Skin Integrity Management Policy and Procedure (P&P) when addressing bruising. Based on the facility's P&P titled, Skin Integrity Management, effective date 5/26/21, the P&P indicated the implementation of an individual patients' skin integrity management occurs within the care delivery process . staff continue to observe and monitor patients changes and implements revision to the plan of care as needed .perform observations and measurements upon initial identification of altered skin integrity .notify physician . A request for facility's P&P for COC was requested but was not provided.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46132 Based on interviews and record reviews, the facility failed to ensure residents' needs were anticipated and frequently needed items, such as water, was within reach for one out of two sampled residents (Resident 1), which resulted in Resident 1's fall on 1/31/24. This fall incident resulted in a small cut on her left index finger. This fall could also put Resident 1 at risk for further fracture (a break in the bone) and pain. Findings: A review of Resident 1's face sheet indicated she was admitted to the facility on [DATE], with a diagnosis of Chronic Pain, Fracture of the left humerus (left upper arm bone) and Repeated Falls. Her Minimum Data Sheet Assessment (MDS, a federally-mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes), dated 1/29/24, Brief Interview for Mental Status (BIMS, a mandatory tool used to screen and identify the cognitive condition of residents) score was 14, indicating intact cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). Her MDS assessment also indicated there was a functional limitation on her upper and lower extremity (limb) and required moderate to maximal assistance when performing her Activities of Daily Living (ADL, activities related to personal care such as bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet). Resident 1 was totally dependent on staff when toileting and showering, with lower body dressing and putting on/taking shoes off. A review of Resident 1's At Risk for Fall care plan (CP, a road map for the care of a patient) included a medication record review, as needed, providing verbal cues, reminding Resident 1 to use call light when attempting to ambulate and transfer. A review of Resident 1's Interdisciplinary (IDT, a group of health care professionals with various areas of expertise who work together toward the goals of the residents) Fall, dated 1/31/24, indicated her functional status as requiring assistance with bed mobility, toileting, transfer and personal hygiene. During an interview on 4/11/24 at 1:55 p.m., Unlicensed Staff A stated, to prevent falls, staff should follow the residents' care plan (CP, a road map for the care of a patient), staff should ensure residents were monitored frequently at least every two hours and incontinence care provided at least every two hours and as needed. Licensed Staff A stated staff should also anticipate residents' needs, all frequently used items should be within residents reach and items should be placed on their good side or side that had no impairment. Unlicensed Staff A stated, not doing these could increase residents ' risk for falls, and residents could get hurt and injured. During an interview on 4/11/24 at 1:59 p.m., Licensed Staff B stated residents were assessed upon admission for fall risk. Licensed Staff B stated fall care plans should be followed to decrease risk of fall incidents. Licensed Staff B stated, to prevent falls, staff should monitor residents frequently at least every two hours, provide incontinence care every two hours or as often as needed, anticipate residents' needs and to place frequently-used items by residents' good side or side that had no impairment. Licensed Staff B stated, if these were not done, it could result in falls. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/10/24 at 2:33 p.m., Unlicensed Staff C stated, to prevent falls, staff should anticipate residents' needs, monitor residents every two hours, provide incontinence care every two hours or as needed and ensure frequently-used items were placed on the resident's uninjured side. Unlicensed Staff C stated, if these were not done, it could result in fall and injury. During an interview on 4/10/24 at 2:33 p.m., Unlicensed Staff C stated, to prevent falls, staff should anticipate residents' needs, monitor residents every two hours, provide incontinence care every two hours or as needed and ensure frequently-used items were placed on the resident's uninjured side. Unlicensed Staff C stated, if these were not done, it could result in fall and injury. The ADON stated Resident 1 was a high fall risk due to frequent falls, impaired balance and medications. The ADON stated Resident 1 fell on [DATE], when she was reaching for water on her table, then she lost her balance and was found on the floor lying on her left side. The ADON stated Resident 1 was a high fall risk, and to decrease risk of Resident 1 falling, staff should follow Resident 1's care plan. The ADON stated the fall policy was to monitor residents closely every two hours, provide incontinence care every two hours or as needed and to put frequently-used items within residents' reach. The ADON stated the water should be placed on Resident 1's right side since this was her good side and the left arm was in a soft cast. The ADON stated the fall could have been prevented. When asked if it was possible the water was not within Resident 1's reach and was placed on the table on her left side, she stated, Yes. The ADON stated Resident 1 might have turned on her left side to try to reach for her water using her right hand, she then lost her balance and fell . During an interview on 4/10/24 at 3:19 p.m., the Infection Preventionist stated it was the facility's fall policy to ensure residents were monitored closely every two hours and to place commonly-used items within residents' reach, on the side that had no impairment. When asked if it was possible Resident 1's fall was caused due to water not being within Resident 1's reach, the IP stated it was possible. When asked if this fall could have been prevented, she stated, Yes. During a telephone interview on 4/15/24 at 2:43 p.m., the ADON stated, as far as she could remember there was no record to indicate a medication regimen review for falls was completed by the Pharmacist, there were no record to indicate Resident 1 was being monitored frequently every two hours and no record to indicate Resident 1's water was within her reach when she fell . A review of the facility's policy and procedure (P&P) titled, Fall Management, effective date 5/26/21, the P&P indicated those at risk will receive appropriate interventions to reduce risk of falling.