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	06/05/2024

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 - 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 ensure the care and needs were identified and provided in accordance with the facility ' s Change of Condition policy and procedure and the professional standards of practice in diagnosing Urinary Tract Infection (UTI, an infection of the urinary system) for one out of two sampled residents (Resident 1) when the physician was not immediately notified of Resident 1 ' s altered mental status (AMS, changes in consciousness, appearance, behavior, mood and cognition, the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) and a urinalysis (a urine test) was not done to rule out UTI . This failure resulted to the hospitalization of Resident 1 with resulting diagnoses of Sepsis (your body ' s extreme reaction to an infection), Acute UTI, and Delirium (a serious change in mental abilities). Findings: A review of Resident 1 ' s face sheet (demographics) indicated she was admitted to the facility on [DATE]. Resident 1 ' s diagnoses included Hyperlipidemia (HLP, an elevated level of lipids (fats, like cholesterol and triglycerides, in your blood), Chronic Kidney Disease Stage 4(CKD stage 4, severe loss of kidney function (the organ that filter waste materials out of the blood and pass them out of the body as urine) and Depression (a serious mental disorder that negatively affects how you feel, think, act, and perceive the world). Resident 1 ' s Minimum Data Sheet Assessment (MDS, a federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes) dated 5/9/24, indicated she needed substantial up to maximal assistance from staff when eating. Resident 1 ' s Brief Interview for Mental Status (BIMS, a mandatory tool used to screen and identify the cognitive condition of residents) dated 5/3/24 score was 10 out of 15 indicating moderately impaired cognition. A review of Resident 1 ' s physician ' s progress note, Skilled Nursing Facility (SNF, facility for care (usually long-term) of patients who are not sick enough to need hospital care but are not able to remain at home) dated 4/29/24 indicated Resident 1 was alert, oriented to name, place and situation (A+Ox3). (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0580 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 1 ' s progress note dated 5/9/24 indicated she was seen by the physician for weakness, leg pain and after receiving a message from Resident 1 ' s primary care physician that her daughter was worried she was not doing well. The progress note indicated Resident 1 was now unable to answer questions. The progress note also indicated Resident 1 has delirium due to multiple etiologies and had advised staff to transfer Resident 1 to the ED. A review of Resident 1 ' s ED to Hospital admission discharge summary note dated 5/18/24 indicated the reason for hospital admission was Delirium, Sepsis (severe infection) without Acute Organ Dysfunction (organ failure), and Acute UTI. A review of Resident 1 ' s electronic medical chart did not indicate staff requested the physician for urinalysis (UA, a test of your urine. It's used to detect and manage a wide range of disorders, such as urinary tract infections) and there was no indication the nursing staff were monitoring Resident 1 for signs and symptoms of UTI or for worsening of Resident 1 ' s agitation, confusion and hallucination (hearing, seeing, feeling, smelling, or even tasting things that are not real). During a concurrent interview, nursing progress notes, change of condition (COC, significant deterioration in an employee's physical health) dated5/9/24 record review on 6/4/24 at 4:35 p.m., Licensed Staff A stated the reason Resident 1 was sent out to the emergency department was due to hallucination (false perception) and pain on her right hip. When asked if Resident 1 ' s confusion and hallucination was a new symptom, Licensed Staff A stated yes as Resident 1 was alert and oriented when she was initially admitted to the facility on [DATE]. When asked if hallucination, confusion and agitation (a feeling of irritability or severe restlessness) should be reported to the physician, Licensed Staff A stated yes. Licensed Staff A verified there was no progress note on 5/4/24 and 5/5/24 indicating the physician was notified of Resident 1 ' s hallucination and agitation. When asked if it was a change of condition if Resident 1 was reported to be confused and was having hallucination, Licensed Staff A stated yes. Licensed Staff A confirmed staff were not monitoring Resident 1 ' s mental status from 5/4/24 up to 5/8/24. Licensed Staff A stated the facility did not know what was causing Resident 1 ' s hallucination, agitation, and confusion and there was no treatment initiated to address Resident 1 ' s hallucination, agitation, and confusion. When asked why, Licensed Staff A was silent. Licensed Staff A stated the physician ordered a St. Louis University Mental Status test (SLUMS, an assessment tool for dementia and mild cognitive impairment). Licensed Staff A stated she was not sure if this test was done or of the test outcome. Despite Resident 1 ' s change in mental status, Licensed Staff A stated staff were not monitoring Resident 1 for signs and symptoms of UTI and did not suspect Resident 1 had a UTI. During an interview on 6/4/24 at 6:00 p.m., when asked if a resident was noted with confusion, hallucination and agitation should be reported to the physician, Licensed Staff B stated yes, because it was a COC. Licensed Staff B stated you report these symptoms to the physician because you want to know the reason for the confusion, hallucination, agitation and to request for treatment. When asked if a urinalysis should be requested if a resident was found with new onset of agitation, hallucination, and confusion, Licensed Staff B stated yes they should ask the physician for UA to rule out UTI and if a treatment was indicated. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	During an interview on 6/5/24 at 9:45 a.m., Licensed Staff C stated if a resident was having a COC such as agitation, confusion, and hallucination, the physician should be notified right away to find out what was causing the COC- agitation, confusion, and hallucination, and what treatment could be implemented to address the agitation, confusion, and hallucination. Licensed Staff C stated if these symptoms were not reported to the physician right away, it could result to worsening of the resident status. During an interview on 6/5/24 at 10:00 a.m., Licensed Staff D stated residents with acute change of condition such as agitation, confusion and hallucination should be reported to the physician immediately, at least before the end of shift, so the physician could assess the resident and provide treatment if needed. When asked if staff should ask the physician for UA, she stated yes, to see if the agitation, confusion and hallucination was caused by the UTI and to see if a treatment was needed. During a telephone interview on 6/7/24 at 4:45 p.m., the DON stated if a resident was noted with a new onset of behavior changes such as agitation, hallucination and confusion, staff should report this to the physician right away. The DON stated this was important so the physician could assess the resident, find out what was causing these behavioral changes and to provide necessary treatment if needed to prevent worsening of resident ' s medical status. A review of the physician progress not dated 5/6/24 indicated the physician ordered a St. Louis Mentals Status(SLUMS, an assessment tool for dementia and mild cognitive impairment) test to address Resident 1 ' s confusion, agitation, and hallucination. The email sent by the Medical Record Director (MRD) on 6/7/24 stated the rehabilitation department told her they did not complete Resident 1 ' s SLUM test as ordered by the physician. The American Journal of Kidney Diseases indicated the diagnosis of UTI can be confirmed by 2 main laboratory tests: urinalysis and urine cultures. It also stated urinalysis can help with the diagnosis of UTIs. A review of the facility ' s policy and procedure (P&P) titled Change of Condition) revised 8/25/21, the P&P indicated the facility must immediately consult with the physician where there was a significant change in residents physical, mental and psychosocial status such as deterioration in health, mental or psychosocial status in either life threatening condition or clinical complication. A review of the facility ' s policy and procedure (P&P) titled Urinary Tract Infection/Bacteriuria (presence of bacteria in the urine) Clinical Protocol, the P&P indicated the staff and practitioner will identify individuals with possible signs and symptoms of UTI .signs and symptoms of a UTI may be specific to the urinary tract and/or generalized .acute deterioration in stable chronic urinary symptoms may indicate an acute infection .the physician will help nursing staff interpret any signs and symptoms and labs test result.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46132 Based on interviews and record reviews, the facility failed to ensure for one out of two sampled residents (Resident 2): 1. An abuse allegation was reported timely. 2. Staff were aware of the abuse allegation reporting time frame. 3. The alleged staff was suspended after an abuse allegation was made. These failures were a safety risk and could result in the abuse to continue and had Resident 2 feeling scared and upset. Findings: A review of Resident 2 ' s face sheet (demographics) indicated an admitted [DATE]. Her diagnoses included Hyperlipidemia (HLP, an elevated level of lipids (fats, like cholesterol and triglycerides, in your blood), Major Depression (a serious mental disorder that negatively affects how you feel, think, act, and perceive the world) and Anxiety (a feeling of fear, dread, and uneasiness). Resident 2 ' s Brief Interview for Mental Status (BIMS, a mandatory tool used to screen and identify the cognitive condition of residents), dated 3/15/24, score was 14, indicating intact cognition (a term for the mental processes that takes place in the brain, including thinking, attention, language, learning, memory and perception). Resident 2 required the assistance of staff when performing her Activities of Daily Living (ADLs, the tasks of everyday life. Basic ADLs include eating, dressing, getting into or out of a bed or chair, taking a bath or shower, and using the toilet). During an interview on 6/4/24 at 4:35 p.m., Licensed Staff A stated an abuse allegation should be reported within 24 hours from when the allegation was made. Licensed Staff A stated, not reporting an abuse allegation immediately could result in a resident being fearful, sad and frustrated. Licensed Staff A stated, if an abuse allegation was not reported timely, it could be a risk for the abusive behavior to continue. Licensed Staff A stated, if an allegation was made against a staff, the alleged staff should be asked to go home to prevent further interaction with the resident or other residents. Licensed Staff A stated this was for residents ' safety. During an interview on 6/4/24 at 5:45 p.m., the Director of Nursing (DON) stated that on Sunday, 5/19/24, Resident 2 spoke to the nurse about how her CNA was rough to her during care. When asked if this incident should have been reported by the facility to the appropriate agencies timely, she stated, Yes. When asked if this allegation was reported to the appropriate agencies timely, she stated, No. The DON verified this abuse allegation was not reported to the appropriate agencies until Monday, 5/20/24. The DON verified the alleged CNA should have been asked to go home on 5/19/24, after the abuse allegation was made, however the alleged CNA was allowed to continue working at the facility. The DON stated the alleged CNA did not go to work beginning 5/20/24. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/4/24 at 6 p.m. Licensed Staff B stated an abuse allegation should be reported within 24 hours after an allegation was made. Licensed Staff B stated, if an abuse allegation was made against staff, this staff should be suspended right there and then until further investigation. Licensed Staff B stated, not reporting an abuse allegation timely could result for the abuse to continue and could lead to residents ' feeling afraid, fearful, and upset. During an interview on 6/4/24 at 6:02 p.m., Unlicensed Staff F stated an allegation of abuse should be reported to the appropriate agencies within 24 hours after an allegation was made. Unlicensed Staff F stated alleged staff should not be allowed to work at the facility, pending investigation. Unlicensed Staff F stated, not reporting an abuse allegation timely and allowing the alleged staff to continue working at the facility, was a safety risk and could result in the abuse to continue. During an interview on 6/4/24 at 6:06 p.m. Unlicensed Staff G stated an abuse allegation should be reported to the appropriate agencies within 24 hours. Unlicensed Staff G stated, not reporting an abuse allegation timely could result for the abuse to continue. Unlicensed Staff G stated, if a resident made an abuse allegation against staff, this staff should be sent home and not allowed to continue working at the facility pending further investigation During an interview on 6/5/24 at 8:58 a.m., the Administrator verified the abuse allegation was reported late and was not reported to the appropriate agencies until 5/20/24. The Administrator stated staff was aware about the abuse allegation on 5/19/24, but did not report to the Administrator or the DON about the incident. The Administrator stated, on 5/20/24, when he and the DON was made aware of the abuse allegation, that was when they reported this allegation to the Ombudsman (an official who investigates complaints), the State and the local police. When asked if the alleged staff should be allowed to continue working at the facility after an abuse allegation was made, the Administrator stated the alleged staff should have been suspended pending investigation. A review of the facility ' s policy and procedure (P&P), titled, Abuse Prohibition, review date 2/23/21, the P&P indicated, the employee alleged to have committed the act of abuse will be immediately removed from duty pending investigation . upon receiving information concerning a report of suspected or alleged abuse, the CED or designee will report the allegations involving abuse not later than 2 hours after an allegation was made.