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	12/05/2024

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49933 49950 Based on observation, interview and record review, the facility failed to ensure two of 31 sampled residents (Resident 97 and Resident 103) received care which met professional standards when: 1. Family reported to licensed nurse that Resident 103 had an injury of unknown origin on 12/2/24 and was not documented in the nursing notes until 12/3/24; and 2. The facility did not obtain authorization for physical therapy treatment. These failures resulted in inaccurate assessment documentation and had the potential to result in unmet nursing needs for Resident 103 and had the potential to cause a decline in Resident 97's activities of daily living (ADLs - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) and worsening weakness. Findings: 1. During a review of Resident 103's Admission Record indicated she was admitted in early 2023 with diagnosis of Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities). During a review of Resident 103's clinical record included the following documents: A Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 5/26/24, indicated Resident 103 had severe memory impairment. A Body Check Assessment, dated 12/2/24, completed by Licensed Nurse 2 (LN 2), indicated body check completed with no skin issues. A Weekly Summary Documentation, dated 12/2/24, completed by LN 2, indicated no to the question Resident has skin issues. A progress note, dated 12/3/24 and written by LN 2 indicated Resident 103 had bruises on the right arm and hospice made aware. (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident's 103 nursing assessments for 12/2/24 and 12/3/24 had no documented evidence that a change of condition assessment was done by LN 2. During a concurrent observation and interview, on 12/2/24 at 11:36 a.m., Resident 103 was lying in bed talking to herself in her own language. Resident 103's right forearm was observed to have a greenish, yellow discoloration. Resident 103's daughter stated that she has been gone for a week and nursing staff did not notify her of change of condition. Resident 103's daughter confirmed that she spoke with LN 2 to find out about new skin issue that morning. During an interview, on 12/3/24 at 12:42 p.m., LN 2 confirmed that Resident 103's daughter reported the new skin issue while in Resident 103's room on 12/2/24. During a concurrent record review and interview, on 12/4/24 at 8:20 a.m., the Director of Nursing (DON) acknowledged that a bruise was a change of condition for the resident. The DON further stated that when there is a change of condition, the family and doctor should also be notified. The DON reviewed Resident 103's Body Check and Weekly Assessment and confirmed that it did not address the discoloration on her right forearm. The DON acknowledged that the assessment documentation was not accurate. During a review of the facility's policy and procedure (P&P) titled Skin integrity Management, dated 5/26/21, indicated Staff continually observes and monitors patients for changes and implements revisions to the plan of care .Identify patient's skin integrity status and need for prevention intervention or treatment .through review of all appropriate assessment . During a review of the facility's P&P titled, Notification of Change of Condition, dated 8/25/21, indicated to ensure residents, family, legal representative, and physicians are informed of changes in resident's condition. 2. During a review of Resident 97's face sheet (front page of the chart that contains a summary of basic information about the resident), the face sheet indicated Resident 97 was admitted to the facility July 2022 with multiple diagnoses which included muscle weakness and cerebral palsy (group of conditions that affect movement and posture). During a review of Resident 97's MDS, dated [DATE], the MDS indicated Resident 97 had an impairment in upper and lower range of motion and was dependent with most ADLs. During a review of Resident 97's care plan, initiated 5/19/23, the care plan indicated Resident 97 had a deficit in ADL self-care. The care plan indicated the goal was for resident to improve level of function. The care plan indicated that interventions included PT (physical therapy)/OT (occupational therapy) evaluation and treatment. During a review of Resident 97's physician orders, dated 11/14/24, the physician orders indicated .PT (physical therapy) for 2 weeks d/t (due to) weakness . (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/3/24 at 2:39 p.m. with physical therapist (PT), the PT stated Resident 97 was not on the physical therapy caseload. PT further stated he was not sure why physical therapy evaluation was not done. PT further stated the expectation was for physical therapy to be initiated between 24-48 hours after an order was received. PT further stated there was a risk for ADL decline, falls, and contractures when physical therapy was not initiated after it was ordered. During an interview on 12/3/24 at 2:47 p.m. with the Clinical Coordinator (CC), the CC stated Resident 97 requested physical therapy on 11/14/24 and a physician order was entered that day. The CC further stated an insurance authorization was needed for Resident 97 to receive physical therapy. The CC further stated the facility did not follow up on obtaining a physical therapy authorization. The CC further stated Resident 97 did not receive therapy as a result of the facility not following up with physical therapy order. The CC further stated there was a risk for resident's weakness to worsen when physical therapy orders were not initiated within 72 hours. During an interview on 12/4/24 at 8:07 a.m. with Resident 97, Resident 97 stated she requested physical therapy on 11/14/24 because she had not received physical therapy in several months and would become bedbound if she did not continue being active. During an interview on 12/4/24 at 9:07 a.m. with DON, the DON stated that new orders should be implemented as soon as possible. The DON further stated orders that the need of an insurance authorization should be followed up on right away. The DON further stated there was a risk for resident harm if orders were not followed up on. During a review of the facility's P&P, titled Physician Orders, dated 3/22/2022 the P&P indicated, .the Licensed Nurse .will be responsible for documenting and implementing the order . During a review of the undated document titled, Nursing Practice Act Rules and Regulations, the document indicated, Article 2. Scope of Regulation 2725 (b). The practice of nursing within the meaning of this chapter means those functions, including basic health care, that help people cope with difficulties in daily living that are associated with their actual or potential health or illness problems or the treatment thereof, and that require a substantial amount of scientific knowledge or technical skill, including all of the following: (1) Direct and indirect patient care services that ensure the safety, comfort, personal hygiene, and protection of patients; and the performance of disease prevention and restorative measures. (Nursing Practice Act Rules and Regulations Issued by Board of Registered Nursing- Stated of California Department of Consumer Affairs).