

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056243	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/08/2026
NAME OF PROVIDER OR SUPPLIER Western Slope Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3280 Washington Street Placerville, CA 95667	
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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on interview and record review, the facility failed to provide necessary care and services to one of four sampled residents (Resident 1) when appropriate monitoring, care planning, and Resident 1's representative notification were not implemented following the removal of a chronic indwelling catheter (a flexible tube placed in the bladder to continuously drain urine) and by failing to document post voiding residual (a monitoring process to check if the bladder is emptying after indwelling catheter is removed). These failures resulted in inappropriate urinary catheter management and led to Resident 1 requiring an emergency room visit for the replacement for urinary catheter only hours after being discharged from the facility. Findings: Resident 1 was admitted to the facility in mid-2026 with diagnoses that included neuromuscular dysfunction of the bladder (neurogenic bladder, lack of bladder control when the nerve signals between the brain and bladder muscles are broken or damaged), dementia, and chronic kidney disease (kidneys are damaged and lose the ability to filter waste and extra fluid from the blood). Resident 1 was not her own responsible party (RP). During a review of Resident 1's Discharge Summary [DS, instructions and information provided by the hospital to the facility], dated 5/15/26, the DS indicated, .discharge diagnosis. neurogenic bladder with chronic [brand name] catheter. During a review of Resident 1's Order Summary Report [OSR], order date 5/15/26, the OSR indicated, Indwelling Urinary Catheter. For urinary retention. and Resident is not capable of understanding rights and responsibilities, or able to participate in treatment plan. Resident is incapable of making her own health decisions. During a review of Resident 1's Minimum Data Set (MDS, federally mandated resident assessment tool) dated 5/22/26, the MDS showed a Brief Interview for Mental Status (BIMS-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 3/15, which indicated severe cognitive impairment. During a review of Resident 1's progress notes (PN) dated 6/24/26 at 7:09 p.m. the PN indicated, Resident pulled catheter during shower. No c/o [complaint of] pain or bleeding. Per NP [Nurse Practitioner] orders started (sic) voiding test. The PN did not indicate Resident 1's RP was notified. There was no physician order to re-insert a urinary catheter for Resident 1. During a review of Resident 1's medical record, no care plans (CP, a written guide outlining a person's health needs, goals, and specific treatments) were found to address Resident 1's chronic indwelling catheter care, management or staff instructions for actions to take if the catheter became dislodged. During a review Resident 1's Medication Administration Record [MAR] dated 6/24/26-6/27/26, the MAR indicated, .Voiding Trial x 72 hours. PVR [post void residual, the amount of urine that remains in the bladder after a person has finished urinating] Q [every] Shift (Ensure Resident Voids Prior to Bladder Scan if Possible). which indicated to document the amount of residual each shift in the MAR; however, there was no documented evidence in Resident 1's clinical record that the PVR was measured during the 72 hours of voiding trial. During a review Resident 1's PN, dated 6/30/26, the PN note indicated Resident 1 left the facility at 1 p.m. The PN did not indicate any voiding assessment of (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the resident at the time of the discharge.During a review Resident 1's emergency department [ED] visit notes, dated 6/30/26 at 4:49 p.m., the ED notes indicated, [Resident 1 name and age] who presents (sic) urinary retention. Recently discharged from a skilled nursing facility and [brand name] catheter was removed. States unable to urinate since last night.During a review Resident 1's hospital record, Clinical Decision Area (CDA notes), dated 6/30/26 at 10:36 p.m., the CDA notes indicated a urinary catheter was re-inserted at the ED: ED course: High PVR, [brand name] catheter placed.Review of systems.positive for difficulty urinating.During a phone interview on 7/8/26 at 11:10 a.m. with the Assisted Living Facility Administrator (ALF/ADM), the ALF/ADM stated Resident 1 returned to the Assisted Living Facility on 6/30/26 at 1:48 p.m. without an indwelling catheter and was only able to void a small amount. The ALF/ADM stated Resident 1 was sent to the emergency department at 4 p.m. and Resident 1 then returned later that night to the ALF after having an indwelling catheter inserted. During an interview on 7/8/26 at 11:40 a.m. with Licensed Nurse (LN 1), LN 1 stated the protocol for a voiding trial was for staff to scan the resident's bladder after voiding and record the PVR in milliliters (measurement) in the medical record every shift for 72 hours. LN 1 also stated that family notification was required when a catheter was removed.During a concurrent interview and record review on 7/8/26 at 1:17 p.m. with the Director of Nursing (DON) of Resident 1's chart, the DON confirmed Resident 1 had a diagnosis of urinary retention and had a chronic indwelling catheter. The DON reviewed the PN which indicated the nurse had notified the NP when Resident 1 pulled out her indwelling catheter stated the NP, had access the chart as well so she would be able to see it was a chronic catheter. The DON indicated that staff should have documented bladder scan results in the MAR during a voiding trial. The DON confirmed that Resident 1's chart lacked the post void residual amount and stated without the documentation staff would not be able to determine if Resident 1 had any urinary retention. The DON confirmed that no care plan was created for Resident 1's catheter and emphasized the importance of care plans for ensuring appropriate care. During an interview on 7/8/26 at 2 p.m. with the Nurse Practitioner (NP), the NP confirmed that staff called to inform her Resident 1 had pulled out the catheter and had requested a voiding trial. The NP stated she was not told the catheter was chronic and had she known she would have ordered to re-insert a urinary catheter back. The NP stated staff should monitor and document PVR and notify the family, especially if the resident was not their own responsible party.During a review of the facility's policy and procedures (P&P) titled, Change in a Resident's Condition or Status, dated 9/25, the P&P indicated, Our facility promptly notifies the resident, his or her attending physician and the resident representative of changes in the resident's medical/mental condition and/or status.Prior to notifying the physician or healthcare provider, the nurse will make detailed observations and gatherer relevant and pertinent information for the provider.During a review of the facility's P&P titled, Care Plans, Comprehensive Person- Centered, dated 10/25, the P&P indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.The comprehensive, person-centered care plan.describes the services that are to be furnished to attain or maintain the resident's highest practicable, physical, mental, and psychosocial wellbeing.		