STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056266	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Keystone Post-Acute	3672 North First Street Fresno, CA 93726

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 51134

Based on interview and record review, the facility failed to revise and implement a comprehensive person-centered care plan for two of six sampled residents (Resident 1 and Resident 2) when Resident 1 and Resident 2 were involved in a resident to resident verbal altercation on 9/20/24, the Interdisciplinary Team (IDT-a group of health care professionals with various areas of expertise who work together to establish goals for residents) met on 9/23/24 and implemented Social Services Director (SSD) and Activities Director (AD) daily visits from 9/23/24 to 9/25/24 and Resident 1 and Resident 2's care plans were not updated to reflect these interventions. Resident 1 and Resident were not seen by the SSD and the AD on 9/24/24 and 9/25/24.

This failure resulted in Resident 1 and Resident 2 at risk of not receiving appropriate, consistent, and individualized care interventions to ensure their safety and well-being.

Findings:

During a review of Resident 1's Admission Record (AR), dated 10/3/24, the AR indicated Resident 1 was admitted to the facility on [DATE].

During a review of Resident 1's Progress Note (PN), dated 9/23/24, the PN indicated . IDT Event Review . Events being reviewed: Resident-to-resident, event occurred on 9/20/24 approximately on [2:15 p.m.] . Root Cause Analysis for event: [Resident 2] was in dining room . [with] screen door open to patio, [Resident 1] was on the patio waiting for dialysis transport, when [Resident 2] made a comment. Per [Resident 1]: Resident said oh there he goes to sit outside and vape (a device for inhaling vape containing nicotine) . [Resident 1] had gotten upset and spoke loudly towards [Resident 2], words were exchanged between both residents . New interventions suggested following current IDT review: IDT interventions: SSD daily visits, Activities daily visit .

During a review of Resident 1's Mood Care Plan, dated 9/20/24, the Mood Care Plan indicated . Interventions .monitor for psychosocial distress for 72 hours . Social Services, or Nursing to Address the Altered Mood and Behaviors as Applicable . The Mood Care Plan was not revised to indicate SSD and AD daily visits for 72 hours starting on 9/23/24.

During a review of Resident 2's AR dated on 10/3/24, the AR indicated Resident 2 had been admitted to the facility on [DATE].

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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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056266	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Keystone Post-Acute	3672 North First Street Fresno, CA 93726

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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 0656

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

During a review of Resident 2's PN dated 9/23/24, the PN, indicated . New interventions suggested following current IDT review: IDT interventions . SSD daily visits, Activities daily visit .

During a review of Resident 2's Mood Care Plan, dated 9/20/24, the Mood Care Plan indicated . Interventions .Encourage Activity Services of Interest Daily . monitor for psychosocial distress for 72 [hours] . Social Services, or Nursing to Address the Altered Mood and Behaviors as Applicable . The Mood Care Plan did not indicate daily visits from the SSD and the AD for 72 hours starting on 9/23/24.

During an interview on 10/9/24 at 3:39 p.m. with the Social Services Director (SSD), the SSD stated she visited Resident 2 on 9/23/24 and 9/24/24. The SSD stated there was no visit done on 9/25/24 and should have.

During a concurrent interview and record review on 10/11/24 at 9:14 a.m. with the Assistant Director of Nursing (ADON), Resident 1's PN dated 9/23/24 and Resident 2's PN dated 9/23/24 and Mood Care Plan dated 9/20/24 were reviewed Resident 1's PN indicated . New interventions suggested following current IDT review: IDT interventions: SSD daily visits, Activities daily visit . The ADON stated Resident 1 ' s care plan should have been updated on 9/23/24 to reflect the SSD and AD daily visits. The PN indicated . New interventions suggested following current IDT review: IDT interventions: . SSD daily visits, Activities daily visit . The ADON stated Resident 2 ' s care plan should have been updated with the new IDT interventions. The ADON stated the ADON or the SSD are responsible for updating care plans with the IDT interventions. The ADON stated the importance of updating the care plan and implementing interventions was to follow up with the residents and make sure there was no psychosocial distress [unpleasant emotions that can negatively impact a person ' s quality of life], and to make sure the residents did not retaliate against each other.

During a concurrent interview and record review on 10/11/24 at 11:50 a.m. with the Activities Director (AD), Resident 1's Mood Care Plan dated 9/20/24 and Resident 2's Mood Care Plan dated 9/20/24 and PN dated 9/23/24 were reviewed. The AD stated the activities visits for Resident 1 and Resident 2 were to start on 9/20/24 to 9/23/24 (72 hours). The AD validated Resident 1 ' s Mood Care Plan did not indicate activities daily visits for 72 hours. The AD stated Resident 1's Mood Care Plan should have been updated and reflected in the care plan. The AD stated she was not part of the IDT meeting on 9/23/24. The AD stated Resident 2 had daily AD visits from 9/20/24 to 9/23/24 but did not have AD visits on 9/24/24 and 9/25/24 as indicated by the IDT. The AD stated Resident 2's Mood Care Plan did not reflect activities daily visits. The AD stated the activities daily visits intervention for 72 hours should have been included in the care plan for Resident 1 and Resident 2. The AD did not conduct daily visits for Resident 1 and Resident 2 on 9/24/24 and 9/25/24.

During a concurrent interview and record review on 10/11/24 at 2:07 p.m. with the ADON, Resident 1's PN dated 9/23/24 was reviewed. The PN did not indicate how long SSD and AD daily visits were to occur. The ADON stated the SSD and AD daily visits interventions were to begin following the IDT Meeting on 9/23/24 for 72 hours. The ADON stated a time frame was not written in the IDT Meeting Progress note but those in attendance at the IDT meeting were aware the interventions were to begin on 9/23/24 for 72 hours.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Keystone Post-Acute	3672 North First Street Fresno, CA 93726

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 10/11/24 at 2:17 p.m. with the SSD, Resident 1's PN dated 9/24/24 was reviewed. The SSD stated when she conducted visits with residents, she would go and sit with them, .ask them how they are doing, if they have any concerns regarding the situation they were involved in . when I do this, I do both observing and talking to residents. The SSD stated on 9/24/24 and 9/25/24 she did not visit Resident 1 as discussed in the IDT meeting. During a review of the facility's P&P titled Person Centered Care Planning, dated 9/27/24, the P&P indicated . The care planning process will include .the resident's .needs .and will incorporate goals of care. During a review of the facility's Policy & Procedure (P&P), titled, Care Planning -Interdisciplinary Team, dated 3/2022, the P&P indicated, .2. Comprehensive, person-centered care plans are based on resident assessments and developed by an interdisciplinary team (IDT) .

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NAME OF PROVIDER OR SUPPLIER Keystone Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 3672 North First Street Fresno, CA 93726	

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51134 Based on interview and record review, the facility failed to maintain complete, accurately documented and readily accessible medical records in accordance with accepted professional standards and practices for three of six sampled residents (Resident 1, Resident 2, and Resident 4) when: 1.Resident 1 had care plan interventions for 15 Minute Checks (staff member is checking on resident every 15 minutes) documentation from 9/20/24 to 9/23/24 (72 hours) and facility staff was unable to locate 15 Minute Checks documentation for 9/20/24 to 9/21/24. 2.Resident 2 ' s care plan had goals documented for Resident 1. 3.Resident 4 had care plan intervention for 15 Minute Checks documentation from 9/15/24 to 9/18/24 (72 hours) and facility staff was unable to locate 15 Minute Checks documentation for 9/17/24 and 9/18/24. This failure resulted in incomplete medical records for Resident 1, Resident 2 and Resident 4, inaccurate medical record for Resident 1 or 2 and the facility not following their policy and procedure titled, Charting and Documentation. Findings: 1.During a review of Resident 1's Admission Record (AR), dated on 10/3/24, the AR indicated Resident 1 was admitted to the facility on [DATE]. During a review of Resident 1's Mood Care Plan dated 9/20/24, the Mood Care Plan indicated, . [Resident 1] was involved in a resident to resident verbally aggressive . Interventions . Monitor [every] 15 minute checks, for 72 hours date initiated 9/20/24 . During a review of Resident 1's Progress Note, dated 9/23/24, the PN indicated .Interventions initiated and residents response/compliance with Intervention: Immediate interventions on 9/20/24 .monitor for [signs and symptoms] of psychosocial distress [(unpleased emotions that can negatively impact a person's quality of life)]. Q15min [every 15 minute] check for 72 hours .New Interventions suggested following current IDT review: . During a review of Resident 1's 15 Minute Checks dated 9/21/24 to 9/23/24 the 15 Minute Checks indicated, Resident 1 was monitored from 9/21/24 starting at 6:30 a.m. to 9/23/24 ending at 6:15 a.m. There was incomplete documentation to indicate Resident 1 was monitored every 15 minutes from 9/20/24 at 2:30 p.m., after the incident occurred, to 9/21/24 at 6:30 a.m. During a concurrent interview and record review on 10/3/24 at 3:55 p.m. with the Director of Staff Development (DSD), the DSD reviewed the Certified Nursing Assistant (CNA) assignment binder and was unable to locate Resident 1's 15 Minute Checks documentation for 9/20/24 to 9/21/24. (continued on next page)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Assistant Director of Nursing (ADON), on 10/3/24 at 4 p.m. the ADON stated she unable to locate Resident 1's every 15 minute checks documentation for 9/20/24 and 9/21/24. During an interview on 10/9/24 at 2:30 p.m. with Licensed Vocational Nurse (LVN) 1 stated every 15 minute checks were documented on the resident paper charts. During an interview on 10/11/24 at 9:14 a.m. with the ADON, the ADON stated she was unable to locate Resident 1's every 15 Minute Checks for 9/20/24 and 9/21/24. During a review of the facility's Policy & Procedure (P&P), titled, Charting and Documentation, dated 7/2017, the P&P indicated, . 2. The following information is to be documented in the resident medical record: .a. Objective observations .c. Treatments or services performed 3. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate .7. Documentation of procedures and treatments will include care-specific details, including: a. the date and time the procedure/treatment was provided; b. the name and title of the individual(s) who provided the care; c. the assessment data and/or any unusual findings obtained during the procedure/treatment; . g. the signature and title of the individual documenting . During a professional reference reviewed retrieved from https://bok.ahima.org/doc?oid=301868 titled, Ethical Standards for Clinical Documentation Improvement (CDI) Professionals dated June 2016, the professional reference review indicated, .Ethical Standards .Facilitate accurate, complete, and consistent clinical documentation within the health record to demonstrate quality care . 2. During a review of Resident 2's AR dated 10/3/24, the AR indicated Resident 2 was admitted to the facility on [DATE]. Resident 2's admitting diagnosis included cognitive communication deficit (difficulty with communication that is affected by a disruption in thought). During a review of Resident 2's Mood CP dated 9/20/24, the Mood CP indicated, . [Resident 2] is At Risk for Altered Mood and Behavior [As Evidenced By]: Resident to resident incident [manifested by] making threatening comments to peer .Goal . [Resident 1] will have no signs and symptoms of altered mood and behavior status . During a concurrent interview and record review on 10/9/24 [AC5] at 3:15 p.m. with LVN 2, Resident 2 ' s Mood Care Plan, dated 9/20/24 was reviewed. LVN 2 stated .Goal .[Resident 1] will have no signs and symptoms of altered mood and behavior status identified . LVN 2 stated, the medical record was inaccurate because Resident 2 ' s CP had Resident 1 ' s name and it should have goals for Resident 2. During a concurrent interview and record review on 10/11/24 at 9:14 a.m. with the ADON, Resident 2's Mood Care Plan, dated 9/20/24 was reviewed. The Mood Care Plan, indicated .Goal . [Resident 1] will have no signs and symptoms of altered mood and behavior status identified .The ADON stated, .this would be considered a typo [error] . The ADON stated the goals sections should have Resident 2's name on it and not Resident 1's name. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Keystone Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE: 3672 North First Street Fresno, CA 93726	

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's Policy & Procedure (P&P), titled, Charting and Documentation, dated 7/2017, the P&P indicated, . 2. The following information is to be documented in the resident medical record: .a. Objective observations .c. Treatments or services performed 3. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate .7. Documentation of procedures and treatments will include care-specific details, including: a. the date and time the procedure/treatment was provided; b. the name and title of the individual(s) who provided the care; c. the assessment data and/or any unusual findings obtained during the procedure/treatment; . g. the signature and title of the individual documenting . During a professional reference reviewed retrieved from https://bok.ahima.org/doc?oid=301868 titled, Ethical Standards for Clinical Documentation Improvement (CDI) Professionals dated June 2016, the professional reference review indicated, .Ethical Standards .Facilitate accurate, complete, and consistent clinical documentation within the health record to demonstrate quality care . 3.During a review of Resident 4's AR dated on 10/3/24, the AR indicated Resident 4 was admitted to the facility on [DATE]. During a review of Resident 4's Progress Notes (PN) dated 9/16/24, the PN indicated, . [Resident 4 to Resident 3 [altercation] occurred on 9/15/24 at 5:18 p.m. related to seating arrangements in the dining room Root Cause Analysis for event: Resident 4 had Resident to resident to altercation with Resident 3 over seating arrangements in the dining room. Resident 4 was also seated on the table by the sliding glass door, facing the TV. Per Resident 4: I told her to move out of my seat, because I like sitting next to the window. Resident 3 was already sitting next to the glass door. Resident 3 manages to kick Resident 4 in the right lower extremity Interventions initiated and residents response/compliance with intervention: immediate intervention on 9/15/24 . immediately separated . assessed resident for any injuries, no injuries . every 15 minutes checks . new interventions suggested following current interdisciplinary team (IDT review: Intervention on 9/16/24 . continue with every 15 minute checks] . During a review of Resident 4's CP dated 9/15/24 and revised on 9/16/24, the CP indicated, . [Resident to resident altercation Resident stating was kicked in the left lower leg . Interventions . Every 15 minute checks for 72 hours to monitor whereabouts to ensure resident safety for coming within arms reach with resident involved in resident-to-resident altercation .]. During a concurrent interview and record review on 10/11/24 at 9:15 a.m., with the ADON, Resident 4's 15 Minutes Checks were reviewed. The ADON stated Resident 4 had an altercation with Resident 3 on 9/15/24 and one of the interventions implemented was to begin 15 minutes checks and to document. The ADON stated the 15 minutes checks were started on 9/15/24 for 72 hours. The ADON stated the IDT met on 9/16/24 at 6:35 p.m. and continued the 15 minutes checks as an intervention. The ADON stated the 15 minute checks for 9/17/24 and 9/18/24 were missing. The ADON was unable to provide the 15 minutes checks documentation for Resident 4. During a review of Resident 4's 15 Minute Checks dated 9/15/24 to 9/16/24 the 15 Minute Checks indicated, Resident 4 was monitored from 9/15/24 starting at 5:30 p.m. to 9/16/24 ending at 6:15 a.m. There was missing documentation to indicate Resident 4 was monitored every 15 minutes on 9/17/24 and 9/18/24. (continued on next page)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility ' s Policy & Procedure (P&P), titled, Charting and Documentation, dated 7/2017, the P&P indicated, . 2. The following information is to be documented in the resident medical record: . a. Objective observations .c. Treatments or services performed 3. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate .7. Documentation of procedures and treatments will include care-specific details, including: a. the date and time the procedure/treatment was provided; b. the name and title of the individual(s) who provided the care; c. the assessment data and/or any unusual findings obtained during the procedure/treatment; . g. the signature and title of the individual documenting . During a professional reference reviewed retrieved from https://bok.ahima.org/doc?oid=301868 titled, Ethical Standards for Clinical Documentation Improvement (CDI) Professionals dated June 2016, the professional reference review indicated, .Ethical Standards .Facilitate accurate, complete, and consistent clinical documentation within the health record to demonstrate quality care .