STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056416	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mayers Memorial Hospital	43563 Hwy 299 E Fall River Mills, CA 96028

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40425 Based on interview and record review, the facility failed to ensure one of three residents sampled for abuse (Resident 10) was free from physical and verbal abuse, when confidential informant (CI1) witnessed the Director of Nursing (DON) yelling at and shaking Resident 10's wheelchair. This failure resulted in physical and verbal abuse to Resident 10 and had the potential for a decline in Resident 10's psychosocial wellbeing and isolation. Findings: During a review of the facility's policy and procedure (P&P) titled, Abuse, Resident, dated 7/15/2022, included the following statement, For all intents and purposes, the word patient(s) refers to all customers receiving health care services in our facilities, including inpatients, outpatients, residents, and clients, the P&P indicated, each patient has the right to be free from abuse (verbal, sexual, physical and mental) including corporal punishment and isolation. Patients must not be subjected to any of the above by anyone, including, but not limited to, facility staff, other patients, consultants, volunteers, and other agencies that service the patient, family members, legal guardians, friends, or other individuals. During a review of Resident 10's clinical record, Resident 10 was admitted to the facility on [DATE] with diagnoses that included high blood pressure, intellectual disability (limits to a person's ability to learn at an expected level and function in daily life), need for assistant at home and no other household member able to render care, and traumatic brain injury (sudden trauma causes damage to the brain). The most recent Minimum Data Set (MDS, a standardized resident assessment) dated 02/12/24, indicated that Resident 10 was cognitively intact (able to think and reason.) During an interview on 5/6/24, at 10:00 a.m., with Resident 10, Resident 10 stated, when I go down the hallway, I have to wheel myself backwards in my wheelchair and look over my shoulder. I was in front of the nurses station by the DONs office when I bumped my wheelchair into another residents chair. The resident I bumped into yelled out, I said sorry. The DON came out of the office and yelled at me and told me I was not supposed to wheel myself down the hallway backwards. The DON grabbed my chair and turned me around, shook my chair and said I had to go forward. I was very embarrassed, and I cried. Now I am afraid to leave my room because I don't want to get yelled at. (continued on next page)

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

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/7/24, at 11:00 a.m., with Confidential Informant (CI)1, CI1 stated the DON has a problem when anyone makes too much noise, including residents. The DON yells at people constantly. Resident 10 was hit by a car and has had a stroke and Resident 10's right side extremities are too weak to use adequately. Resident 10 has to wheel herself backwards to get around. About a month ago Resident 10 was wheeling herself down the hall and accidently bumped into another resident. The other resident yelled out. This was close to the DON's office and nurses station. DON came out of her office yelling at Resident 10 about the incident. DON stated she cannot keep wheeling backwards. DON grabbed Resident 10's wheelchair and physically shook it and turned her around to try to make her steer to her frontwards. Resident 10 was so embarrassed and in tears. During an interview on 5/7/24, at 11:45 a.m., with CI2, CI2 stated Resident 10 told her the DON was yelling or speaking to her in a very loud manner and grabbing Resident 10's wheelchair. I know that DON does not talk to people appropriately.

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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 - Some	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** 40425 Based on interview and record review, the facility failed report abuse allegations on 4/8/24 and unknown date for Resident 10 and reported late for Resident 50 and 278 when: 1. One of three sampled residents (Resident 10) was verbally and physically abused. 2. Two of three sampled residents (Resident 50 and 278) were reported late. Findings: 1. During a review of the facility's policy and procedure (P&P) titled, Abuse, Resident, dated 7/15/2022, included the following statement, For all intents and purposes, the word patient(s) refers to all customers receiving health care services in our facilities, including inpatients, outpatients, residents, and clients, the P&P indicated, each patient has the right to be free from abuse (verbal, sexual, physical and mental) including corporal punishment and isolation. Patients must not be subjected to any of the above by anyone, including, but not limited to, facility staff, other patients, consultants, volunteers, and other agencies that service the patient, family members, legal guardians, friends, or other individuals. Procedure: 5. Investigation: b) any person who becomes aware of a report of potential physical or mental abuse will inform the licensed nurse on duty. The licensed nurse will: ix) notify Chief Nursing Officer (CNO) - Skilled Nursing Facility (SNF) and Director of Quality (DIQ). X) notify ombudsman. Xi) call Department of Health Services Licensing and Certification no later than two hours after allegation is made. C) i) complete form State of California 341 (SOC 341). During a review of Resident 10's clinical record, Resident 10 was admitted to the facility on [DATE] with diagnoses that included high blood pressure, intellectual disability (limits to a person's ability to learn at an expected level and function in daily life), need for assistant at home and no other household member able to render care, and traumatic brain injury (sudden trauma causes damage to the brain). The most recent Minimum Data Set (MDS, a standardized resident assessment) dated 02/12/24, indicated, Resident 10 was cognitively intact (able to think and reason.) During an interview on 5/7/24, at 11:00 a.m., with Confidential Informant (CI)1, CI1 stated the DON has a problem when anyone makes too much noise, including residents. The DON yells at people constantly. Resident 10 was hit by a car and has had a stroke and Resident 10's right side extremities are too weak to use adequately. Resident 10 has to wheel herself backwards to get around. About a month ago Resident 10 was wheeling herself down the hall and accidently bumped into another resident. The other resident yelled out. This was close to the DON's office and nurses station. DON came out of her office yelling at Resident 10 about the incident. DON stated she cannot keep wheeling backwards. DON grabbed Resident 10's wheelchair and physically shook it and turned her around to try to make her steer to her frontwards. Resident 10 was so embarrassed and in tears. CI1 stated I am afraid for my job. I did not know who else to report it to but the DON. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/7/24, at 11:45 a.m., with CI2, CI2 stated Resident 10 told her the DON was yelling or speaking to her in a very loud manner and grabbing Resident 10's wheelchair. CI2 stated, I did not know this was a reportable incident. During an interview on 5/8/24, at 10:00 a.m., with Certified Nurse Assistant (CNA) 4, CNA 4 stated, I do no know who the abuse coordinator is or if there is an abuse coordinator. During a concurrent interview and record review on 5/8/24, at 3:30 p.m., with Social Service (SS), Resident 10's Progress Note (PN), dated 4/8/24 was reviewed. The PN indicated, Resident 10 filled a grievance regarding her roommate and feeling unsafe. Resident 10 reported not being able to sleep and being scared to sleep as her roommate has thrown things at her in the middle of the night. Social Services report to the charge nurse on duty and DON. SS stated, when she returned to work the next day, she found the grievance note from Resident 10 and reported it to the Charge nurse and Director of Nursing (DON). 2. During a review of Resident 50's clinical record, Resident 50 was admitted to the facility on [DATE] with diagnoses that included conduct disorder, high cholesterol, and Dementia (forgetful). The most recent MDS dated [DATE], indicated, Resident 50 was severely cognitively impaired. During a review of Resident 278's clinical record, Resident 278 was admitted to the facility on [DATE] with diagnoses that included behavioral disturbances, high cholesterol, and sleep apnea. During a record review of state of California-Health and Human Services Agency. Unusual Incident/Injury Report (SOC 342), dated 4/22/24, at 2:35 p.m., the SOC 342 indicated, during a chart review from the weekend, a nursing note was discovered stating that on 4/19/24 at 4:57 p.m. a CNA witnessed Resident 278 hitting Resident 50 while walking in the hallway. DON During a concurrent interview and record review on 5/7/24, at 10:00 a.m., with DON, Resident 278's PN was reviewed. The PN indicated, on 4/19/24, at 4:57 p.m., Resident 278 hit Resident 50's head while walking on the hallway. During a concurrent interview and record review on 7/7/24, at 12:00 p.m., with Director of Staff Development (DSD), the RELIAS (education for abuse for all staff) dated 2022, was reviewed. DSD confirmed in the RELIAS program Section 3: Screening and Reporting Abuse, Staff are educated to report suspected abuse with in two hours to the abuse coordinator, DON, law enforcement, and the state of California Health and Human services. 40204 2. On 5/09/2024 at 12:15 PM during a concurrent interview and record review regarding abuse reporting with the Quality Manager (QM) the QM stated, I interviewed the resident and she gave a real detailed account and it was virtually the same as staff. Staff didn't want to report it and we have to change that culture. Maybe a good thing can come out of this now that we know and they feel comfortable reporting. It should be a just culture and people shouldn't be afraid to say something if they see it. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The QM confirmed the staff witness did not report the abuse of Resident 10 when the Director of Nursing yelled and shook her wheelchair because there was not a culture that supported reporting. As to a written report the QM stated, I looked and didn't find anything. On record review there was no regulatory required documentation that the facility reported the incident to the California Department of Public Health.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39942 Based on interview and record review, the facility failed to review and revise the Care Plans for two of four sampled residents (Residents 27 and 128) when information about their risk for elopement (leaving the facility without staff's knowledge) and exit alarm devices was not included in their Care Plans. This failure had the potential to put the residents at risk for accidents related to elopement. Refer to F 689. Findings: A review of Resident 27's clinical record indicated they were admitted to the facility on [DATE]. Resident 27's diagnoses included anoxic (lack of oxygen) brain damage and a prior heart attack. Resident 27's BIMS (Brief Interview for Mental Status) score was three, which indicated severe cognitive (intellectual) impairment. A review of Resident 27's physician's orders for May 2024 showed a verbal order entered on 12/9/23 for, Wander guard (a device that emitted an audible alarm when the resident approached an exit) applied to left ankle for safety Change Q (every) 90 days every shift for elopement check Q shift. A review of Resident 27's Care Plan showed no entries about elopement risk or a Wanderguard (R) device. A review of Resident 128's clinical record indicated they were admitted to the facility on [DATE]. Resident 128's diagnoses included dementia, anxiety, and legal blindness. Resident 128's BIMS score was seven, which indicated severe cognitive impairment. A review of Resident 128's physician orders for May 2024 showed a phone order entered on 4/24/24 for, Wander guard applied to resident for safety Change Q 90 days and per shift for proper use. two times a day. A review of Resident 128's Care Plan showed no entries about elopement risk or a Wanderguard (R) device. During a concurrent interview and record review, on 5/9/24, at 10:59 AM, the Assistant Director of Nursing (ADON) stated they usually discussed elopement risk in the resident's Care Conference. ADON confirmed the Wanderguards (R) and elopement risk were not on Resident 27's and Resident 128's Care Plans and should have been. They were in the middle of drafting a new elopement policy which had not yet been approved.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 39942 Based on observation, interview, and record review, the facility failed to make sure the environment was free of all accident hazards for two of four sampled residents (Residents 27 and 128) when they had orders for Wanderguard (R) (a device worn on the body that caused an alarm to sound at exit doors) placement, with no follow-up or monitoring. This failure had the potential to put the residents at risk for accidents related to elopement (leaving the facility without staff's knowledge). Refer to F 657. Findings: A review of Resident 27's clinical record indicated they were admitted to the facility on [DATE]. Resident 27's diagnoses included anoxic (lack of oxygen) brain damage and a prior heart attack. Resident 27's BIMS (Brief Interview for Mental Status) score was three, which indicated severe cognitive (intellectual) impairment. A review of Resident 27's physician's orders for May 2024 showed a verbal order entered on 12/9/23 for, Wander guard applied to left ankle for safety Change Q (every) 90 days every shift for elopement check Q shift. Review of Resident 27's Medication Administration Record (MAR) showed no monitor for nursing to document elopement behaviors. Record review of a Multidisciplinary Care Conference - V2, note, dated 3/26/24, indicated the healthcare team met on 3/20/24 to discuss Resident 27's care. Resident 27's cognitive status was described as, Alert, oriented to self only, confusion & memory loss. For physical functioning, Resident 27 ambulated (walked) independently with cueing (verbal reminders). There was no note about risk of elopement or a Wanderguard (R) device. During a concurrent observation and interview, on 5/09/24, at 10:38 AM, at Resident 27's bedside, Licensed Vocational Nurse (LVN) 4 confirmed there was no Wanderguard (R) present on Resident 27's body. LVN 4 stated that if a resident was an elopement risk, they usually put a monitor in the MAR. A review of Resident 128's clinical record indicated they were admitted to the facility on [DATE]. Resident 128's diagnoses included dementia, anxiety, and legal blindness. Resident 128's BIMS score was seven, which indicated severe cognitive impairment. A review of Resident 128's physician orders for May 2024 showed a phone order entered on 4/24/24 for, Wander guard applied to resident for safety Change Q 90 days and per shift for proper use. two times a day. Review of Resident 128's MAR showed no monitor for nursing to document elopement behaviors. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review, on 5/9/24, at 10:59 AM, the Assistant Director of Nursing (ADON) confirmed Resident 27 was not wearing a Wanderguard (R) as ordered, and there was no Care Conference note about it. ADON stated they usually did an initial elopement risk assessment on admission. Resident 27 may have voiced a desire to leave when they were first admitted . ADON confirmed the lack of documentation and stated they were in the middle of drafting a new elopement policy and it had not yet been approved.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 40204 Based on observation, interview, and record review, the facility failed to meet the required daily Registered Nursing (RN) hours for Payroll Based Journaling (PBJ) staffing information submitted to the Centers for Medicare and Medicaid Services (CMS). Failing to meet the required hours the facility did not ensure an adequate level of staff is working at a given time, potentially leading to inadequate care of residents and adverse clinical outcomes. FINDINGS During a concurrent record review and interview on 05/09/24 at 12:33 PM, the Quality Manager (QM) confirmed the required RN coverage was not met for 20 days of the first Federal Quarter of 2024 (The first Federal Fiscal Quarter begins October 1st of the prior year, in this case, October 1st, 2023). The QM stated, It is all here and matches the PBJ report on these dates. We did not have an RN present on the schedule. We do have them in other roles and we encourage them to clock in when they are giving resident care. Referring to the XML template (computer staffing sheet) the QM stated, It is the 7 group (designation) only which are RN's and these are the days they worked and will show a deficit on the PBJ. The QM provided and reviewed with the surveyor a copy of the XML Submission Form. Gaps in RN Coverage were pointed out by the QM and are as follows: 10/2, 10/3, 10/4, 10/10, 10/16, 10/1,7 10/18, 10/23, 10/23, 10/24, 10/31, 11/01, 11/06, 11/13, 11/14, 11/20, 11/27, 11/28, 11/29, 12/11, 12/18, 12/26 and 12/28/2023. The QM read the list aloud and confirmed the dates no RN's were listed for resident care as required by CMS.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39942 Based on observation, interview and record review, the facility failed to ensure professional food safety and sanitation practices were in place when: 1. the interior of the microwave oven was not clean; 2. two expired food items were available for use; 3. one food item was not labeled with a use-by date; 4. one canned item had a dent on its seam. These failures had the potential to result in foodborne illness for a facility with a census of 79 residents who consumed food prepared in the facility. Findings: A review of The Food Code of the United States Public Health Service, and Food and Drug Administration, dated 2022, indicated the following: ,d+[DATE].13 Nonfood-Contact Surfaces. The presence of food debris or dirt on nonfood contact surfaces may provide a suitable environment for the growth of microorganisms (germs) which employees may inadvertently transfer to food. And, The label on packages intended for consumer sale must contain a combination of a sell-by date and use-by instructions which makes it clear that the product must be consumed within the number of days determined to be safe. Additionally, food products must be protected from physical contamination. During a concurrent kitchen observation and interview, on [DATE], at 10:10 AM, the Certified Dietary Manager (CDM) confirmed the microwave used to prepare resident food had red-colored material splattered on its ceiling and sides. During a concurrent kitchen observation and interview, on [DATE], at 10:29 am, CDM confirmed two plastic bags containing grated cheese were dated [DATE]. CDM stated the cheese should have been discarded three days from the date written on the bags. During a concurrent kitchen observation and interview, on [DATE], at 10:35 am, CDM confirmed three bagels were in a plastic bag with no date on it. During a concurrent kitchen observation and interview, on [DATE], at 10:40 am, CDM confirmed one sealed bottle of a nutritional shake had a printed expiration date of [DATE]. During a concurrent kitchen observation and interview, on [DATE], at 10:48 AM CDM confirmed one large can of soup was dented along its seam, and should have been discarded.