| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 05A340 | A. Building<br>B. Wing | 05/23/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Crestwood Manor - 104 | 1130 Monaco Court<br>Stockton, CA 95207 |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>42432<br><br>Based on observation, interview, and record review, the facility failed to ensure one unsampled resident (Resident 19) was treated with dignity and respect when Certified Nursing Assistant (CNA) 2 stood over Resident 19 while assisting her with her lunch meal on 5/20/24.<br><br>This failure had the potential for CNA 2 to miss a choking event and result in a loss of dignity for Resident 19.<br><br>Findings:<br><br>During a concurrent observation and interview on 5/20/23, at 12:31 p.m., in the large dining room located in Station one, CNA 2 was standing next to Resident 19 while assisting her with her meal. CNA 2 stated Resident 19 needed assistance and supervison with her meals. CNA 2 confirmed she should have been sitting next to Resident 19 while assisting her with her meal, not standing. CNA 2 stated, I forgot.<br><br>A review of Resident 19's care plan, revised 3/4/24, indicated, .[Resident 19] has .self-care performance deficit r/t [related to] Dementia [impaired ability to remember, think, or make decisions], left hand contracture [inability to straighten fingers and wrist], and Schizophrenia [affects a person's ability to think, feel, and behave clearly] .Eating .staff to assist as needed with all meals/snacks .<br><br>During an interview with the Assistant Director of Staff and Develpment (ADSD) on 5/23/24, at 12:55 p.m., the ADSD stated staff should sit next to the resident while assisting them with their meal to be able to see the resident eat and swallow their food, watch for choking, and to create a home-like environment.<br><br>A review of the facility's policy and procedure titled, Dining Program, revised 7/1/15, indicated, .staff is to sit while feeding .Residents are observed for safety issues and functional difficulties .at meal time .issues are reported to the Charge Nurse on duty for follow-up .Smiling at the resident and providing words of encouragement will often help promote and increase intake . |

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 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Reasonably accommodate the needs and preferences of each resident.<br><br>43943<br><br>Based on observation, interview, and record review, the facility failed to ensure 1 of 35 sampled residents (Resident 141)'s needs were met when his call light was found on the floor and not within reach.<br><br>This failure could have resulted in a fall, injury, and/or immediate needs not being met for Resident 141.<br><br>Findings:<br><br>A review of Resident 141's clinical record titled, Admission Record, indicated Resident 141's diagnoses included ataxia (loss of coordination and muscle control in arms and legs - leading to a lack of balance and trouble walking).<br><br>A review of Resident 141's clinical record titled, Fall Risk Assessment, dated 5/13/24, indicated Resident 141 received a score of 10 (high fall risk), due to factors that included low blood pressure (can cause dizziness), unstable gait (a person's manner of walking), being chair bound, balance problems, required use of wheelchair, and was on medications that increased the risk for falls.<br><br>During a concurrent observation and interview on 5/20/24, at 10:48 a.m., with the Certified Nursing Assistant (CNA) 1, Resident 141's call light was observed to be on the floor to the right side of the bed and not within reach of Resident 141. CNA 1 stated because the call light was not within reach, Resident 141 did not have a way to alert staff of an emergency or if he needed assistance. CNA 1 acknowledged the call light was on the floor and not within reach of the resident.<br><br>During a concurrent observation and interview on 5/20/24, at 10:49 a.m., with Licensed Nurse (LN) 1, LN 1 stated Resident 141's call light should have been accessible to the resident at all times. LN 1 stated it was not acceptable for the call light to be on the ground.<br><br>During an interview on 5/22/24, at 1:22 p.m., with LN 2, LN 2 stated Resident 141 moved very fast while in his wheelchair or while transferring from the bed to the wheelchair. LN 2 stated Resident 141 was at risk for falls.<br><br>A review of Resident 141's clinical record titled, Section GG - Functional Abilities and Goals, (a portion of a standardized assessment that measured the health status of residents), dated 5/9/24, indicated Resident 141 relied on his wheelchair to move around the facility. Resident 141 was substantially dependent on staff assistance for oral hygiene, toileting hygiene, shower/bath, upper and lower body dressing, putting on footwear, personal hygiene, change of position from lying to sitting on the side of the bed, transitioning from sit to stand, transferring from chair to bed, and transferring to the toilet.<br><br>A review of Resident 141's clinical record titled, Care Plan, dated 3/1/21, indicated, Resident 141 was at risk for falls. Interventions included anticipate and meet the needs of Resident 141 and encourage use of call light if assistance was needed.<br><br>(continued on next page) |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a concurrent interview and record review on 5/23/24, at 8:23 a.m., with the Director of Nursing (DON), the Policy and Procedure (P&P) titled, Call Lights, dated 9/1/13, was reviewed. The P&P indicated, It is the policy of this facility that each resident/client's call light will be accessible .to meet the needs of the resident/client .place the call light within reach of the resident/client upon leaving the room . The DON stated Resident 141 was dependent on staff for basic care. The DON acknowelged the P&P was not followed when Resident 141's call light was found on the floor and not within reach.<br><br>During a concurrent interview and record review on 5/23/24, at 8:36 a.m., with the Administrator (ADM), the P&P titled, Call Lights, dated 9/1/13, was reviewed. The P&P indicated, It is the policy of this facility that each resident/client's call light will be accessible .to meet the needs of the resident/client .place the call light within reach of the resident/client upon leaving the room . The ADM stated the call light should have been within reach to ensure Resident 141 could call upon staff if needed. The ADM acknowelged the P&P was not followed. |

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| F 0604<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.<br><br>42432<br><br>Based on observation, interview, and record review, the facility failed to ensure an evaluation or assessment was documented in the medical record for 1 of 35 sampled residents (Resident 75) when the use of a lap buddy (a device used to secure a resident in a seated position in a wheelchair) was initiated on 10/13/21, after multiple falls, without a documented initial evaluation for its use, or documented assessments for continued use of the lap buddy for Resident 75.<br><br>These failures resulted in Resident 75 never being assessesed for a device that could potentially be a restraint.<br><br>Findings:<br><br>During an observation on 5/21/24, at 7:40 a.m., Resident 75 was observed sitting in Station one's large dining room in a wheelchair with a lap buddy secured across her lap.<br><br>During an observation on 5/22/24, at 4:26 p.m., Resident 75 was observed sitting in Station one's activity room in a wheelchair with a lap buddy secured across her lap.<br><br>During an interview with Certified Nursing Assistant (CNA) 4 on 5/22/24, at 4:40 p.m., CNA 4 stated Resident 75's lap buddy was used every time she was in her wheelchair. CNA 4 stated if Resident 75 tried to remove the lap buddy, staff would put it back on.<br><br>During a concurrent observation and interview with Resident 75 on 5/22/24, at 4:44 p.m., Resident 75 was observed sitting in Station one's large dining room with a lap buddy secured across her lap. Resident 75 stated the lap buddy was used to keep her braced. Resident 75 stated if she tried to remove the lap buddy staff would secure it back in place. Resident 75 stated, Oh, they put it back on.<br><br>A review of Resident 75's Interdisciplinary (IDT, a group of professionals who manage the care of residents) post fall progress note, dated 10/29/21, indicated, .Resident was found by staff sitting on floor next to bathroom .wheelchair unlocked .Resident ambulates [walks] via wheelchair .Resident has had 3 previous falls on 8/18/21, 9/9/21, 10/13/21 .These falls were unwitnessed and occurred during attempting to transfer independently. Resident is forgetful and has poor safety awareness .Resident was given a lap buddy to aid in reminding her to ask for assistance before attempting to transfer independently .on 10/13/21 . The note did not contain a documented evaluation or assessment prior to initiating the use of the lap buddy for Resident 75.<br><br>A review of Resident 75's care plan, initiated 3/26/14, indicated, .[Resident 75] is at risk for falls r/t [related to] Gait [walking]/balance problems, Psychotropic [mind altering medication] .use, Glaucoma [vision impairment] .Osteoarthritis [pain and stiffness in joints] .Hx [history] of falls .10/30/23-unwitnessed fall outside of bathroom .12/27/23-unwitnessed fall in room .1/27/24-unwitnessed fall in room .4/23/24-Resident had unwitnessed fall in bathroom .10/13/21-May use lap buddy for safety .12/27/23-Client encouraged to use lap buddy at all times .<br><br>(continued on next page) |

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| F 0604<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A review of Resident 75's IDT post fall progress note, dated 12/29/23, indicated, .per [Resident 75] she didn't like using her lap buddy. [Resident 75] was found sitting on the floor next to her bed, lap buddy on the floor . [Resident 75] was encouraged to use her lap buddy at all times . The note did not contain a documented evaluation or assessment for continued use of the lap buddy for Resident 75.<br><br>A review of Resident 75's quarterly IDT care plan conference meeting note, dated 12/13/24, indicated, .Falls: [Resident 75] is at risk for falls .[Resident 75] has a lap buddy but removes it at times . The note did not contain a documented evaluation or assessment for continued use of the lap buddy for Resident 75.<br><br>A review of Resident 75's significant decline IDT care plan conference meeting note, dated 2/16/24, indicated, .A significant decline MDS [minimum data set, a resident assessment tool] was initiated d/t [due to][Resident 75] fracturing her 2nd-5th metatarsals [foot bones] and needing substantial assistance .unable to perform sit to stand activity .using a Hoyer lift [allows a person to be lifted and transferred with a minimum of physical effort] .The following care plans have been reviewed and updated .Falls . The note did not mention the use of a lap buddy and did not contain a documented evaluation or assessment for continued use of the lap buddy for Resident 75.<br><br>During a concurrent interview and record review with Licensed Nurse (LN) 1 on 5/23/24, at 10:56 a.m., LN 1 stated Resident 75 sometimes refused to wear her lap buddy but recently had been compliant. LN 1 stated the reason the lap buddy was used for Resident 75 was to help prevent falls and for her safety. LN 1 confirmed there was not a medical diagnosis from a physician for the use of the lap buddy, or a documented evaluation or assessment in Resident 75's medical record for the lap buddy. LN 1 stated there should have been an initial assessment by a nurse for use of the lap buddy, and periodic assessments for the continued use of the lap buddy in case Resident 75 had a change in condition and could no longer remove the lap buddy or the IDT determined the lap buddy was no longer needed. LN 1 stated the documented assessments should have included whether or not Resident 75 knew what the lap buddy was used for and if Resident 75 was able to remove it on her own.<br><br>A review of the facility's policy and procedure titled Assessment & Reassessment, revised 9/1/13, indicated, . Licensed Nurses conduct nursing assessment of the resident/client .at regular intervals .Additional ancillary assessments are conducted quarterly per facility protocol .a Registered Nurse will complete or directly oversee any necessary nursing assessments . |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43071<br><br>Based on observation, interview, and record review, the facility failed to ensure a resident's assessment was completed accurately for one of 35 sampled residents (Resident 166) when Resident 166's comprehensive assessment did not accurately reflect his dental condition.<br><br>This failure increased the potential for a delay in dental care services.<br><br>Findings:<br><br>Review of Resident 166's Admission Record indicated Resident 166 was admitted to the facility in September 2023 with multiple diagnoses including disturbances of salivary secretions (a combination of signs and symptoms associated with a decrease in the secretion of saliva).<br><br>During a concurrent observation and interview on 5/20/24, at 3:30 PM, Resident 166 stated he had not been seen by a dentist while in the facility. Resident 166 stated, while pointing to his upper gum, that two of his teeth were gone and one tooth had something stuck in it. Resident 166's mouth was observed to have two missing teeth on his left upper jaw, and the first upper tooth (molar) on the right side was black and broken. Resident 166 further stated one of his upper teeth was loose. Resident 166 moved his third upper tooth (molar) on the right side with his fingers back and forth. Resident 166 stated he informed staff at the facility and was told that they would get a hold of a dentist, but nothing happened. Resident 166 stated it was hard to chew his food and took longer to chew his food.<br><br>During a concurrent interview and record review on 5/22/24, at 1:24 PM, with Unit Secretary (US) 1, Resident 166's admission note was reviewed. US 1 verified Resident 166's admission note indicated Resident 166 was admitted with missing teeth and cavities. US 1 confirmed there was no record indicating when the last time Resident 166 was seen by a dentist and no attempts had been made to find out. US 1 stated it should have been done within the first 90 days of being at the facility especially with mention of missing teeth and cavities in the admission note. US 1 stated Resident 166 had not been seen by a dentist since being admitted to the facility.<br><br>Review of Resident 166's nurses admission note dated 9/19/23, indicated, .Resident has own teeth in fair condition. Has Cavities. Has missing teeth to upper and lower gums .<br><br>Review of Resident 166's baseline care plan dated 9/19/2023, indicated Resident 166 had natural teeth and poor dentition (condition of teeth).<br><br>Review of Resident 166's Minimum Data Set (MDS, a standardized assessment tool that measures health status in nursing home residents) assessment dated [DATE], indicated, .section L . Oral/Dental Status . Check all that apply .D. Obvious or likely cavity or broken natural teeth [was not selected] . Inflamed or bleeding gums or loose natural teeth [was not selected] .Z. None of the above were present [was selected] .<br><br>(continued on next page) |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a concurrent interview and record review on 5/22/24, at 4:22 PM, the MDS nurse (nurse who ensures completion of the MDS) stated they assessed the resident and reviewed resident records to complete accurate resident assessments and to be able to compare for changes or decline between each assessment. Resident 166's nurse's admission note was reviewed with the MDS nurse. The MDS nurse verified Resident 166 had cavities and missing teeth to the upper and lower gums upon admission. Resident 166's comprehensive admission MDS assessment dated [DATE] was reviewed with the MDS nurse. The MDS nurse verified the assessment did not reflect that Resident 166 had cavities or broken natural teeth but should have. The MDS nurse stated Resident 166's assessment was inaccurate. The MDS nurse stated it should be accurate because that's how we take care of the resident. The MDS nurse stated when cavities were not documented facility staff would not think it was urgent for the resident to see the dentist. The MDS nurse further stated if it would have been coded correctly Resident 166 would have been referred to the dentist to follow up with concerns with his teeth. The MDS nurse stated Resident 166 did not receive dental services which could affect his chewing if he had pain due to cavities or missing teeth, cavities could have worsened and cause an infection and pain.<br><br>During a concurrent interview and record review on 5/23/24, at 11:36 AM, the Director of Nursing (DON) stated nurses assessed residents' dental health upon admission. If a resident was admitted with cavities or missing teeth, then they would be referred for a dental consult and routine dental exams. The DON stated she expected the MDS nurse to communicate with Medical Records to coordinate a resident's initial dental visit. The DON stated resident assessments should be completed accurately to reflect the resident's present condition, so staff are able to create a plan of care. The DON stated if an assessment was not done accurately then the resident would not receive the required care. The DON stated if a resident did not receive dental services, then it would lead to health complications such as dental pain, infection, new cavities, worsening cavities, difficulty eating, and weight loss.<br><br>Review of a facility policy titled, MDS, MINIMUM DATA SET / RESIDENT ASSESSMENT INSTRUMENT, REVISED 11/19/16, .using the resident assessment instrument (RAI) [ a tool allows care staff to collect the minimum amount of information they require about a resident's strengths, limitations, and preferences to create an individualized care plan] .The assessment must include at least the following .Dental and nutritional status .Documentation of the participation in the assessment will include direct observation and communication with the resident and communication with licensed and non-licensed direct care staff members on all shifts A comprehensive care plan will be developed by the IDT [An interdisciplinary team that brings together knowledge from different health care disciplines to help people receive the care they need], utilizing information obtained during the RAI process, and completed no later than day 21 of admission . |

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| F 0676<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.<br><br>43071<br><br>Based on observation, interview, and record review, the facility failed to ensure necessary care and services were provided to 1 of 35 sampled residents (Resident 166), when Resident 166 did not have oral hygiene supplies and did not receive oral hygiene from staff.<br><br>This failure resulted in poor oral hygiene and had the potential to cause health complications for Resident 166.<br><br>Findings:<br><br>Review of Resident 166's Admission Record indicated Resident 166 was admitted to the facility in September of 2023 with multiple diagnoses including disturbances of salivary secretions (a combination of signs and symptoms associated with a decrease in the secretion of saliva).<br><br>During a concurrent observation and interview on 5/20/24, at 3:30 PM, Resident 166 stated, while pointing to his upper gum, that two of his teeth were gone and one tooth had something stuck in it. Resident 166's mouth was observed to have two missing teeth on his left upper jaw, and the first upper tooth (molar) on the right side was black and broken. Resident 166 stated it was hard to chew his food and took longer to chew his food.<br><br>During a concurrent observation, interview, and record review on 5/21/24, at 3:32 PM, Certified Nursing Assistant (CNA) 3 verified Resident 166 had two missing teeth on his upper left gum, and his third upper tooth on right side was loose. CNA 3 verified Resident 166's first tooth on the upper right side was black, appeared to have a cavity, and looked broken. CNA 3 stated Resident 166's teeth looked not good. CNA 3 stated Resident 166's teeth needed a cleaning. CNA 3 stated Resident 166's teeth looked yellowish and had whitish/yellowish build- up on his teeth. CNA 3 added it might be food particles. CNA 3 stated Resident 166 needed his teeth brushed. CNA 3 stated they offered for residents to brush their teeth after dinner. CNA 3 stated each resident had a personal basket with a toothbrush, toothpaste, and personal hygiene supplies, and was kept in the utility room. CNA 3 stated residents were given their personal supplies anytime they wanted it and after dinner. CNA 3 stated residents would get their supplies in the morning as well. Residents' personal hygiene baskets labeled with their names in the utility room were observed with CNA 3. CNA 3 verified there was not a basket for Resident 166 with his name on it. CNA 3 stated, I don't see it. CNA 3 stated Resident 166's basket was supposed to be in the utility room, and he did not know why it was missing. CNA 3 stated he did not recall Resident 166 brushing his teeth and thought Resident 166 refused to brush his teeth. CNA 3 stated Resident 166 should still have a basket even if he refused to brush his teeth. CNA 3 stated a resident's refusal to brush their teeth would be recorded in their behavior monitoring log. Resident 166's behavior monitoring log was reviewed with CNA 3. CNA 3 verified Resident 166 did not have a refusal of care behavior to monitor. CNA 3 stated oral hygiene care was documented in the electronic record.<br><br>(continued on next page) |

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|---|---|
| F 0676<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a concurrent observation, interview and record review on 5/21/24, at 4:23 PM, CNA 5 stated she cared for Resident 166 yesterday. CNA 5 stated after dinner she would ask residents if they wanted to brush their teeth. CNA 5 stated sometimes they would refuse. CNA 5 stated she would prepare the toothbrush, toothpaste, and mouthwash for the residents to brush their teeth. CNA 5 stated oral hygiene supplies were kept in the utility room. CNA 5 stated Resident 166 refused to brush his teeth yesterday and she documented it in the behavior log. Resident 166's behavior monitoring log was reviewed with CNA 5. CNA 5 verified Resident 166 did not have a refusal of care behavior to monitor. CNA 5 stated she documented residents' oral hygiene task in the electronic record where she would document if the resident performed the task independently, needed assistance, or refused. Resident 166's oral hygiene task for the last 14 days was reviewed with CNA 5. CNA 5 verified it was documented that resident performed the task independently and was not documented as refused. CNA 5 stated she documented yesterday incorrectly. Residents' baskets with personal hygiene supplies in the utility room were observed with CNA 5. CNA 5 stated, He [Resident 166] don't have a basket with oral hygiene supplies. CNA 5 stated Resident 166 should have a basket with a toothbrush, toothpaste, and mouthwash.<br><br>During an interview on 5/22/24, at 08:49 AM, CNA 6 stated oral hygiene was provided to residents during their shower and after breakfast on non-shower days. CNA 6 stated resident's personal hygiene supplies were kept in the utility room in a basket labeled with their name. CNA 6 stated Resident 166's toothbrush and toothpaste were kept in the utility room because otherwise he would keep his toothbrush in his pocket all the time.<br><br>During a concurrent observation and interview on 5/22/24, at 9:10 AM, Resident 166 stated he brushed his teeth this morning, and it was bleeding when he brushed. Resident 166 stated he still had build up in his tooth and pointed to his upper teeth on the right side. Resident 166's teeth were observed to be cleaner than the day before.<br><br>During an interview on 5/23/24, at 11:36 AM, the Director of Nursing (DON) stated she expected staff to provide oral hygiene to the residents twice a day to make sure no food was left in the mouth, cavities did not worsen, and to make residents feel better that their mouth was clean. The DON stated she expected staff to offer and remind residents to brush their teeth, bring supplies to them when it was time for brushing in the morning and at bedtime. The DON stated staff would document in the electronic record if a resident refused oral care. The DON stated residents' toothpaste and toothbrush were kept in the utility room in their own labeled kits/baskets because of the nature of the facility type. Another resident could access and use the toothbrush and that would be an infection control issue. The DON stated residents might not be receiving oral care if they did not have their labeled basket in the utility room.<br><br>Review of a facility policy titled, ORAL CARE & HEALTH, dated 9/1/13, indicated, .Residents/clients receive adequate oral care to maintain dignity, comfort and oral hygiene . |

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| | 05A340 | A. Building<br>B. Wing | 05/23/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Crestwood Manor - 104 | 1130 Monaco Court<br>Stockton, CA 95207 |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42432<br><br>Based on observation, interview, and record review, the facility failed to ensure 2 of 35 sampled residents (Resident 75 and Resident 141) were free from potential accidents and injury when:<br><br>1. A fall mat (a soft mat laid on the floor to cushion a fall) was not laid on the floor while Resident 75 was in bed on 5/21/24 per Resident 75's care plan; and,<br><br>2. Resident 141's bed side rails (metal rail attached to the sides of the bed that could be used for assistance with repositioning) was left in an unsafe position (sticking out from the bed at the floor level).<br><br>Findings:<br><br>1. During a concurrent observation and interview with Licensed Nurse (LN) 4 on 5/21/24, at 8:52 a.m., Resident 75 was observed lying in bed asleep with her fall mat folded up and positioned upright next to Resident 75's nightstand. LN 4 confirmed Resident 75's fall mat was not laid out on the floor next to Resident 75's bed and stated the risks for not implementing the fall mat included a fall with injury that could lead to death.<br><br>During a concurrent interview and record review with LN 1 on 5/23/24, at 10:47 a.m., Resident 75's fall care plan was reviewed. LN 1 confirmed Resident 75 was at risk for falls according to the care plan and a fall mat was added as an intervention to the care plan to prevent injury from falls on 3/7/24.<br><br>A review of Resident 75's care plan, initiated 3/26/14, indicated, .[Resident 75] is at risk for falls r/t [related to] Gait [walking]/balance problems, Psychotropic [mind altering medication] .use, Glaucoma [vision impairment] .Osteoarthritis [pain and stiffness in joints] .Hx [history] of falls .10/30/23-unwitnessed fall outside of bathroom .12/27/23-unwitnessed fall in room .1/27/24-unwitnessed fall in room .4/23/24-Resident had unwitnessed fall in bathroom .3/7/24-Elevated floor mat is added next to [Resident 75's] bed .<br><br>A review of Resident 75's Fall Risk assessment dated [DATE], revealed a score of 18 which indicated Resident 75 was at High Risk for falls.<br><br>43943<br><br>2. A review of Resident 141's clinical record titled, Admission Record, indicated Resident 141's diagnoses included ataxia (loss of coordination and muscle control in arms and legs - leading to a lack of balance and trouble walking).<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a concurrent observation and interview on 5/20/24, at 10:48 a.m., with Certified Nursing Assistant (CNA) 1, Resident 141's bed was observed to be in a low position to the floor. The left side bed rail was up, and the right-side rail was in the down position (touching the floor and angled away from the bed). CNA 1 stated she was unsure why the side rail was angled from the bed and on the floor. CNA 1 stated Resident 141 could have tripped on the bedrail if he got out of bed.<br><br>During a concurrent observation and interview on 5/20/24, at 10:49 a.m., with LN 1, the left side bed rail was up, and the bottom portion of the right-side bed rail was in the down position against the floor and angled away from the bed. LN 1 stated the right side rail was at an angle because the bed was in the low position and forced the side rail to stick out. LN 1 stated Resident 141 was at risk for accidents because his foot could have gotten stuck in the side rail and then cause him to fall.<br><br>During an interview on 5/22/24, at 1:22 p.m., with LN 2, LN 2 stated Resident 141 moved very fast while in his wheelchair or while transferring from the bed to the wheelchair. LN 2 stated Resident 141 was at risk for falls because his side rail stuck out from the bottom of his bed.<br><br>During a concurrent interview and record review on 5/22/24, at 2:59 p.m., with the Maintenance Director (MD), the photograph of Resident 141's right bed rail (photo taken on 5/20/24 at 10:44 a.m.), was reviewed. The MD stated he was not informed of a problem with Resident 141's side rail. MD stated the staff should have informed him via an electronic notification system describing the broken equipment and that it needed to be fixed. MD stated the side rail should not have been at an angle from the side of the bed and could have caused an accident.<br><br>A review of Resident 141's clinical record titled, Fall Risk Assessment, dated 5/13/24, indicated Resident 141 received a score of 10 (high fall risk), due to factors that included low blood pressure (can cause dizziness), unstable gait (a person's manner of walking), being chair bound, balance problems, required use of wheelchair, and was on medications that increased the risk for falls.<br><br>A review of Resident 141's clinical record titled, Care Plan, dated 2/12/21, indicated, Resident 141 was at risk for falls. Interventions included to anticipate and meet the needs of Resident 141.<br><br>A review of the facility's policy and procedure titled, Fall Prevention & Management, revised 4/3/2020, indicated, .Residents scoring high risk per the fall risk assessment process, have strategies implemented to reduce the potential for falls outlined in their plan of care .a care plan will be initiated or updated to provide staff with interventions which are deemed appropriate for the resident .<br><br>During a concurrent interview and record review on 5/23/24, at 8:23 a.m., with the Director of Nursing (DON), the Policies and Procedures (P&P) titled, Side Rails, Bed, dated 11/17/16, and Safety and Dignity of Resident /Client, Maintaining, dated 11/23/16, were reviewed. The P&P titled, Side Rails, Bed, indicated, . Procedure .checking for loosening or bowing of the rails, gaps between the rails and the mattress, or large enough gaps within the rails itself, in which a resident's head, limbs or body may become entrapped . The P&P titled, Safety and Dignity of Resident /Client, Maintaining,, indicated, .report to maintenance or superior any environmental concerns within the resident rooms . The DON stated when the bed was placed in the low position, it bowed out the side rail and placed Resident 141 at risk for accidently stepping in the side rails and sustaining an injury. The DON acknowledged the P&Ps were not followed.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a concurrent interview and record review on 5/23/24, at 8:36 a.m., with the Administrator (ADM), the P&Ps titled, Side Rails, Bed, dated 11/17/16, and Safety and Dignity of Resident /Client, Maintaining, dated 11/23/16, were reviewed. The P&P titled, Side Rails, Bed, indicated, .Procedure .checking for loosening or bowing of the rails, gaps between the rails and the mattress, or large enough gaps within the rails itself, in which a resident's head, limbs or body may become entrapped . The P&P titled, Safety and Dignity of Resident /Client, Maintaining, indicated, .report to maintenance or superior any environmental concerns within the resident rooms . ADM stated the P&Ps were not followed and acknowledged there was a risk for injury with the bed side rail angled out. |

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| F 0791<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide or obtain dental services for each resident.<br><br>43071<br><br>Based on observation, interview, and record review, the facility failed to ensure residents received dental services for 2 of 35 sampled residents (Resident 166 and Resident 75), when:<br><br>1. Dental services were not provided for Resident 166; and,<br><br>2. Dental recommendations were not followed up on for Resident 75.<br><br>These failures resulted in Resident 166 and Resident 75 not obtaining dental services and had the potential to cause health complications for Resident 166 and Resident 75.<br><br>Findings:<br><br>1. A Review of Resident 166's Admission Record indicated Resident 166 was admitted to the facility in September of 2023 with multiple diagnoses including disturbances of salivary secretions (a combination of signs and symptoms associated with a decrease in the secretion of saliva).<br><br>During a concurrent observation and interview on 5/20/24, at 3:30 PM, Resident 166 stated he had not been seen by a dentist since being in the facility. Resident 166 stated, while pointing to his upper gum, that two of his teeth were gone and one tooth had something stuck in it. Resident 166's mouth was observed to have two missing teeth on his left upper jaw and the first upper tooth (molar) on the right side was black and broken. Resident 166 further stated one of his upper teeth was loose. Resident 166 moved his third upper tooth (molar) on the right side with his fingers back and forth. Resident 166 stated he informed the facility staff and was told that they would get a hold of a dentist, but nothing happened. Resident 166 stated it was hard to chew his food and took longer to chew his food.<br><br>During a concurrent observation and interview on 5/21/24, at 3:32 PM, Certified Nursing Assistant (CNA) 3 verified Resident 166 had two missing teeth on his upper left gum, and his third upper tooth on the right side was loose. CNA 3 verified Resident 166's first tooth on the upper right side was black, appeared to have a cavity, and looked broken. CNA 3 stated Resident 166's teeth looked not good. CNA 3 stated Resident 166's teeth needed a cleaning. CNA 3 stated Resident 166's teeth looked yellowish and had whitish/yellowish build up on his teeth.<br><br>During an interview on 5/22/24, at 11:09 AM, Resident 166 stated his teeth on the upper right side were hurting including his loose tooth. Resident 166 stated, I need a deep cleaning. Resident 166 further stated his teeth bled when he brushed. Resident 166 stated his teeth had been hurting since last month and he had told multiple staff members.<br><br>A Review of Resident 166's nurses admission note dated 9/19/24, indicated, .Resident has own teeth in fair condition. Has Cavities. Has missing teeth to upper and lower gums .<br><br>Review of Resident 166's baseline care plan dated 9/19/23, indicated Resident 166 had natural teeth, poor dentition (teeth).<br><br>(continued on next page) |

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| F 0791<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of Resident 166's care plan initiated 9/20/23, indicated, .The resident has oral/dental health problems r/t Poor oral hygiene. RESIDENTS PERCEPTION OF NEED: My teeth are ok. RESIDENTS STRENGTHS: able to make needs known .Interventions .Monitor/document/report PRN [as needed] any s/sx [sign and symptoms] of oral/dental problems needing attention: Pain (gums, toothache, palate), Abscess, Debris in mouth, Lips cracked or bleeding, Teeth missing, loose, broken, eroded, decayed .The resident needs lip balm/ointment PRN .<br><br>During a concurrent interview and record review on 5/21/24, at 4:38 PM, Licensed Nurse (LN) 3 stated resident's dental notes were kept in their physical chart (paper chart). Resident 166's physical chart was reviewed with LN 3. LN 3 stated, I don't see anything regarding dental in Resident 166's chart. LN 3 verified there was no record indicating Resident 166 was seen by a dentist.<br><br>During a concurrent interview and record review on 5/22/24, at 1:24 PM, Unit Secretary (US) 1 stated residents obtained routine dental services every 6 months to a year. US 1 stated nurses assessed residents upon admission, listed their name in a binder if they needed to be seen by a dentist, and were usually seen within 90 days after admission. US 1 further stated nurses checked residents' history and updated their medical record with the last time the resident was seen by a dentist. US 1 stated some residents were seen by an outside provider for dental services based on their insurance and the facility would schedule them with their outside provider. Resident 166's admission note was reviewed with US 1. US 1 verified Resident 166's admission note indicated Resident 166 was admitted with missing teeth and cavities. US 1 confirmed there was no record indicating when the last time Resident 166 was seen by a dentist and no attempts had been made to find out. US 1 stated it should have been done within the first 90 days of being at the facility especially with mention of missing teeth and cavities in the admission note. US 1 stated it was important to know when the last time a resident had a dental check up to possibly avoid incidents of infection, choking, and also to know when the next follow up and/or routine checkup was due. US 1 stated Resident 166 had not been seen by a dentist since being admitted to the facility.<br><br>During a concurrent interview and record review on 5/22/24, at 4:22 PM, the MDS (Minimum Data Set: a standardized assessment tool that measures health status in nursing home residents) nurse verified Resident 166 had cavities and missing teeth to the upper and lower jaw upon admission. The MDS nurse stated Resident 166 should have been referred to the dentist to follow up with concerns with his teeth. The MDS stated Resident 166 did not receive dental services which could affect his chewing if he had pain due to cavities or missing teeth, the cavities could have worsened and can cause an infection and pain.<br><br>During an interview on 5/23/24, at 9:11 AM, US 2 stated she scheduled residents' dental appointments who were seen by outside providers. US 2 stated nurses assessed the residents upon admission, if they had any complaints then the nurses would list their name in a binder to be seen by the dentist. US 2 further stated the consultation coordinator checked the binder and informed her to schedule appointments for residents who needed to be seen by an outside provider. She thought residents who obtained dental services from outside providers were seen annually for routine dental services. When asked what the process was to keep track of residents' routine dental visits, US 2 replied, I have no idea who gets seen at what month and what year for routine dental services. US 2 stated she did not keep a log of residents' dental visits to ensure they received routine dental services. She thought even residents who were seen by outside providers received routine dental services from their in-house dentist. US 2 stated she was never told to schedule a dental appointment for Resident 166.<br><br>(continued on next page) |

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| F 0791<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 5/23/24, at 10:09 AM, the MDS nurse stated residents who received dental services from outside providers due to their insurance were not seen by the in-house provider for routine dental services. The MDS nurse stated those residents received routine dental services from their outside provider. The MDS nurse stated residents were needed to be seen at least annually or as needed for dental services to find any problem with their teeth, including pain and infection, and to maintain dental health. The MDS nurse stated the MDS nurses would put newly admitted resident's name in the binder to see the dentist for routine services.<br><br>During an interview on 5/23/24, at 11:31 AM, US 1 stated she obtained Resident 166's dental record from his outside provider which indicated his last dental visit was on 9/25/2019. US 1 stated, Yeah, that's bad.<br><br>During a concurrent interview and record review on 5/23/24, at 11:36 AM, the Director of Nursing (DON) stated residents received routine dental services at least annually and as needed to make sure they were getting checked routinely to promote dental health, prevent oral issues such as cavities, and infection. The DON stated nurses assessed residents' dental health upon admission, if a resident was admitted with cavities or missing teeth, they were referred for a dental consult, and to initiate routine dental exams. The DON stated she expected the MDS nurse to communicate with Medical Records to coordinate resident's initial dental visit. The DON stated during care conferences the team reviewed resident records to make sure the resident received all consultations including dental and to ensure all follow ups were completed. The DON stated she expected the care conference team to ensure all residents received annual dental services including residents seen by an outside provider. The DON stated if a resident did not receive dental services, then it would lead to health complications such as dental pain, infection, new cavities, worsened cavities, difficulty eating, and weight loss.<br><br>42432<br><br>2. During an interview on 5/21/24, at 10:28 a.m., Resident 75 stated she had not seen a dentist in a long time.<br><br>A record review of Resident 75's dental care plan, initiated 5/17/15, indicated, .[Resident 75] has impaired dentition [teeth] r/t [related to] HX [history] poor oral hygiene .coordinate arrangements for dental care .<br><br>A record review of Resident 75's dental note, dated 9/29/23, indicated, .several attempts made to extract #2 [the molar on the upper right side of the mouth] but still unsuccessful. Need to see patient in bed with bite block [help prevent your upper teeth and lower teeth from touching] .<br><br>A record review of Resident 75's dental note, dated 10/27/23, indicated, .tooth #2 can be restored .DDS [dentist] recommends to restore tooth instead of ext [extraction] .NOA [authorization] pending .<br><br>During an interview with the Consultant Coordinator (CC) on 5/22/24, at 2:33 p.m., the CC confirmed Resident 75's last dental visit was 10/27/23. The CC stated the company who performed the residents dental care came to the facility every month. The CC stated seven months was not an appropriate amount of time to wait for the recommended dental treatment for Resident 75.<br><br>(continued on next page) |

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| F 0791<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview with Resident 75 on 5/22/24 at 4:50 p.m., Resident 75 pointed at a lower right molar in her mouth and stated she had tooth pain.<br><br>Review of a facility policy titled, DENTAL SERVICES, revised 10/28/17, indicated, .Routine and emergency dental services are available to meet the oral and dental health needs of residents .Licensed Nursing staff are responsible for notifying Social Services of a resident's need for dental services .Social Services personnel are responsible for assisting the resident/family in making dental appointments and transportation arrangements . |