STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555118	A. Building B. Wing	08/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Almond Vista Healthcare	2030 Evergreen Avenue Modesto, CA 95350

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 21382 Based on interview, record review, and facility policy review, the facility failed to correctly issue Medicare Part A beneficiaries CMS-10055 (Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) when the residents completed therapy or skilled nursing services for two of three residents (Residents (R) 76, and R102) reviewed for beneficiary notices. This failure had the potential of a resident or responsible party to make an informed decision related to continuing to receive Medicare A services, by having the facility continue services and bill Medicare A, continue the services, and bill the resident, or no receive the services. Findings include: 1. Review of the facility completed SNF Beneficiary Protection Notification Review form revealed R76 was admitted for a Medicare A stay on 07/15/24 after a short stay in a hospital. Her last covered date (LCD) was 07/27/24. R76 received a SNFABN on 07/27/24 with financial liability to begin on 07/28/24. Review of R76's, facility provided, SNFABN was revealed in the section titled Care facility staff documented You no longer require skilled of a daily basis. In the section labeled Estimated Cost the facility wrote $1,071. 00 and in the section for Reason Medicare May Not Pay was written Medicare will not pay for your stay at this facility unless you require skilled care daily. R76 signed the SNFABN for herself. During an interview on 08/02/24 at 1:06 PM, R76 confirmed she signed the SNFABN and chose not to continue receiving therapy. 2. Review of the facility completed SNF Beneficiary Protection Notification Review form revealed R102 completed a Medicare A stay on 03/21/24. R102 was given a SNFABN on 03/18/24 with her becoming financially responsible for her stay on 03/22/23. Review of R102's, facility provided, SNFABN was revealed in the section titled Care facility staff documented, You no longer require skilled care on a daily basis. The Estimated Cost was $0.00 and the Reason Medicare May Not Pay was completed as Medicare will not pay for your stay unless you require skilled daily care. (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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/02/24 at 1:45 PM, R102 she confirmed she understood the SNFABN and no longer wanted therapy. Review of the SNFABN instructions revealed the Care section should have been completed indicating services the facility believed Medicare would no longer cover for R76 and R102 in plain language, Inpatient Skilled Nursing Facility Stay was listed as an example. The Reason Medicare May Not Pay section should have been completed with a brief explanation of why the beneficiary's medical needs or condition to not meet Medicare coverage guidelines. The reason must be sufficient and specific enough to enable the beneficiary to understand why Medicare may deny payment. The Cost section of the SNFABN should have contained an estimate of the costs for daily skilled care. During an interview on 08/02/24 at 2:00 PM, the Social Services Director (SSD) indicated she had been instructed in the past by the state surveyors the SNFABN was to be completed showing their return to Medicaid as a payor source for their continued stay in the facility. The SSD was not aware the SNFABN was to be completed to provide information related to the skilled services ending. The facility followed the directions for completion of the SNFABN. The directions were titled, Form Instructions Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage (SNFABN) Form CMS-10055 revealed the directions stated the facility was to complete the section titled, Care Section. The directions indicated the facility was to enter . the SNF lists list the care that it believes may not or won't be covered by Medicare. In the Reason Medicare May Not Pay section stated the The SNF must give the applicable Medicare coverage guideline(s) and a brief explanation of why that beneficiary's medical needs or condition do not meet Medicare coverage guidelines . In the box labeled .Estimated Cost Section. the facility was supposed to document, . In this section, the SNF enters the estimated cost of the corresponding care that may not be covered Medicare.

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15406 Based on observation, interview, record review, and policy review, the facility failed to ensure two out of two residents (Resident (R) 78 and R203) reviewed for restraints out of total of 32 sampled residents were free from physical restraints. R78 was positioned in bed in a manner to prevent him from getting out of bed as a fall intervention. R203 was observed with his hand to mid forearm wrapped with a bandage with a sock worn over it on his left hand/arm that he was not able to remove. Unnecessary physical restraints created the potential for psychological distress to R78 and R203. Findings include: 1. Review of the undated Admission Record in the electronic medical record (EMR) under the Profile tab revealed R78 was admitted to the facility on [DATE]; current diagnoses included chronic obstructive pulmonary disease (COPD), chronic pain, major depressive disorder, psychotic disorder with delusions, and anxiety disorder. Review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/23/24 in the EMR under the MDS tab revealed R78 was severely impaired in cognition with a Brief Interview for Mental Status (BIMS) of seven out of 15. R78 exhibited physical behaviors, verbal behaviors, and other behavioral symptoms not directed towards others, one to three days during the assessment period. R78 required substantial/maximal assistance to go from a lying to sitting position on the side of the bed and from sitting to standing. R78 was impaired in range of motion on both sides to his lower extremities. R78 experienced shortness of breath or trouble breathing when lying flat. According to the MDS R78 did not utilize restraints. Review of the Orders in the EMR under the Resident tab revealed no physical restraints had been ordered for R78. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 07/30/24 from 1:21 PM through 1:50 PM, staff members Certified Nursing Assistant (CNA) 1 and Resident Companion (RC) 1 were in R78's room with R78. The bed was positioned such that the head of the bed was down and in a low position near the floor. The foot of the bed was up in an elevated position. The foot of the bed was approximately a foot and a half higher than the head of the bed. The bed had third rails in the up position on both sides at the head of the bed. There was a large foam wedge under the middle section of the bed in addition to a bunched-up blanket, creating a large lump on the left side of the bed midsection (while standing at the foot of the bed and looking toward the head of the bed). There were mats on the floor on both sides of the bed. CNA1 was talking to R78 and trying to get him back into bed by moving his legs back onto the mattress from over the side of the bed. R78 had been sitting on the edge of the bed on the left side in the middle of the mattress. R78 began to holler, yelling, You are manhandling me. God damn. Get out of my way. How many times do I have to tell you? CNA1 and RC1 talked quietly to the resident and continued to try to get him to lay back down, repositioning his legs back onto the mattress when he got his legs over the side while trying to sit up. CNA1 and RC1 asked R78 to save his strength and to lay back down. R78 continued to try to get to a sitting position on the left side of the bed, struggling as the head of the bed was low and his feet were elevated on the mattress. This continued. R78 stated, Help me up. R78's right arm was shaking and he was upset and angry. Each time R78 requested help to sit up, CNA1 and RC1 talked to him and physically moved his legs from over the side of the bed back onto the mattress to stay in bed. CNA1 and RC1 asked R78, Can you lay in bed? R78 stated, No. I want to get up. R78 told CNA1 and RC1, Let me do it myself. R78 struggled again, with his head down below his legs that were significantly higher, to get to a sitting position. R78 was unable to fully sit up on the side of the bed, struggling while trying. R78 then asked, Are you going to help me or not? CNA1 and RC1 continued to reposition R78 into a lying position in the bed by moving his legs from over the side of the mattress back onto the mattress, preventing him from getting up. R78 stated he needed to go to the bank and get groceries and he needed help to get up. This scenario continued with CNA1 and RC1 talking calmly to the resident and assisting him back to a lying position on the mattress with the head of the bed low and feet high. RC1 told R78 that activities staff could help take him to the bank, but he would have to wait. R78 exclaimed loudly, I know all this! I'll get myself up. At this time RC1 and CNA1 were asked about the awkward positioning of the bed and stated, We position the bed this way with the head of the bed down and foot of the bed up to keep him from getting out of bed. RC1 and CNA1 stated R78 was at risk of falling, was agitated, and it was best to keep him from getting up. RC1 and CNA1 stated the bed positioning was safer because it helped to prevent him from being able to get out/up. R78 continued to struggle in the bed. CNA1 stated he was trying to be careful to prevent falls. R78 continued to struggle and put his feet over the edge of the bed but was unable to sit up independently. CNA1 stated they had placed a wedge under the left side of the mattress as a form of protection so R78 could not come out of the bed on that side. RC1 stated she was a sitter and R78 was assigned a sitter all the time due to fall risk. Review of the Care Plan dated 02/05/24 in the EMR under the Care Plan tab identified a problem of Risk for falls. The goal was for R78 to be free from falls. Intervention in pertinent part was to assist the resident with transfers. The Care Plan did include positioning the bed in a manner which prevented him from getting up with the head of the bed low and his feet elevated and with a wedge under one side to create a barrier. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Care Plan dated 09/15/23 in the EMR under the Care Plan tab identified a problem of [R78] has a behavior problem r/t [related to] yelling/screaming/cussing, physical behaviors, and rejects care at times. The goal was for R78 to have fewer episodes. Interventions included in pertinent part, Anticipate and meet the resident's needs . Divert attention. Remove from situation and take to alternate location as needed. Requires a sitter when available. During an interview on 07/31/24 at 3:35 PM, CNA2 stated R78 needed a lot of help with activities of daily living but could get out of bed by himself although he could not walk. CNA2 stated R78 was at risk of falling and had a sitter to make sure he did not get out of bed. CNA2 stated if R78 started acting up, she got him up out of bed and into the Geri chair (reclining wheelchair) and took him outside. When asked about the position of the bed, CNA2 stated the head of the bed should be up. CNA2 stated she had seen CNAs position R78 in the bed with the head of the bed down and the foot of the bed up because it was harder for R78 to get out of bed. CNA2 stated she did not position him this way because it made him angrier. CNA2 verified R78 was not capable of operating the bed controls. During an interview on 08/01/24 at 1:00 PM, Assistant Director of Nursing (ADON) 1 stated R78 was on one-to-one observation due to him falling a lot. ADON1 stated if R78 wanted to get out of bed, the staff should assist him to get up, stating he got tired of being in bed and could not stay there all the time. ADON1 stated R78 should not be positioned with the head of the bed low and foot of the bed high and that this could function as a restraint prohibiting him from getting out of bed. ADON1 stated R78 should be positioned with the head of the bed at 30 degrees. During an interview on 08/02/24 at 3:44 PM, Licensed Vocational Nurse (LVN) 5 stated she was R78's nurse on 07/30/24 during day shift. LVN5 stated she was passing medications on Station 1 when R78 was trying to get out of bed. LVN5 stated she was not aware of the incident of R78 becoming agitated, wanting to get out of the bed, and it had not been reported to her. LVN5 stated she had not seen the bed positioned with the head down and feet elevated; however, stated that position would act as a restraint to R78. LVN5 stated the head of the bed should be elevated to prevent shortness of breath. During an interview on 08/02/24 at 4:52 PM, the Director of Nursing (DON) stated she had been in her position a short time and did not know R78 well. The DON stated CNA1 and RC1 were trying to keep R78 safe by keeping him in bed. The DON stated the bed should not be in a position in which the head was low, the foot of the bed was high, and it could be considered a restraint if used to keep him from getting out of bed. 2. Review of the undated Admission Record, located in the EMR under the Profile tab, revealed R203 was admitted to the facility on [DATE]; diagnoses included encephalopathy (any brain disease that alters brain function or structure) and cerebrovascular disease. Review of the admission MDS with an ARD of 07/21/24, located in the EMR under the MDS tab, revealed R203 was severely impaired in cognition with a BIMS score of three out of 15. R203 exhibited other behavioral symptoms not directed toward others one to three days during the assessment period. R203 was impaired on one side to his upper extremities and to both sides of his lower extremities. R203 was dependent on staff for most of his activities of daily living (ADLs), including dressing. R203 was not documented as using a restraint. Review of the Orders in the EMR under the Resident tab revealed no physical restraints had been ordered for R203. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 07/30/24 at 10:49 AM with Family Member (F) 203, R203 was lying in bed. F203 was observed with a blue sock on his left hand with a gauze bandage wrapped underneath the sock. The bandage came up approximately three inches above his wrist on his arm and the sock was on top of the bandage that was secured. F203 stated he did not know what sock/bandage was for, stating possibly R203 had been trying to scratch himself. F203 stated R203 had been more active a few days ago and his condition was declining. F203 stated R203 had a stroke in February 2024 and was now on hospice care. During an observation on 07/30/24 at 1:32 PM, the Restorative Nursing Assistant pulled back the covers in the bed over R203's left hand and the bandage/sock combination was in place. The Restorative Nursing Assistant stated she did not know why R203 had the bandage/sock combination in place. Review of the Care Plan, dated 07/26/24 and located in the EMR under the Care Plan tab, revealed a problem of ADL self-care performance deficit r/t [related to] weakness/decreased mobility, dx [diagnosis] of acute encephalopathy, DM [diabetes mellitus], dysphagia [swallowing disorder], hx [history] of CVA [cerebrovascular accident or stroke]. The Care Plan did include application of a sock to R203's hand and did not identify restraint use. During an interview on 07/31/24 at 3:42 PM, CNA2 stated she had not applied a sock to R203's hand and had not seen this. CNA2 stated R203 had previously unfastened his incontinence brief on one side and then urinated in the bed, soiling the bedding and that was likely why he had something applied to his left his hand. CNA2 stated R203 was confused and dependent for care. During an interview on 08/01/24 at 1:18 PM, LVN3 (the wound care nurse) stated she was not aware of R203 wearing a sock on his left hand and further stated he should not be wearing one. LVN3 stated R203 had one skin tear to his forearm that had a dry dressing applied; however, she was not aware of other skin issues to his arms or scratching. ADON1, who was present, stated the sock would prevent R203 from accessing his body and there should be a physician's order for something like that. During an interview on 08/02/24 at 3:35 PM, LVN5 stated she was R203's nurse on 07/30/24 during day shift. LVN5 stated she was notified by the day shift CNA around 6:30 AM on 07/30/24 that R203 had a sock on his left hand. LVN5 stated she had not been aware of the sock being there prior to that day. LVN5 stated there was nothing in report about the sock and she asked the night shift nurse about it and was told the night shift nurse did not know about it. LVN5 stated she meant to go and check on the application of the sock on R203's left hand but got busy, and when she went to give R203 medications, his arm was covered with the bedding and she forgot. LVN5 stated she was not aware of a reason for the application of the sock. LVN5 stated R203 was anxious at times and placed his hand in his incontinence brief and rubbed himself. LVN5 stated R203 was not able to put the sock on his hand and would not be able to remove it either. During an interview on 08/02/24 at 3:32 PM, the hospice LVN stated she had never seen a sock on R203's hand and there were no directions from hospice that would warrant it. The hospice LVN stated R203 would not have been able to put the sock on himself and did not think he could remove it. The hospice LVN stated R203's sister stated he was putting his hand in his brief and was fidgeting in that area. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/02/24 at 4:12 PM, the hospice Registered Nurse (RN) stated she saw R203 on 07/30/24 and noticed a sock on his left hand. The hospice RN stated she did not know why it was there or if it was a facility intervention for something. The hospice RN stated hospice would not order a sock to be applied. During an interview on 08/02/24 at 4:43 PM, the DON stated she had heard about the sock that was applied on 07/30/24 to R203's hand. The DON stated she did not know why it was there or who applied it. The DON verified the bandage/sock combination could function as a restraint. The DON stated for all restraints there should be a physician's order, assessment, and care plan in place. Review of the facility's Use of Restraints policy dated April 2017 revealed, Restraints shall only be used to treat the resident's medical symptom(s) and never for discipline or staff convenience, or for the prevention of falls . The definition of a restraint is based on the functional status of the resident and not the device. If the resident cannot remove a device in the same manner in which the staff applied it given that resident's physical condition (i.e. side rails are put back down, rather than climbed over), and this restricts his/her typical ability to change position or place, that device is considered a restraint . Examples of devices that are/may be considered physical restraints include . hand mitts . Practices that inappropriately utilize equipment to prevent resident mobility are considered restraints and are not permitted .

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15406 Based on record review, interviews, and policy review, the facility failed to ensure four of five residents (Resident (R) 99, R126, R68, and R102) reviewed for hospitalization out of a total sample of 32 were given a written notice prior to or as soon as practical following transfer to the hospital. Additionally, there was no documentation that the Ombudsman was notified of the transfers for R68 or R102. This failure created the potential for residents or their responsible party to not have the information needed to understand their transfer to the hospital. Findings include: 1. Review of the undated Admission Record in the electronic medical record (EMR) under the Profile tab revealed R99 was admitted to the facility on [DATE]. Review of R99's annual MDS with an Assessment Reference Date (ARD) of 07/07/24, located in the EMR under the MDS tab, revealed R99 was unimpaired in cognition with a Brief Interview for Mental Status (BIMS) score of 14 out of a total of 15. Review of the SBAR [Situation, Background, Assessment, and Recommendation] Summary for Providers, dated 06/17/24 and located in the EMR under the Progress Notes tab, revealed on this date, Nursing observations, evaluation, and recommendations are CNA [Certified Nursing Assistant] notified LN [Licensed Nurse] that patient was breathing, but not responding to verbal commands or touch. LN assessed pt [patient] vital signs were unstable. LN attempted to arouse pt with eyes opening for only brief seconds. Patient not able to get words out. Patient tremors increased in severity from pt normal. LN notified supervisor and MD [Medical Doctor]. LN called 911. Ambulance arrived transported pt to [hospital] for further evaluation. Review of a Health Status Note dated 06/18/24 in the EMR under the Progress Notes tab revealed R99 was admitted to the hospital with diagnoses of sepsis (severe response to an infection in which the immune system attacks the body's tissues) and septic shock (sepsis accompanied by a drop in blood pressure that can lead to organ failure). Review of the Census located in the EMR under the Resident tab revealed on 06/28/24 R99 was readmitted to the facility after hospitalization . During an interview on 07/30/24 at 12:33 PM, R99 stated she was recently sent to the hospital for a severe infection. R99 stated the facility had not provided a written discharge notice at the time or immediately following hospitalization on [DATE]. R99 stated she was her own RP. Review of the Notice of Proposed Transfer or discharge date d 06/17/24 in the EMR under the Evaluation tab revealed R99 was notified in person of the facility-initiated transfer to the hospital. The section for Resident or RP signature and date the resident or RP received the notice was blank (not filled out). (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/01/24 at 11:06 AM, the Social Service Director (SSD) stated the nurses issued discharge notices when residents were sent to the hospital in emergency situations (via 911 and an ambulance). During an interview on 08/01/24 at 1:26 PM, Licensed Vocational Nurse (LVN) 3 stated nurses filled out the transfer/discharge notice with emergent transfers to the hospital. LVN3 stated the resident did not receive a copy of the notice; the notice went to the hospital and to the ombudsman. During an interview on 08/02/24 at 4:35 PM, the Director of Nursing (DON) stated the discharge notice was not provided in writing to the resident or RP when a resident was transferred emergently to the hospital. The DON stated a call would be placed to the RP; however, the notice was not provided in writing. The DON stated there was no process in place for providing written transfer/discharge notices for emergent hospitalization s. The DON stated R99's family member was notified via a phone call of R99's transfer to the hospital. The DON verified R99 was her own RP. 25232 2. Review of R126's undated "Admission Record," located under the EMR "Profile" tab, indicated R126 was readmitted to the facility on [DATE] with diagnoses including dementia. Review of "General Notes," located under the tab "Notes" in the EMR, dated 02/05/24 indicated "Patient was sent to hospital via ambulance d/t [due to] unresponsiveness. Patient was observed sitting-slouched in her wheelchair . Patient was breathing and responding to physical stimuli but could not verbalize appropriately. Patient was taken to the hospital for further evaluation." Review of the EMR "Evaluations" tab indicated no evidence of a written transfer notice to the resident or RP for hospitalization on [DATE]. During an interview on 08/01/24 at 4:15 PM, the DON confirmed R126 did not have a written notice of transfer to the hospital for 02/05/24. 40824 3. Review of R68's undated "Admission Record" located in the EMR under the "Profile" tab included an original admitted [DATE] and most recent readmission on 06/30/24. Review of R68's "Clinical Census" located in the EMR under the "Census" tab indicated on 08/10/23 a hospital leave with readmission on 08/13/23. Review of R68's "Progress Note," located in the EMR under the "Progress Note" tab and dated 08/10/23, included transfer to the Emergency Department (ED) for foley catheter evaluation and possible obstruction/malfunction with bleeding. No documentation was located in the EMR indicating a transfer/discharge notice was provided to the resident or representative. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/01/24 at 3:15 PM, the Director of Nursing (DON) confirmed that R68's hospitalization from [DATE]-[DATE] did not a include a transfer/discharge notification to the resident or RP; or Ombudsman notification. 4. Review of R102's "Admission Record" located in the EMR under the "Profile" tab included an original admitted [DATE] and most recent readmission on 03/12/24. Review of R102's "Clinical Census" located in the EMR under the "Census" tab indicated on 03/08/24 a hospital leave with readmission on 03/12/24. Review of R102's "Progress Note" located in the EMR under the "Progress Note" tab and dated 03/08/24 included transfer to the ED for diarrhea, coffee ground emesis, high blood pressure, and anxiety. No documentation was located in the EMR indicating a transfer/discharge notice was provided to the resident or representative. During an interview on 08/01/24 at 3:15 PM, the DON confirmed that R102's hospitalization from [DATE]-[DATE] did not a include a transfer/discharge notification to the resident or RP; or Ombudsman notification but should have. Review of the facility policy titled "Transfer or Discharge Notice" revised 03/2021 indicated " . 3. Except as specified below, the resident and his or her representative are given a thirty (30-day) advance written notice of an impending transfer or discharge from this facility. 4. Under the following circumstances, the notice is given as soon as it is practicable but before the transfer or discharge: . d. An immediate transfer or discharge is required by the resident's urgent medical needs . 5. The resident and representative are notified in writing of the following information: a. The specific reason for the transfer or discharge; b. The effective date of the transfer or discharge; c. The location to which the resident is being transferred or discharged . 6. A copy of the notice is sent to the Office of the State Long-Term Care Ombudsman at the same time the notice of transfer or discharge is provided to the resident and representative ."

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15406 Based on interview, record review, and policy review, the facility failed to ensure five out of five sampled residents who were reviewed for hospitalization (Residents (R)126, R151, R99, R69, R102) were provided with a bed hold notice within 24 hours of emergent transfer to the hospital. This failure increased the potential that residents would not know to request a bed hold and may be unable to return to the facility. Findings include: 1. Review of the undated Admission Record, located in the electronic medical record (EMR) under the Profile tab, revealed R99 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD), heart failure, and chronic kidney disease (CKD). R99 was her own responsible party (RP). Review of R99's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/07/24, located in the EMR under the MDS tab, revealed R99 was unimpaired in cognition with a Brief Interview for Mental Status (BIMS) score of 14 out of a total of 15. Review of the SBAR [Situation, Background, Assessment, and Recommendation] Summary for Providers, dated 06/17/24 and located in the EMR under the Progress Notes tab, revealed on this date, Nursing observations, evaluation, and recommendations are CNA [Certified Nursing Assistant] notified LN [Licensed Nurse] that patient was breathing, but not responding to verbal commands or touch. LN assessed pt [patient] vital signs were unstable. LN attempted to arouse pt with eyes opening for only brief seconds. Patient not able to get words out. Patient tremors increased in severity from pt normal. LN notified supervisor and MD [Medical Doctor]. LN called 911. Ambulance arrived transported pt to (hospital) for further evaluation. Review of a Health Status Note dated 06/18/24 in the EMR under the Progress Notes tab revealed R99 was admitted to the hospital with diagnoses of sepsis (severe response to an infection in which the immune system attacks the body's tissues) and septic shock (sepsis accompanied by a drop in blood pressure that can lead to organ failure). Review of the Census in the EMR under the Resident tab revealed on 06/28/24 R99 was readmitted to the facility after hospitalization . During an interview on 07/30/24 at 12:33 PM, R99 stated she was recently sent to the hospital for a severe infection. R99 stated the facility had not provided a bed hold notice at the time or immediately following hospitalization on [DATE]. R99 stated she was her own RP. The EMR was reviewed and there was no bed hold notice dated 06/17/24. During an interview on 08/01/24 at 11:06 AM, the Social Service Director (SSD) stated the nurses issued bed hold notices when residents were sent to the hospital in emergency situations (via 911 and an ambulance). (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/01/24 at 1:26 PM, Licensed Vocational Nurse (LVN) 3 stated nurses filled out the bed hold notice with emergent transfers to the hospital. LVN3 stated residents did not receive a copy of the bed hold notice. During an interview on 08/02/24 at 4:35 PM, the Director of Nursing (DON) verified there was no bed hold notice dated 06/17/24 corresponding with R99's emergent transfer to the hospital. The DON stated normally residents were notified of the bed hold verbally when hospitalized . The DON verified R99 was her own RP. 25232 2. Review of R126's "Admission Record," located under the EMR tab "Profile," indicated that R126 was admitted to the facility on [DATE] and most recently readmitted on [DATE] with diagnoses including dementia. Review of the "Nurse's Notes," dated 06/25/24, located in the EMR under tab "Notes" revealed "Per family request. Patient is not her usual self. She is having altered mental status (AMS). Requested to be sent to the acute for evaluation." Review of R126's facility provided "Notice of Proposed Transfer or Discharge" dated 06/25/24 revealed "Facility initiated discharge . The resident's welfare and needs cannot be met in the facility." Review of the EMR under tab "Documents" indicated no evidence of a bed hold notice for hospitalization [DATE]. During an interview on 08/01/24 at 1:25 PM, the DON confirmed R126 did not have a bed hold for the hospitalization . During an interview on 08/02/24 at 2:00 PM, Resident Companion 2 confirmed that there was no audit for bed hold for R126's hospitalization on [DATE]. 3. Review of "Face Sheet," located under EMR tab "Profile" indicated R151 was admitted to the facility on [DATE] for dementia and chronic obstructive pulmonary disease (COPD). Review of "Nurses Note," dated 05/10/24 and located under tab "Notes" in the EMR indicated "[R151] becoming increasingly lethargic . agitated, needing additional assistant . Sent patient to emergency department [ED] to rule out (r/o) sepsis." R151 did not return to the facility. Review of the EMR located under tab "Documents" indicated no evidence of a bed hold. During an interview on 08/02/24 at 7:50 AM, the DON confirmed there was not a bed hold. 40824 4. Review of R68's "Admission Record," located in the EMR under the "Profile" tab, included an original admitted [DATE] and most recent readmission on 06/30/24. R68's primary diagnosis was chronic systolic congestive heart failure. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R68's "Clinical Census" located in the EMR under the "Census" tab indicated on 08/10/23 a hospital leave with readmission on 08/13/23. Review of R68's "Progress Note" located in the EMR under the "Progress Note" tab and dated 8/10/2023 included transfer to the Emergency Department (ED) for foley catheter evaluation and possible obstruction/malfunction with bleeding. No documentation was located in the EMR indicating a bed hold notice was provided to the resident or representative. During an interview on 08/01/24 at 3:15 PM, the DON confirmed that R68's hospitalization from [DATE]-[DATE] did not a include a bed hold notification but should have. 5. Review of R102's "Admission Record," located in the EMR under the "Profile" tab, included an original admitted [DATE] and most recent readmission on 03/12/24. R102's primary diagnosis was myocardial infarction. Review of R102's "Clinical Census," located in the EMR under the "Census" tab, indicated on 03/08/24 a hospital leave with readmission on 03/12/24. Review of R102's "Progress Note" located in the EMR under the "Progress Note" tab and dated 03/08/24 included transfer to the ED for diarrhea, coffee ground emesis, high blood pressure, and anxiety. No documentation was located in the EMR indicating a bed hold notice was provided to the resident or representative. During an interview on 08/01/24 at 3:15 PM, the DON confirmed that R102's hospitalization from [DATE]-[DATE] did not a include a bed hold notification but should have. Review of the facility policy titled "Bed-Holds and Returns" revised 10/2022 indicated ". All residents/representatives are provided written information regarding the facility and state bed-hold policies, which address holding or reserving a resident's bed during periods of absence (hospitalization or therapeutic leave). Residents, regardless of payor source, are provided written notice about these policies at least twice: a. notice 1: well in advance of any transfer . and b. notice 2: at the time of transfer (or, if the transfer was an emergency, within 24 hours) ."

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40824 Based on interview, record review, and facility policy review, the facility failed to ensure one of two residents (Resident (R) 95) reviewed for "Pre-Admission Screening and Resident Review (PASARR)" had a level two assessment completed. Specifically, the facility failed to re-submit a positive PASSAR Level I screening, after a PASARR Level II was not able to be conducted. This failure placed the resident at risk for unmet care needs and not receiving appropriate mental health support/services as needed. Findings include: Review of R95's "Admission Record," located in the electronic medical record (EMR) under the "Profile" tab, showed a facility admitted [DATE] and re-admission on 06/03/24. R95's primary medical diagnoses included schizoaffective disorder and bipolar disorder. Review of R95's admission "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 05/03/24, located in the EMR under the "MDS" tab, included a "Brief Interview for Mental Status (BIMS)" score of 12 out of 15, indicating R95 had moderate cognitive impairment. Per the MDS, diagnoses included bipolar disease and schizoaffective disorder; and R95 was noted to be taking antipsychotic medications. Review of R95's "Care Plan," located in the EMR under the "Care Plan" tab, included problems including mood swings, agitation, hallucinations, aggressive behaviors with staff, makes non-factual claims regarding staff, difficult to redirect, demanding expectations of staff, yelling, screaming, disruptive, sexually inappropriate comments/insults, verbal aggression with staff and roommate, mood swings, and attention seeking behaviors. Additionally, she was noted to take psychotropic medications for the treatment of bipolar and schizoaffective disorders. Review of R95's letter, provided by the facility and dated 12/13/23, from the State of California- Health and Human Services Agency, Department of Health Care Services "Re: Positive Level I Screening Indicates a Level II Mental Health Evaluation is Required," indicated a Level I screening was submitted by the facility on 12/14/23 with results indicating "positive for suspected MI [mental illness] .Your facility will be contacted within two to four days to set up an appointment for an evaluator to conduct a Level II Mental Health Evaluation. The evaluation process involves a thorough review of your records and may include telephone contact or a visit with you. Once the Level II Mental Health Evaluation is complete, you will receive a report that will provide recommendations for specialized services ." (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R95's letter, provided by the facility, dated 12/17/23 from the State of California- Health and Human Services Agency, Department of Health Care Services, UNABLE TO COMPLETE LEVEL II EVALUATION indicated they were "unable to complete level II evaluation . Federal law requires all individuals seeking admission to a Medicaid Certified Nursing Facility (NF) receive a Level I Mental Health Screening. The Level I Mental Health Screening identifies if an individual has a suspected Mental Illness (MI) or an Intellectual/Developmental Disability or Related Condition (ID/DD/RC). If MI is suspected, then a Level II Mental Health Evaluation may be conducted to determine if the individual can benefit from specialized mental health services. a Level II Mental Health Evaluation was not scheduled for the following reason: The individual was unable to participate in the Evaluation. The case is now closed. To reopen, please submit a new Level I Screening ." During an observation on 08/02/24 at 2:30 PM, R95 was observed yelling in the hall stating staff did not care about her because they did not immediately stop what they were doing to bathe/shower her. During an observation on 08/02/24 at 6:00 PM, R95 was observed sitting up in her wheelchair in her room yelling it was about time that they bathed her. During an interview on 08/01/24 at 10:47 AM, the Social Services Director (SSD) confirmed R95 had a positive PASARR Level I screening dated 12/13/23. The SSD stated the normal process was for the PASARR office to call the facility during the week, the determination letter was dated 12/17/23 which was a Sunday, and she felt that maybe the nurses on duty did not have access to the PASARR information. During an interview on 08/01/24 at 11:28 AM, the Director of Nursing (DON) confirmed R95 had a positive PASARR Level I screening dated 12/13/23. The DON stated the state of California contracted with a company of psychologists that followed-up with PASARR Level II's. This process usually occurred during the week and the DON or Assistant DON would assist with the process. The DON stated she was not employed at the facility in 12/2023 and was not sure why the PASARR Level II letter dated 12/17/23 indicated that the resident was "unable to participate in the evaluation." The DON confirmed the facility did not have a process in place to ensure that follow-ups were completed but should have been. During an interview on 08/01/24 at 1:26 PM, the PASRR Manager reviewed internal documentation that indicated the Level I screening was submitted by Registered Nurse (RN) 1 on 12/13/23. The normal process was for the contracted PASRR staff to contact the individual that submitted the Level I screening and in this particular case, the available staff that answered the phone could not answer the questions to complete the PASRR II screening. The expectation was for the facility to submit a new Level I PASRR screening so that the Level II could be completed for determination of services needed. During an interview on 08/01/24 at 1:51 PM, the Admissions Director (AD) stated the PASARR office did not typically notify the facility of screening results unless they spoke directly with someone at the facility. A determination letter would be uploaded to the PASARR system. The determination letter should be followed up by the person submitting the Level I screening. The AD was not sure why the PASARR screening was not followed up but should have been. The AD confirmed that the facility did not have a process in place to ensure that follow-ups were completed. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, "Admission Criteria" revised 03/2019 ". All new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID) or related disorders (RD) per the Medicaid Pre-Admission Screening and Resident Review (PASARR) process. a. The facility conducts a Level I PASARR screen for all potential admissions, regardless of payer source, to determine if the individual meets the criteria for a MD, ID or RD. b. If the level I screen indicates that the individual may meet the criteria for a MD, ID, or RD, he or she is referred to the state PASARR representative for the Level II (evaluation and determination) screening process . The social worker is responsible for making referrals to the appropriate state-designated authority. c. Upon completion of the Level II evaluation, the state PASARR representative determines if the individual has a physical or mental condition, what specialized or rehabilitative services he or she needs, and whether placement in the facility is appropriate . The interdisciplinary team determines whether the facility is capable of meeting the needs and services of the potential resident that are outlined in the evaluation."

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21382 2. Review of R253's undated Admission Record, located in the EMR Profile tab, revealed R253 was admitted on [DATE] with diagnoses including secondary malignant neoplasm of unspecified ovary and cutaneous abscess of the abdominal wall with hospice services. Review of the EMR revealed a POLST (Physician Order for Life Saving Treatment) completed by R253 on 07/21/24 located in the Documents tab of the EMR which documented R253 did not want resuscitation. Review of the Orders tab of the EMR revealed a physician order for DNR (Do Not Resuscitate), dated 07/21/24. Review of the care plan, dated 07/22/24 and located in the EMR Care Plan tab, revealed there was not a care plan for advance directives or her code status. During an interview on 08/02/24 at 4:00 PM, the MDS Director confirmed a care plan for code status should have been initiated when R253 was admitted . Review of facility policy titled, "Care Plans-Baseline," revised 03/2022, revealed, "A baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight (48) hours of admission. Policy Interpretation and Implementation: 1. The baseline care plan includes instructions needed to provide effective, person-centered care of the resident that meet professional standards of quality care and must include the minimum healthcare information necessary to properly care for the resident including, but not limited to the following: a. Initial goals based on admission orders and discussion with the resident/representative; b. Physician orders; c. Dietary orders; d. Therapy services; e. Social services; and f. PASARR recommendations, if applicable." 25232 (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, record review, interview, and policy review, the facility failed to ensure that a baseline care plan included the usage of side rails for one of one resident (Resident (R) 304) reviewed for side rails out of a total sample of 32 residents; and included code status for one of 32 sampled residents (R253). This failure created the potential for staff to not have all the information needed to care for residents. Findings include: 1. Review of Admission Record," located under the "Profile" tab in the electronic medical record (EMR), indicated that R304 was admitted to the facility on [DATE] with a diagnosis of systemic lupus erythematosus (a chronic autoimmune disease) and systemic sclerosis (stiffening of the tissue). During observation in R304's room and interview on 07/30/24 at 10:00 AM, bilateral 1/4 side rails observed in the up position. R304 said that she used them sometimes to reposition. During observation of R304's room on 07/31/24 at 3:50 PM, bilateral 1/4 side rails were observed in the up position even though R304 was sitting at the end of her bed. Again on 08/01/24 at 8:30 AM, observed R304 lying in her bed with bilateral 1/4 side rails in the up position. Review of admission "Minimum Data Set (MDS)" assessment, located under the "MDS" tab in the EMR, with an Assessment Reference Date (ARD) of 07/27/24 indicated a "Brief Interview of Mental Status (BIMS)" score of 14 out of 15, indicating intact cognition. Review of "Side Rail Assessment," located under the EMR "Evaluation" tab and dated 07/22/24, revealed the side rails were used to promote independence." Review of "Physician Order," dated 07/22/24, located under the EMR "Orders" tab, indicated "Side rail 1/4 X 2 up in bed as enabler to assist with bed mobility- nonrestraint." Review of "Baseline Care Plan," located under the "Evaluation" tab, dated 7/23/24 indicated no evidence of side rails being used for positioning. During an interview on 08/02/24 at 10:00 AM, the Director of Nursing (DON) confirmed that the baseline care plan did not address side rails.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15406 Based on interview and record review, the facility failed to ensure one out of one residents (Resident (R) 204) reviewed for bowel and bladder out of a total sample of 32 residents received timely care for constipation. The bowel protocol was not initiated until R204 failed to have a bowel movement for five days. R204 went a total of ten days without having a bowel movement putting him at risk for a fecal impaction. Findings include: Review of the undated Admission Record, located in the electronic medical record (EMR) under the Profile tab revealed R204 was admitted to the facility on [DATE] with diagnoses including COVID 19, type two diabetes mellitus, and acute kidney failure. Review of the admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/26/24, located in the EMR under the MDS tab, revealed R204 was intact in cognition with a Brief Interview for Mental Status (BIMS) score of 13 out of 15. R204 was continent of bowel and did not have constipation. Review of the Order Summary Report from 07/17/24 through 08/01/24, located in the EMR under the Orders tab, revealed R204 was not prescribed any regularly scheduled medications for constipation. However, the physician prescribed the following bowel regimen: Bowel Regimen: (1) MOM [milk of magnesia] 400 mg [milligrams]/5 ml [milliliters], give 30 cc [cubic centimeters] po [by mouth] Q [every] 24 hrs [hours] PRN [as needed] [for] constipation; Bowel Regimen: (2) Dulcolax suppository 10 mg per rectum QD [day] PRN for constipation in MOM is ineffective; Bowel Regimen: (3) Fleet Enema 7-19 gm [grams]/118 ml per rectum Q 3-day PRN for constipation if Dulcolax is ineffective. Review of the POC [Point of Care] Response History, Task: Bowel Movements report from 07/17/24 through 08/01/24 in the EMR under the Tasks tab revealed R204 had his first bowel movement on 07/27/24 (ten days after admission). Review of the Medication Administration Record (MAR) for July 2024 in the EMR under the Orders tab revealed R204 first received medication (per the bowel protocol consisting of MOM 400 mg/5 ml, 30 cc) to treat constipation on 07/22/24. This was the fifth day of not having a bowel movement. Review of the MAR for July 2024 in the EMR under the Orders tab revealed that after 07/22/24, the facility took timely action to address R204's constipation by enacting steps two and three of the bowel regimen, receiving and administering orders for additional laxative medications, obtaining a complete blood count and basic metabolic panel, providing intravenous fluids, and providing extra oral fluids. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Nurse's Note dated 07/26/24 in the EMR under the Progress Notes tab, revealed R204 was sent to the emergency roiagnom on [DATE] due to not having a bowel movement. R204 returned later on 07/26/24 without having a bowel movement, R204 did not have impaction or other complications. Review of R204's EMR revealed that neither the Baseline Care Plan dated 07/18/24 under the Evaluation tab or the Care Plan initiated on 07/18/24 under the Care Plan tab included the problem of constipation. During an interview on 07/30/24 at 2:15 PM, R204 stated he had been extremely sick when he was admitted to the facility due to COVID 19 and had not felt like eating or drinking much. R204 stated he was tired and did not want to be interviewed further. During an interview on 08/01/24 at 1:43 PM, Assistant Director of Nursing (ADON) 1 stated the bowel protocol called for MOM was to be administered after 72 hours (three days) if a resident failed to have a bowel movement. ADON1 stated if MOM did not result in a bowel movement, then the Dulcolax suppository was given the next shift, and then if that did not work a fleets enema was given the next shift. ADON1 reviewed R204's record and confirmed the bowel protocol was initiated on the fifth (07/22/24) day instead of on the third day without R204 having a bowel movement. During an interview on 08/01/24 at 5:32 PM, the Director of Nursing (DON) stated MOM should be given if a resident went three days without a bowel movement. The DON stated if MOM did not produce a bowel movement, the suppository should be given on the next shift and if that did not produce a bowel movement, the enema should be given on the next shift. The DON stated the managed care provider had contacted the facility and requested they conduct an investigation into the failure to institute the bowel protocol timely. The DON stated the investigation revealed that the bowel protocol was not initiated timely. The DON stated there were alerts in the EMR that prompted nurses that R204 failed to have a bowel movement and was due for initiation of the bowel protocol. The DON stated the EMR flagged R204's failure to have a bowel movement after three days. The DON stated the floor nurses had not initiated MOM for two days (on 07/20/24 and 07/21/24) even though a failure to have a bowel movement was flagged in the EMR for R204. During an interview on 08/02/24 at 5:05 PM, the DON verified there was no care plan initiated to address R204's constipation. The DON stated nurses should add acute problems that arose prior to the due date for developing a comprehensive care plan of 21 days after admission. The DON stated an episodic care plan should have been opened to address constipation for R204. A constipation/bowel policy was requested on 08/01/24; no policy was provided as of the survey exit on 08/02/24.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15406 Based on observation, interview, record review, and policy review, the facility failed to ensure one out of three residents (Resident (R) 204) reviewed for nutrition/hydration out of 32 sampled residents received sufficient fluids to maintain adequate hydration status. R204 was not assessed timely for fluid requirements even though he was prescribed intravenous (IV) fluids twice within the first ten days of admission due to poor nutritional and fluid intake. R204's care plan goal for fluids was inadequate to meet his fluid needs, and his supplement intake was not monitored. R204 was at risk for dehydration and weight loss. Findings include: Review of the undated Admission Record, located in the electronic medical record (EMR) under the Profile tab, revealed R204 was admitted to the facility on [DATE] with diagnoses including COVID 19, type two diabetes mellitus, and acute kidney failure. His stay was projected to be short term. Review of the admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/26/24, located in the EMR under the MDS tab, revealed R204 was intact in cognition with a Brief Interview for Mental Status (BIMS) score of 13 out of 15. Review of the Weight Summary dated 07/17/24 through 08/02/24 in the EMR under the Vitals tab revealed R204 weighed 170.2 pounds on 07/17/24 and was 72 (6') tall; his body mass index (BMI) was 23.4, within the normal weight range. Review of the Order Summary Report from 07/17/24 through 08/01/24, located in the EMR under the Orders tab, revealed on 07/17/24: -Monitor/document/report to MD [Medical Doctor] s/sx [signs/symptoms] of dehydration: decreased or no urine output, concentrated urine, strong odor, tenting skin, cracked lips, furrowed tongue, new onset confusion, dizziness on setting [sic]/standing, increased pulse, headache, fatigue/weakness, dizziness, fever, thirst, recent sudden wt [weight] loss, dry sunken eyes every shift, -I/O [intake and output] Monitoring: Fluid Intake Q [every] shift every shift for 30 Days. I/O Monitoring: Fluid Intake Total 24 hrs every night shift for 30 Days Review MAR [Medication Administration Record] and total intake for past 24 hours. Review of the Order Summary Report from 07/17/24 through 08/01/24, located in the EMR under the Orders tab, revealed on 07/18/24 the Physician ordered, Sodium Chloride Solution 0.9 %, Use 60 ml [milliliters]/hr [hour] intravenously (IV) one time only for poor po [oral] intake, rhabdomyolysis (medical condition that occurs when muscle tissue breaks down and releases harmful substances into the blood), AKI [acute kidney injury] for one day 1L [liter]. Review of the Order Summary Report from 07/17/24 through 08/01/24, located in the EMR under the Orders tab, revealed on 07/24/24 the Physician ordered, Sodium Chloride Solution 0.9 %, Use 70 ml/hr intravenously one time only for poor po intake, constipation for one Day 1L IV. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Order Summary Report from 07/17/24 through 08/01/24, located in the EMR under the Orders tab, revealed on 07/25/24 the Physician ordered, Give 500 ml extra fluid each shift. Review of the Batch Update dated 07/24/24, provided by the facility, revealed Health Shakes were ordered with meals on 07/24/24 and were discontinued on 08/01/24. Review of the Medication Administration Record (MAR) for July 2024 did not show the Health Shakes were administered or consumed. Review of the Medication Administration Record (MAR) for July 2024 revealed R204's total fluid intake within 24 hours was documented as: -07/18/24 1480 ml -07/19/24 1530 ml -07/20/24 940 ml -07/21/24 1000 ml -07/22/24 880 ml -07/23/24 1600 ml -07/24/24 1310 ml -07/25/24 1070 ml -07/26/24 2980 ml -07/27/24 900 ml -07/28/24 600 ml -07/29/24 680 ml -07/30/24 890 ml, and -07/31/24 540 ml Review of the Registered Dietitian Nutrition Assessment initiated on 07/23/24, located in the EMR under the Evaluation tab, revealed the assessment was initiated on this date; however, the sections for calculating estimated energy needs, protein needs, fluid needs, intake percentage, actual nutrition intake, nutrition goal, nutrition interventions, and nutrition plan were incomplete (blank). (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Registered Dietitian Nutrition Assessment initiated on 07/31/24, located in the EMR under the Evaluation tab, revealed the assessment was initiated on this date. R204's fluid needs were calculated and were 2400 ml fluid per day. R204 was documented as consuming 25% or less with poor nutritional intake noted. R204 was documented as receiving health shakes three times a day. R204's risk for dehydration was not identified nor was the provision of IV fluids on 07/18/24 or 07/25/24. Review of the Care Plan, dated 07/26/24 and located in the EMR under the Care Plan tab, revealed a problem of, The resident has dehydration or potential fluid deficit r/t [related to] poor intake. The goal was, The resident will drink/take in a minimum of 1000 cc's [cubic centimeters] each 24-hour period. The Dietitian's calculation on 07/31/24 (see Registered Dietitian Nutrition Assessment initiated on 07/31/24, in the EMR under the Evaluation tab) revealed a minimum intake of 2400 cc was necessary to meet R204's fluid needs. During an interview on 07/30/24 at 2:15 PM, R204, who was lying in bed, stated he had been extremely sick when he was admitted to the facility due to COVID 19 and had not wanted to eat or drink much. R204 stated he was tired and did not want to be interviewed further. R204 stated he was discharging to home soon. During an interview on 08/01/24 at 8:51 AM, Licensed Vocational Nurse (LVN) 6 stated R204's nutritional intake had been poor since admission, and he was currently being referred for hospice. LVN6 stated R204 experienced constipation during his stay and had received IV fluids in the facility. LVN6 stated R204 was monitored for intake and output during his stay, documented on the MAR. LVN6 stated R204 was expected to discharge home today. During an interview on 08/01/24 at 1:52 PM, Assistant Director of Nursing (ADON) 1 verified intake and output records were monitored by nursing staff in accordance with the Physician's Orders. During an interview on 08/02/24 at 8:53 AM, the Registered Dietitian (RD) stated her standard was to complete nutrition assessments on newly admitted residents, and especially those at higher risk, within the first seven days of admission. The RD stated she assessed R204 on 07/31/24 and verified this was 14 days after admission. The RD stated she calculated R204's fluid needs on 07/31/24 and he required 2400 ml per day. The RD verified the care plan had a goal of 1000 ml per day for fluid intake, which was inadequate to meet his needs. The RD stated the nurses had communicated with her about R204 not eating or drinking well. The RD stated the provision of IV fluids was a trigger for high nutritional/dehydration risk. The RD verified R204 was at high nutrition risk due to poor intake and provision of IV fluids; she stated she had not completed R204's nutritional assessment timely. During a joint interview on 08/02/24 at 10:14 AM, the RD, Dietary Director, and the Director of Nursing (DON) stated on 07/24/24 the Physician wrote an order for Health Shakes to be administered three times a day with meals. The RD stated the order was discontinued on 08/01/24 once Boost (supplement) was initiated. The DON stated the facility did not document supplements that were administered with meals; it was considered part of the meal. The DON stated only supplements administered between meals by nurses were recorded on the MAR. The DON and RD verified there was no documentation of whether R204 received the Health Shakes or what his intake of the Health Shakes was. The RD verified it would be helpful to know if the shakes were consumed. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/02/24 at 5:10 PM, the DON verified the care plan goal indicated 1000 cc of fluid intake per 24 hours. The DON stated it may have been written incorrectly and may have been associated with the Physician's Order for nursing to administer 500 cc of fluid per shift (two shifts daily) a total of 1000 cc. The DON verified the care plan should be accurate. Review of the facility's Resident Hydration and Prevention of Dehydration policy dated October 2017 revealed, The facility will strive to provide adequate hydration and to prevent and treat dehydration . The dietitian will assess all residents for hydration as part of the comprehensive assessment . Minimum fluid needs will be calculated and documented on initial, annual, and significant change assessments . Nursing will monitor and document fluid intake and the dietitian will be kept informed of status.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15406 Based on interview, record review, and policy review, the facility failed to ensure one out of five residents (Resident (R)78) reviewed for unnecessary medications out of 32 sampled residents did not receive an as needed antianxiety medication for more than fourteen days without a physician rationale for extending the use and without the stop date specified. This failed practice increased the risk of experiencing adverse reactions to medications which they may not need to treat a clinical condition. Findings include: Review of the undated Admission Record in the electronic medical record (EMR) under the Profile tab revealed R78 was admitted to the facility on [DATE]; current diagnoses included major depressive disorder, psychotic disorder with delusions, and anxiety disorder. Review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/23/24, located in the EMR under the MDS tab, revealed R78 was severely impaired in cognition with a Brief Interview for Mental Status (BIMS) score of seven out of 15. The MDS revealed R78 was taking an antianxiety medication. R78 exhibited physical behaviors, verbal behaviors, and other behavioral symptoms not directed towards others, one to three days during the assessment period. Review of the Order Summary Report, dated 07/10/24 and located in the EMR under the Orders tab, revealed R78 was prescribed on 07/10/24, Ativan [antianxiety medication] Oral Tablet 0.5 mg [milligrams] (Lorazepam), Give 1 tablet by mouth every 8 hours as needed for Anxiety m/b [manifested by] restlessness. The order did not include a stop date. Review of the Progress Notes and Physician's Notes from 07/23/24 through 08/01/24 in the EMR failed to include documentation for the continued use of PRN Ativan beyond the 14-day period ending on 07/24/24. Review of the Medication Administration Record (MAR) for July 2024, located in the EMR under the Orders tab, revealed Ativan was administered in July 2024 following 07/24/24 (14th day after it was prescribed) as follows: once on 07/26/24, twice on 07/27/24, twice on 07/28/24, once on 07/29/24, and twice on 07/30/24. During an interview on 08/01/24 at 1:00 PM, Assistant Director of Nursing (ADON) 1 stated Ativan was prescribed on a PRN basis on 07/10/24. ADON1 stated the PRN Ativan should be renewed after 14 days on 07/24/24. ADON1 stated nursing should have called the physician to determine if the medication should be renewed. ADON1 stated there would typically be a nurse's note addressing the expiration of the 14-day period and the contact with the physician for the renewal. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/02/24 at 4:58 PM, the Director of Nursing (DON) stated if a new PRN order for an antianxiety medication came in, there should be a 14 day stop date. The DON stated if the resident had already been on it, the medication could be administered longer if the physician deemed it necessary. The DON reviewed the EMR and stated R78 had been on Ativan previously; however, it had been discontinued in February 2024. Ativan had not been ordered from that time (February 2024) until 07/10/24. The DON verified there was no stop date for the PRN Ativan prescribed on 07/10/24. Review of the facility's Psychotropic Medication Use policy dated July 2022 revealed, Residents will not receive medications that are not clinically indicated to treat a specific condition . Psychotropic medications are not prescribed or given on a PRN [as needed] basis unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record. a. PRN orders for psychotropic medications are limited to 14 days . If the prescriber or attending physician believes it is appropriate to extend the PRN order beyond 14 days, he or she will document the rationale for extending the use and include the duration for the PRN order .

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 40824 Based on interview and facility assessment reviews, the facility failed to create and implement a comprehensive Facility Assessment to determine what resources the facility needs to meet the needs of its residents which had the potential to affect 161 residents residing in the facility. Findings include: Review of the "SNF/NF [Skilled Nursing Facility/Nursing Facility] Capabilities List" dated 07/2021 was not a comprehensive Facility Assessment. Review of the "Facility Assessment Tool" provided by the facility and updated 07/30/24. During an interview on 08/02/24 at 6:04 PM with the Administrator confirmed that the current "Facility Assessment" dated 07/30/24 was updated and created after the surveyors entered the facility on 07/30/24. Additionally, the Administrator provided "SNF/NF [Skilled Nursing Facility/Nursing Facility] Capabilities List," dated 07/2021, which he stated was a "snapshot" of what the facility was able to provide. The Administrator was unable to provide annual "Facility Assessments" for 2020, 2021, 2022, and 2023.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 40824 Based on interview, review of facility documents, and facility policy review, the facility failed to ensure a Quality Assurance Performance Improvement (QAPI) plan was developed and implemented to drive quality assurance (QA) measures. This failure had the potential to affect all 161 residents who currently live in the facility. Findings included: Review of the facility policy titled, "Quality Assurance and Performance Improvement (QAPI) Program" revised 04/2014 included, ". Establishing a QAPI Plan that guides quality efforts and serves as the main document that supports the QAPI implementation . Providing frequent leadership and staff training on the QAPI plan and its underlying principles, including the concept that systems of care and business practices must support quality care or be changed ." Review of facility documents revealed the facility did not have a QAPI Plan. During an interview on 08/02/24 at 6:04 PM, the Administrator confirmed the facility did not have a QAPI Plan.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 40824 Based on interview, review of facility documents, and facility policy review, the facility failed to ensure bed hold audits were completed per the performance improvement project. This failure had the potential to affect residents who were emergently sent out to the hospital. Findings included: Review of the facility policy titled, "Quality Assurance and Performance Improvement (QAPI) Program" revised 04/2014 included, ". Performance improvement projects (PIPs) are initiated when problems are identified . Prioritizing identified quality issues based on risk of harm and frequency of occurrence, and determining which will become the focus of PIPs . Planning, conducting and documenting PIPs .Taking systematic action targeted at the root causes of identified problems. This encompasses the utilization of corrective actions that provide significant and meaningful steps to improve processes and do not depend on staff to simply 'do the right thing'." Review of the facility policy titled, "Quality Assurance and Performance Improvement (QAPI) Program-Analysis and Action" dated 03/2020 included ". The methodology for analysis and action is guided by a written QAPI plan that includes: . Methods and frequency of monitoring performance improvement projects ." Review of facility documents revealed the facility did not have a QAPI Plan. Review of a facility document titled "Quality Assurance Performance Improvement Action Plan" dated 04/10/24 and provided by the Director of Nursing (DON) included Bed Holds were not being issued to residents/RPs in advance of transfers (or within 24 hours if emergent). The Action Plan solution included "Upon transfer to the acute from SNF [Skilled Nursing Facility] . assigned charge nurse will ensure a copy of the bed hold policy is given to resident/RP prior to transfer. If unpractical due to emergency situation, attempt(s) will be made to contact the resident/RP within 24 hours of transfer. ADON [Assistant Director of Nursing] on assigned unit will assist in procress [sic] as needed. Follow Up: ADON will audit for compliance on a weekly basis. Medical Records will also audit for completion/obtained signatures on bed hold form." Review of facility documents revealed that bed holds were not being provided to residents/responsible parties (RPs). R99, R126, R151, and R68 had emergent hospital transfers after the facility identified a deficient practice with bed holds and did not receive bed hold notices.Cross-reference F625. During an interview on 08/01/24 at 3:15 PM, the DON confirmed the facility had a PIP in place for ensuring Bed Hold notifications were provided to residents or their responsible parties. The DON confirmed the PIP included conducting audits for bed hold notifications, which she was not able to provide. During an interview on 08/02/24 at 3:01 PM, ADON1 stated she was aware of the PIP for bed holds but had not been conducting audits herself, because this was being done by Medical Records. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/02/24 at 3:01 PM, the Medical Records Director (MRD) stated when a resident was sent out to the hospital there should be a transfer/discharge notice and bed hold notification provided to the resident/RP upon discharge. MRD stated she started conducting bed hold audits in May 2024, however confirmed that audits were incomplete. During an interview on 08/02/24 at 6:04 PM, the Administrator confirmed he was made aware that bed hold audits had not been completed per the facility's current PIP but should have been.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 40824 Based on interview, review of facility documentation, and review of facility policy, the Quality Assurance and Performance Improvement (QAPI) committee failed to ensure the required members of the committee attended the quarterly meetings. This failure had the potential to affect all 161 residents who currently live in the facility. Findings include: Review of the facility policy titled, "Quality Assurance and Performance Improvement (QAPI) Program" revised 04/2014 and provided by the facility did not include QAPI attendance expectations. Review of the facility policy titled, "Quality Assurance and Performance Improvement (QAPI) Program-Analysis and Action" revised 03/2020 and provided by the facility did not include QAPI attendance expectations. During an interview on 08/02/24 at 6:04 PM, the Administrator confirmed that QAPI meetings were held at a minimum every quarter and that all meetings should include an Administrator, DON, Infection Preventionist (IP), and Medical Director (MD). The Administrator confirmed that for the third and fourth quarters of 2023 the MD did not attend QAPI meetings, and for the first quarter of 2024 neither the IP or MD were in attendance but should have been.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25232 Based on observation, interview, and record review, the facility failed to ensure that two of three residents (Resident (R) 81 and R79) reviewed for catheters out of 32 sampled residents received catheter care in a manner to prevent cross-contamination. Nursing staff did not change gloves appropriately while providing catheter care to R81 and the facility failed to ensure R79's catheter bag was kept off the floor. This failure has the potential for staff to spread infections between residents. Findings include: 1. Review of R81's undated Admission Record under the "Profile" tab in the electronic medical record (EMR) indicated that R81 was readmitted to the facility on [DATE] with a diagnosis of obstructive and reflux uropathy, unspecified. Review of R81's urinalysis culture, dated 02/04/24 and located under the tab "Results" in the EMR, indicated that R81 had a urinary tract infection which had bacteria including Citrobacter freundii (healthcare associated infection). During suprapubic catheter observation with Licensed Vocational Nurse (LVN) 1 on 08/02/24 at 8:41 AM, LVN1 put gloves on and cleaned R81's suprapubic catheter. Then without changing her gloves, LVN1 rinsed and patted dry R81's suprapubic catheter. LVN1 removed her gloves at this time and washed her hands. LVN1 placed a new pair of gloves on and placed a dressing around R81's suprapubic catheter. During an interview on 08/02/24 at 9:00 AM, LVN1 did not realize that she did not change her gloves when going from dirty to clean and confirmed that she should have. During an interview on 08/02/24 at 10:00 AM, the Director of Nursing (DON) confirmed that gloves should be changed when going from a dirty area to a clean area. During an interview on 08/02/24 at 3:04 PM, the Infection Preventionist (IP) confirmed gloves should be changed when going from a dirty to clean area. Review of facility provided "In-Service Sign-In Sheet," dated 05/22/24, indicated LVN1 attended this training on Personal Protective Equipment (PPE) about donning (put on) and doffing (take off). There was no evidence of an agenda. 40824 2. Review of R79's undated "Admission Record," located in the EMR under the "Profile" tab, indicated an original admitted [DATE] and re-admission on 03/18/23 with a primary diagnosis of asthma and comorbidities including benign prostatic hyperplasia with lower urinary tract symptoms. Review of R79's quarterly "Minimum Data Set (MDS)," located in the EMR under the MDS tab, with an Assessment Reference Date (ARD) of 06/21/24 included a "Brief Interview for Mental Status (BIMS)" score of seven out of 15 indicating the resident had severe cognitive impairment. Per the MDS, R79 had an indwelling catheter. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555118	A. Building B. Wing	08/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Almond Vista Healthcare	2030 Evergreen Avenue Modesto, CA 95350

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R79's "Care Plan," located in the EMR under the "Care Plan" tab and dated 07/14/19, included placement of a supra pubic catheter related to neurogenic bladder. Review of R79's "Order Summary Report," located in the EMR under the "Orders" tab, included suprapubic catheter 16 French with 10 cubic centimeter (cc) flush every shift dated 11/24/23 and suprapubic catheter to gravity drainage every shift dated 01/30/20. During an observation and interview on 08/02/24 at 3:24PM with LVN2, R79 was lying in bed with the linens over his head and his urinary collection bag on the floor next to his bed without a dignity bag. LVN2 confirmed the urinary collection bag was on the floor, should have been in a dignity bag, and off the floor due to risk for infection. During an interview on 08/02/24 at 5:40 PM, DON stated it was her expectation that urinary collection bags be in a dignity bag and kept off the floor due to risk for infection. Review of the facility's policy titled, "Catheter Care, Urinary" revised 08/2022 indicated "The purpose of this procedure is to prevent urinary catheter-associated complications, including urinary tract infections . Be sure the catheter tubing and drainage bag are kept off the floor ."