

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555143	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/03/2024
NAME OF PROVIDER OR SUPPLIER Westland House		STREET ADDRESS, CITY, STATE, ZIP CODE 100 Barnet Segal Lane Monterey, CA 93940	
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)		
<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45853</p> <p>Based on interview and record review, the facility failed to issue the Notice of Medicare Non-Coverage (NOMNC, informs beneficiaries on how to file an appeal before their insurance coverage ends) timely for two of three sampled residents (Resident 80 and 81).</p> <p>This deficient practice had the potential to result in residents not being able to exercise their right to file an appeal.</p> <p>Findings:</p> <p>During a review of Resident 80's face sheet (a document that contains a summary of a resident's personal and demographic information) and NOMNC, it indicated Resident 80 was admitted to the facility on [DATE] and her stay was paid by Medicare (federal health insurance for anyone age 65 and older, and some people under 65 with certain disabilities) until 11/1/23. The NOMNC also indicated it was signed by the resident one day prior to her last day of Medicare coverage on 10/31/23.</p> <p>During a review of Resident 81's face sheet and NOMNC, it indicated Resident 80 was admitted to the facility on [DATE] and her stay was paid by Medicare until 1/19/24. The resident was discharged on [DATE], and the NOMNC was signed by the resident's responsible party on the discharge day.</p> <p>During an interview on 5/1/24 11:29 a.m. with the Social Services Designee (SSD), the SSD stated usually the facility issues the NOMNC 72 hours prior to a resident's last covered date. For Resident 80, the NOMNC should have been delivered on 10/30/23, because it required at least 48 hours window for the resident to file an appeal. For Resident 81, her initial discharge date was on 1/18/24, but she had a change in condition, so the facility held the discharge and issued a new NOMNC that day.</p> <p>During an interview on 5/1/24 at 11:47 a.m. with the Patient Care Coordinator (PCC), the PCC stated the facility should have issued a NOMNC on 1/18/24 with last covered date 1/20/24 for Resident 81 to be compliant with the regulation.</p> <p>During a review of the facility provided Centers for Medicare & Medicaid Services (CMS) form instruction (FI), titled Form Instruction for the Notice of Medicare Non-Coverage (NOMNC) CMS-10123, OMB Approval 0938-xxxx, the FI indicated, The NOMNC must be delivered at least two calendar days before Medicare covered services end or the second to last day of service if care is not being provided daily.</p>		

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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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48590</p> <p>Based on interview and record review, the facility failed to ensure the plan of care for one of 25 sampled residents (Resident 1) was individualized and revised to reflect the resident's current care needs and interventions. This failure had the potential to result in not meeting the residents' needs.</p> <p>Findings:</p> <p>During an observation on 4/30/24 at 9:10 a.m., in the resident's room, Resident 1 was sitting at the edge of the bed with the two upper side rails in upright position.</p> <p>Review of Resident 1's clinical record indicated she was admitted on [DATE] with a diagnosis of Cellulitis of the left hand.</p> <p>Review of Resident 1's care plans indicated care plans for problems addressing return activities of daily living status to a safe level of function and at risk for fall. There was no care plan addressing the use of side rails.</p> <p>During a concurrent interview and record review on 4/30/24 at 10:43 a.m., with Registered Nurse (RN) B, RN B reviewed the care plans of Resident 1 and stated the care plan for side rails are incorporated in the care plan addressing risk for fall. RN B further stated there was no care plan for the use of side rails.</p> <p>During a concurrent interview and record review on 4/30/24 at 1:21 p.m., with RN C, RN C reviewed the care plans for Resident 1 and stated they use the fall care plan to address the side rails. RN C further stated there was no care plan specific for the use of side rails.</p> <p>During an interview on 5/2/24 at 1:10 p.m., with the Director of Nursing (DON), the DON stated there was no specific care plan for side rails. The DON stated the facility has no policy specific for side rails.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>45853</p> <p>Based on observation and interview, the facility failed to ensure two of 25 residents (Residents 74 and 79)'s foot boards of their beds were properly locked.</p> <p>This failure had the potential to negatively affect the residents' well-being and increased the risk of accidents or injuries to the residents.</p> <p>Findings:</p> <p>During a concurrent observation and interview on 4/29/24 at 3:34 p.m. in Resident 74's room, there was a six-inch (a unit of length or distance) gap between Resident 74's mattress and the foot board of the bed. The resident stated he did not like the bed.</p> <p>During a concurrent observation and interview on 4/29/24 at 3:40 p.m. in Resident 79's room, there was a six-inch gap between Resident 79's mattress and the foot board of the bed. The resident had just finished his Physical Therapy session with Physical Therapist (PT) D, PT D stated, all beds are adjustable, the gap between the foot board and the mattress was here when she got here this morning, she had to check with the resident's nurse to find out why there was a gap.</p> <p>During a concurrent observation and interview on 5/2/24 at 8:55 a.m. in Resident 74's room with Registered Nurse (RN) E, there was still a gap between the food board and the mattress, and the resident's blanket had fallen into the gap. RN E stated maybe when the resident slid down to the foot of the bed, the foot board was pushed. RN E and Certified Nursing Assistant (CNA) F then pushed the foot board back until there was no more gap.</p> <p>During an interview on 5/2/24 at 9:50 a.m. with CNA F, CNA F stated she double checked the bed, the foot board just needed to be pushed back in and locked in place. She further stated there should be no gap between the mattress and the board because it can potentially cause the resident to get injured.</p> <p>During an interview on 5/2/24 at 11:28 a.m. with RN G, RN G stated if there was a gap between the mattress and the foot board, potentially the resident can slide down and get injured.</p> <p>During an interview on 5/2/24 at 1:20 p.m. with the Director of Nursing, the DON stated the staff should make sure the foot board was locked and secured, the mattress could slide down due to there was a gap.</p> <p>During a review of the facility's policy and procedure (P&P), titled Fall Mitigation PC-4039, the P&P indicated, Hospital Bed Safety Features & Exit Alarm 2. Before leaving the patient room, check that iBED awareness lights are illuminating green. Key Point: The lights flash amber if the bed does not meet the safety parameters set. i. Review the digital display control panel at the foot of the bed to determine the alert and adjust the bed to appropriate configuration. [.] iii. Set the bed to the appropriate configuration (set brake, raise side rail, etc.).</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p>48590</p> <p>Based on observation, interview, and record review, the facility failed to ensure the proper use of side or bed rails ((adjustable rigid bars attached to the side of a bed) for 25 of 25 sampled residents (Residents 122, 120, 175, 70, 73, 1, 79, 125, 72, 126, 71, 74, 76, 128, 171, 75, 172, 127, 123, 173, 78, 121, 174, 77, and 170) when:</p> <ol style="list-style-type: none"> 1. The facility failed to assess for the risk of entrapment from side rails prior to use of side rails for 25 of 25 residents (Residents 122, 120, 175, 70, 73, 1, 79, 125, 72, 126, 71, 74, 76, 128, 171, 75, 172, 127, 123, 173, 78, 121, 174, 77, and 170). 2. The facility failed to review the risks and benefits of side rails with the resident or resident representatives (RP) and obtain informed consent (a process which patients are given important information, including possible risks and benefits, about a medical procedure or treatment) prior to the use of side rails for 25 of 25 residents (Residents 122, 120, 175, 70, 73, 1, 79, 125, 72, 126, 71, 74, 76, 128, 171, 75, 172, 127, 123, 173, 78, 121, 174, 77, and 170). 3. The facility failed to attempt alternative measures prior to the use of side rails for 25 of 25 residents (Residents 122, 120, 175, 70, 73, 1, 79, 125, 72, 126, 71, 74, 76, 128, 171, 75, 172, 127, 123, 173, 78, 121, 174, 77, and 170). 4. The facility failed to ensure physician orders were obtained prior to the use of the side rails for 25 of 25 residents (Residents 122, 120, 175, 70, 73, 1, 79, 125, 72, 126, 71, 74, 76, 128, 171, 75, 172, 127, 123, 173, 78, 121, 174, 77, and 170). <p>These failures had the potential to put all 25 residents at risk of entrapment and serious injury.</p> <p>Findings:</p> <p>Review of the U.S Food and Drug Administration (FDA) Hospital Bed Safety Workgroup Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities, and Home Care Settings, dated April 2003, indicated the FDA issued a Safety Alert entitled, Entrapment Hazards with Hospital Bed Side Rails. This alert indicated National surveys of patient deaths occurring in the bed environment demonstrate the risk of entrapment when a patient slips between the mattress and bed rail or when the patient becomes entrapped in the bed rail itself. The population at risk for entrapment are patients who are frail or elderly or those who have conditions such as agitation, delirium, confusion, pain, uncontrolled body movement . that cause them to move about the bed or try to exit from the bed.</p> <p>During an observation on 4/29/24 at 9 a.m., in the resident's room, Resident 120's bed had 4 side rails installed with the two upper side rails in the upright position.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an observation on 4/29/24 at 9:10 a.m., in the resident's room, Resident 121's bed had 4 side rails installed with the two upper side rails in the upright position.</p> <p>During an observation on 4/29/24 at 9:14 a.m., in the resident's room, Resident 175's bed had 4 side rails installed with the three side rails in the upright position.</p> <p>During an observation on 4/29/24 at 9:16 a.m., in the resident's room, Resident 122's bed had 4 side rails installed with the two upper side rails in the upright position.</p> <p>During an observation on 4/29/24 at 9:24 a.m., in the resident's room, Resident 125's bed had 4 side rails installed with the two upper side rails in the upright position.</p> <p>During an observation on 4/29/24 at 9:29 a.m., in the resident's room, Resident 126's bed had 4 side rails installed with the two upper side rails in the upright position.</p> <p>During an observation on 4/29/24 at 9:37 a.m., in the resident's room, Resident 128's bed had 4 side rails installed with the two upper side rails in the upright position.</p> <p>During an observation on 4/29/24 at 9:38 a.m., in the resident's room, Resident 173's bed had 4 side rails installed with one upper side rail in the upright position.</p> <p>During an observation on 4/29/24 at 9:41 a.m., in the resident's room, Resident 127's bed had 4 side rails installed with the two upper side rails in the upright position.</p> <p>During an observation on 4/29/24 at 9:50 a.m., in the resident's room, Resident 123's bed had 4 side rails installed with the two upper side rails in the upright position.</p> <p>During an observation on 4/29/24 at 11:32 a.m., in the resident's room, Resident 170's bed had 4 side rails installed with the two upper side rails in the upright position.</p> <p>During an observation on 4/29/24 at 2:54 p.m., in the resident's room, Resident 70's bed had 4 side rails installed with the two upper side rails in the upright position.</p> <p>During an observation on 4/29/24 at 3:31 p.m., in the resident's room, Resident 71's bed had 4 side rails installed with the two upper side rails in the upright position.</p> <p>During an observation on 4/29/24 at 3:31 p.m., in the resident's room, Resident 72's bed had 4 side rails installed with the two upper side rails in the upright position.</p> <p>During an observation on 4/29/24 at 3:31 p.m., in the resident's room, Resident 73's bed had 4 side rails installed with the two upper side rails in the upright position.</p> <p>During an observation on 4/29/24 at 3:31 p.m., in the resident's room, Resident 75's bed had 4 side rails installed with the two upper side rails in the upright position.</p> <p>During an observation on 4/29/24 at 3:31 p.m., in the resident's room, Resident 76's bed had 4 side rails installed with the two upper side rails in the upright position.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an observation on 4/29/24 at 3:33 p.m., in the resident's room, Resident 74's bed had 4 side rails installed with the two upper side rails in the upright position.</p> <p>During an observation on 4/29/24 at 3:42 p.m., in the resident's room, Resident 79's bed had 4 side rails installed with the two upper side rails in the upright position.</p> <p>During an observation on 4/30/24 at 9:22 a.m., in the resident's room, Resident 171's bed had 4 side rails installed with the two upper side rails in the upright position.</p> <p>During an observation on 4/30/24 at 9:22 a.m., in the resident's room, Resident 174's bed had 4 side rails installed with the two upper side rails in the upright position.</p> <p>During an observation on 4/30/24 at 9:22 a.m., in the resident's room, Resident 172's bed had 4 side rails installed with the two upper side rails in the upright position.</p> <p>During an observation on 4/30/24 at 10:23 a.m., in the resident's room, Resident 1's bed had 4 side rails installed with the two upper side rails in the upright position.</p> <p>During a concurrent interview and record review on 4/30/24 at 10:53 a.m., with Registered Nurse (RN) B, RN B reviewed the electronic records of some residents, then RN B stated that all residents were assessed and informed about the use of side rails but there was no documentation about the risk and benefits for the use of side rails given to all residents. RN B further stated there was no need for physician orders for the use of side rails unless if it was used as a restraint. RN B also stated there was no alternatives to the use of side rails discussed with any of the residents and their responsible parties.</p> <p>During a concurrent interview and record review on 4/30/24 at 1:21 p.m., with RN C, RN C reviewed all the 25 residents' electronic records and stated that all the residents must always have the side rails in the upright position. RN C stated that no alternatives were used because every patient (meant Resident) must have the two side rails up. RN C further stated the use of side rails does not need to have a consent and physician orders. RN C also stated that residents were assessed and informed of the risk and benefits of the use of side rails verbally but there was no documentation done. RN C also stated there was no policy for the use of side rails.</p> <p>During an observation on 5/1/24 at 2:55 p.m., in the resident's room, Resident 77's bed had 4 side rails installed with the two upper side rails in the upright position.</p> <p>During an observation on 5/1/24 at 2:57 p.m., in the resident's room, Resident 78's bed had 4 side rails installed with the two upper side rails in the upright position.</p> <p>During an interview on 05/02/24 at 1:10 p.m., with the Director of Nursing (DON), the DON stated there was no alternatives for the use of side rails. The DON stated consent and physician order were not required because the use of side rails was an intervention used to prevent falls. The DON stated that assessment was done for the prevention of falls and not for the use of side rails. The DON also stated they have no side rails policy.</p> <p>45853</p> <p>(continued on next page)</p>		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	46939		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46939</p> <p>Based on observation, interview, and record review, the facility failed to ensure food items were labeled properly and expired food were not stored in the kitchen and accessible to be used in preparing foods for 23 of 25 residents. This practice had the potential to result in the residents ingesting expired food, which can result in foodborne illnesses.</p> <p>Findings:</p> <p>During a concurrent observation and interview on [DATE], at 8:43 a.m., with [NAME] A, in the walk-in refrigerator, three stalks of [NAME], and two bunches of cilantro were noted to be in a clear plastic container on the top shelf. No dates or labels were noted on the produce or the container which held the produce. Another clear plastic container held approximately 7 green squash with no labels on the produce or the container. [NAME] A stated there are no labels on these produce or the containers, they are supposed to have a receive date and a use by date.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Food Safety: Storage Handling, Preparation, serving, dated 2019, the P&P indicated, 4. Food is covered, labeled, dated, and used within the specified time periods, and is stored off the floor.</p>		