

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555158	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/15/2024
NAME OF PROVIDER OR SUPPLIER El Centro Post-Acute Care		STREET ADDRESS, CITY, STATE, ZIP CODE 1700 S. Imperial Ave El Centro, CA 92243	

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 0563</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to receive visitors of his or her choosing, at the time of his or her choosing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46235</p> <p>Based on interview, and record review, the facility failed to ensure a resident ' s right was honored when one of 3 residents was not allowed to have a visitor after a fall incident (Resident 6).</p> <p>This deficient practice had the potential for the resident to have feelings of isolation, anxiety (feeling of fear, dread, and uneasiness) and/or sadness.</p> <p>Findings:</p> <p>On 8/15/24 at 11:08 A.M., an unannounced onsite visit at the facility was conducted related to a reported complaint regarding Resident 6 ' s fall incident at the facility.</p> <p>Resident 6 was admitted to the facility on [DATE] with diagnoses including weakness and unspecified fall according to the facility ' s Admission Record.</p> <p>During a review of Resident 6 ' s nurse ' s notes dated 6/9/24, at 3:22 A.M., the nurse ' s note indicated Resident 6 was found on the floor lying on her back. The nurse ' s notes indicated Resident 6 was resistant, yelling in Spanish, hitting staff, refused assessment and then called her daughter on the phone. The nurse ' s note indicated 911 (emergency number) was called per Resident 6 ' s and daughter ' s request to be transferred to the hospital. The nurse ' s note further indicated Resident 6 ' s daughter arrived at the facility, but was not allowed to enter the facility due to visitors were not allowed after hours at night.</p> <p>An interview was conducted on 8/15/24, at 12:09 P.M. with licensed nurse (LN) 1. LN 1 stated if staff called a resident ' s family member due to an incident and the resident was not doing well, the family member should be allowed to visit the resident.</p> <p>During an interview on 8/16/24, at 1:46 P.M. with the Director of Nurses (DON), the DON stated if there was a resident incident and the family was notified after hours, staff should make an exception and allow the family member to enter the facility to alleviate the resident ' s anxiety.</p> <p>A review of the facility ' s policy and procedure (P&P) titled, Resident Rights, dated February 2021, the P&P indicated, .Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident ' s right to: .aa. visit and be visited by others from outside the facility .</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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