STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555184	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heartwood Avenue Healthcare	1044 Heartwood Ave. Vallejo, CA 94591

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44968 Based on observations, interviews and records review, the facility failed to ensure two of two sampled residents (Resident 1 and Resident 2) were free from accidents, when: 1. The facility did not provide two-person assistance to Resident 1 during care, when Resident 1 was dependent (resident does none of the effort to complete the activity, or the assistance of two or more helpers is required for the resident to complete the activity) from staff to maintain perineal hygiene (washing the genital and rectal areas of the body) and to turn in bed. This failure resulted in Resident 1 rolling over while receiving perineal care and falling on the other side of the bed sustaining a left tibia (the inner and usually larger of the two bones of the leg between the knee and ankle) fracture (a break on the bone). 2. The facility staff took more than an hour to answer Resident 2's call light (an alerting device for nurses or other nursing personnel to assist a patient when in need), when Resident 2 turned on her call light for assistance to use the toilet. This failure resulted in Resident 2 falling on the floor while attempting to get out of bed without staff assistance, causing Resident 2 to experience neck pain and headache. Resident 2 subsequently was sent to the hospital for complaint of dizziness. Findings: Resident 1 A review of the Admission Record indicated Resident 1 was admitted on [DATE], with diagnoses including but not limited to Cerebral Infarction (also known as stroke) and Muscle Weakness. A review of the Activities of Daily Living (ADL - the tasks of everyday life like eating, dressing, getting into or out of a bed or chair, turning in bed, taking a bath or shower, and using the toilet), Care Plan, revised on 9/23/21, indicated Resident 1 was totally dependent on staff for all ADLs. (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of the Minimum Data Set (MDS -health status screening and assessment tool used for all residents), dated 3/15/24, indicated Resident 1 had a BIMS score of 02 out of 15 points (Brief Interview for Mental Status, a 15-point cognitive [relating to the mental process involved in knowing, learning, and understanding things] screening measure that evaluates memory and orientation. A score of 00 to 07 is severe impairment). The MDS indicated Resident 1 had functional limitations in range of motion (ROM - the extent or limit to which a part of the body can be moved around a joint or a fixed point) to both upper and lower extremities. The MDS indicated Resident 1 was dependent on staff to maintain perineal hygiene and to turn in bed. A review of the Progress Note, dated 3/22/24 at 7:11 a.m., indicated around 6 a.m. on 3/22/24, Resident 1 fell out of bed. The Progress Note indicated Resident 1 had contusion (also known as bruise) and swelling close to her right eye. Resident 1 also had left shin swelling and bruising. The Progress Note indicated the NP (Nurse Practitioner - nurse who has advanced clinical education and training) ordered an X-ray (a type of medical imaging that creates pictures of the bones and soft tissues) and to send Resident 1 out to the hospital if her condition changed. A review of the X-ray report, dated 3/22/24 at 11:29 a.m., indicated Resident 1 had left tibia fracture. A review of the Progress Note, dated 3/23/24 at 1 a.m., indicated Resident 1 returned to the facility around 11 p.m., with a cast (holds a broken bone in place and prevents the area around it from moving as it heals) above her left knee. The Progress Note indicated Resident 1 had a fracture to her left tibia. During an interview with Unlicensed Staff A on 5/03/24 at 10:54 a.m., when Unlicensed Staff A was asked how much assistance was needed to turn Resident 1 in bed, Unlicensed Staff A stated Resident 1 was dependent from staff with turning and repositioning. When Unlicensed Staff A was asked how many staff were required to assist dependent resident with turning in bed, Unlicensed Staff A stated at least two staff. She stated Resident 1 had contractures (a fixed tightening of muscle, tendons, ligaments, or skin preventing normal movement of the associated body part) and could not help with turning. She stated she would always ask another staff to help her when providing care, for safety. During an interview with Licensed Staff B on 5/03/24 at 11:02 a.m., when Licensed Staff B was asked how much assistance was needed to turn Resident 1 in bed, Licensed Staff B stated Resident 1 was dependent on staff with turning and repositioning. During an observation in Resident 1's room on 5/03/24 at 11:08 a.m. with Licensed Staff B, Resident 1 was sitting on a geriatric chair (a large, padded chair that is designed to help seniors with limited mobility) with her right leg flexed and left leg extended. Resident 1 appeared uncomfortable, grimacing, face reddened and moaning. Resident 1 was nonverbal. During an interview with the Director of Nursing (DON) on 5/03/24 at 11:11 a.m., when the DON was asked about the fall incident on 3/22/24, involving Resident 1, the DON stated, when Unlicensed Staff C was providing care to Resident 1, Resident 1 inadvertently moved and accidentally fell on the other side of the bed. The DON stated Unlicensed Staff C could not move fast enough on the other side of the bed to catch Resident 1. When the DON was asked how many staff was required to assist a dependent resident with turning in bed, the DON stated usually one to two staff. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview with Unlicensed Staff C on 5/03/24 at 12:16 p.m., when Unlicensed Staff C was asked about the fall incident involving Resident 1, Unlicensed Staff C stated he was providing care to Resident 1 when the incident happened. He stated Resident 1 was turned on her side when Resident 1 suddenly moved, rolled over and fell out of bed. When Unlicensed Staff C was asked how much assistance was needed to turn Resident 1 in bed, Unlicensed Staff C stated Resident 1 was dependent on staff with two-person assist. However, he stated he had been providing care to Resident 1 with no help from other staff for a long time and was familiar with Resident 1. Resident 2 A review of the Admission Record indicated Resident 2 was admitted on [DATE], with diagnoses including but not limited to left side Hemiplegia (the loss of the ability to move [and sometimes to feel anything] one side of the body) and Hypertension (high blood pressure). A review of the MDS, dated [DATE], indicated Resident 2 had a BIMS score of 14 out of 15 (a score of 13 to 15 is cognitively intact). The MDS indicated Resident 2 required Substantial/maximal assistance (Helper lifts or holds trunk or limbs and provides more than half the effort) with toileting, hygiene; toilet transfer; and chair/bed-to-chair transfer. Resident 2 was always incontinent (unable to voluntarily control retention of urine or feces in the body) with bowel and bladder function. A review of the ADL Functioning with Self-Care Deficit Care Plan, initiated on 3/25/24, indicated Resident 2 required substantial assistance with ADL. A review of the Progress Note, dated 4/23/24 at 8:01 p.m., indicated Resident 2 was found lying on her right arm on the left side of the bed and complained of neck pain and headache on 4/23/24. The Progress Note indicated Resident 2 was subsequently sent to the hospital on 4/23/24, for complaint of dizziness. During an interview with Unlicensed Staff D on 5/03/24 at 10:57 a.m., when Unlicensed Staff D was asked how much assistance was needed to transfer Resident 2 from her bed/wheelchair-to-bed, Unlicensed Staff D stated Resident 2 was dependent with transfer requiring two staff assistance. During an interview with Licensed Staff B on 5/03/24 at 11:05 a.m., when Licensed Staff B was asked how much assistance was needed to transfer Resident 2 from her bed/wheelchair-to-bed, Licensed Staff B stated Resident 2 was dependent with transfer requiring two staff assistance. During an interview with DON on 5/03/24 at 11:11 a.m., when the DON was asked about the fall incident on 4/23/24, involving Resident 2, the DON stated Resident 2 was taking Lactulose (used in the treatment of constipation (a problem with passing stool [poop]) and hepatic encephalopathy (a disorder caused by a buildup of toxins in the brain that can happen with advanced liver disease) causing Resident 2 to have loose bowel movement. She stated the CNA (Certified Nursing Assistant) had just gone to Resident 2's room to provide bowel incontinence care. The DON stated, when Resident 2 turned her call light again for assistance, the CNA was busy assisting other residents, and when the nurse went to answer Resident 2's call light, Resident 2 was already on the floor. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an observation and concurrent interview with Resident 2 in her room on 5/03/24 at 11:27 a.m., Resident 2 was sitting in her wheelchair waiting for staff to assist her back to bed. She stated she had asked the staff thirty minutes ago to assist her back to bed because her back was hurting but nobody had come to help her. When Resident 2 was asked about her fall incident on 4/23/24, Resident 2 stated she turned her call light for assistance because she was, all covered with poop. She stated an unidentified staff came and told her she would be right back. Resident 2 stated one hour, and twenty minutes past but nobody came to help her, so she decided to get up to use the toilet and fell on the floor. Resident 2 stated she had neck pain, headache and felt dizzy after the fall and ended up going to the hospital. When Resident 2 was asked how much help she needed to transfer from her bed to her wheelchair, Resident 2 stated her left side was paralyzed (unable to move or feel all or part of the body), and she always needed two persons to help her. A review of the Facility policy and procedure titled, Activities of Daily Living (ADLs), Supporting, revised on March 2018, indicated, Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: . b. Mobility (transfer and ambulation, including walking); c. Elimination (toileting).