STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555200	A. Building B. Wing	11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Almond View Care Center	1224 E Street Williams, CA 95987

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43755 Based on observation, interview, and record review, the facility failed to ensure one of four sampled residents (Resident 3) dignity was honored when Certified Nursing Assistant C (CNA C) provided personal cares with the window covering open which exposed Resident 3 to an outside courtyard accessible to staff and residents. This failure had the potential to negatively affect Resident 3 ' s physical and mental well-being. Findings: A review of the facility ' s policy titled Promoting/Maintaining Resident Dignity dated 11/2023, indicated It is the practice of this facility to protect and promote residents ' rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident ' s quality of life by recognizing each resident ' s individuality. Compliance Guidelines 11. Maintain resident privacy. A review of Resident 3 ' s Admission Record (undated) indicated that Resident 3 was admitted to the facility on [DATE] with diagnoses including Alzheimer ' s Disease (a disease that destroys memory and other important mental functions), dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), chronic (ongoing) pain, need for assistance with personal care. A review of Resident 3 ' s Quarterly Minimum Data Set (MDS, a complete clinical assessment) dated 9/10/24, indicated a Brief Interview for Mental Status (BIMS, an evaluation of cognition [thinking, recalling, and making decisions]) was done with results indicating her cognition was severely impaired. Section GG indicated Resident 3 was dependent on staff for toileting needs. Section H indicated Resident 3 was always incontinent with urination and bowel movements. (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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 11/15/24 at 1:33 pm, Resident 3 ' s room was observed. Resident 3 was in bed and the right side of her bed was against an outside wall. There was a window alongside the lower half of her bed that looked outside onto a courtyard (grassy area and a sidewalk). The window shade was completely open. CNA C was observed entering Resident 3 ' s room and pulling a privacy curtain around Resident 3 ' s left side of the bed and the end of the bed but stopped a foot short of the wall. The window shade was all the way up and Resident 3 was in full view of the outside. CNA C was observed changing Resident 3 ' s brief (incontinent product worn like a diaper that collects bowel and urine). Resident 3 ' s peri area (resident ' s private area) was exposed to the outside area through the uncovered window. During a concurrent observation and interview with Licensed Vocational Nurse A (LVN A) on 11/15/24 at 1:35 pm, in Resident 3 ' s room. LVN A entered the room and when it was pointed out by the surveyor that the window shade was up and Resident 3 was having personal cares done, LVN A immediately pulled the window shade down. During a concurrent observation and interview with the Activity Director (AD) on 11/15/24 at 1:40 pm, the outside courtyard was observed. The AD indicated this area was accessible to staff and residents. The AD confirmed that she was able to see in the windows when the shades were up. The AD indicated it would be a dignity issues to do personal cares for a resident with the window shades up exposing private areas of a resident. During an interview on 11/15/24 at 1:45 pm, CNA C indicated she should have pulled the window shade down before she started to give cares and it was a dignity issue that she had not. During an interview on 11/15/24 at 2:59, the Administrator and Director of Nursing both concurred that window shades should be closed to maintain privacy when doing personal cares with a resident.

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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** 43755 Based on observation, interview, and record review, the facility failed to ensure that one of four sampled residents (Resident 1) was free from physical restraints (any manual method, physical or mechanical device that the individual cannot remove easily that restricts movement or normal access to one ' s body) when a staff member (unknown) put two pillows under Resident 1 ' s mattress which tilted the mattress up and prevented him from getting out of bed. This failure had the potential for Resident 1 to be unable to move freely increasing the risk for the decline of physical functioning, injury, and mental harm from being restricted to his bed. Findings: A review of the facilities policy titled Restraint Free Environment dated 11/2023, indicated that It is the policy of this facility that each resident shall attain and maintain his/her highest practicable wellbeing in an environment that prohibits the use of restraints for discipline or convenience Falls do not constitute self-injurious behavior or a medical symptom that warrants the use of a physical restraints. A review of Resident 1 ' s Admission Record (undated), indicated Resident 1 was admitted on [DATE] with diagnoses that included Parkinson ' s disease (a movement disorder that may cause stiffness, slowing of movement and trouble with balance that raises the risk of falls), diabetes (high blood sugar levels), Chronic Obstructive Pulmonary Disease (lung disease), history of falling, difficulty in walking, and cognitive communication deficit. A review of Resident 1 ' s Quarterly Minimum Data Set (a complete clinical assessment) dated 10/2/24, indicated Resident 1 required supervision by staff when transferring in and out of the bed and the chair. Resident 1 was able to walk with supervision. Resident 1 ' s Brief Interview of Mental Status (BIMS, an evaluation of cognition [thinking, recalling, and making decisions]) indicated his cognition was moderately impaired. A review of Resident 1 ' s Fall Care plan dated 12/29/24, indicated an intervention to use the safest, least restrictive measures to prevent falls. An observation of Resident 1 ' s room on 11/15/24 at 9:55 am, displayed Resident 1 lying in bed with his wife ' s bed pushed up against the right side of Resident 1 ' s bed. The left side of Resident 1 ' s bed was observed as the only exit side of the bed for Resident 1. Two pillows were observed stuffed under the left side of the mattress (between the mattress and supporting frame) which created a tilt of the mattress forcing Resident 1 to roll toward the center of the bed and away from the exit (left) side of the bed. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview with Certified Nursing Assistant (CNA) B on 11/15/24 at 10:00 am, Resident 1 ' s room and bed were observed. CNA B confirmed that there were pillows stuffed under his mattress and that Resident 1 was not able to remove them by himself. CNA B indicated she did not know why they were there, and they should be removed. Resident 1 was asked if he knew why there were pillows stuffed under his mattress and Resident 1 stated The night nurse put them there so I would not fall out of bed. They thought I was tending to roll out of bed. CNA B confirmed that this restricted his ability to get out of bed on his own and move freely in bed. During an interview with the Director of Nursing (DON) on 11/15/24 at 10:12 am, the DON indicated that the pillows were not supposed to be there and will be removed.

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F 0689 Level of Harm - Minimal harm or potential for 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** 43755 Based on observation, interview, and record review, the facility failed to ensure residents received assistance devices to prevent accidents for two of four sampled residents (Resident 1 and Resident 2) when: 1. Staff did not ensure that Resident 1 had his call light (a bedside button that directly signals the nursing staff when a resident required assistance) and a urinal (a plastic container that a resident can urinate in while in bed or next to the bed) within reach per his fall prevention care plan. 2. Staff did not ensure that Resident 2 had anti-rollback brakes (a device that attaches to a wheelchair and locks the wheels when a resident stands up, preventing the chair from rolling away from the resident) on her wheelchair per her fall prevention care plan. These failures had the potential to place Resident 1 and Resident 2 at risk for falls and possible injuries. Findings: A review of the facility ' s policy titled Falls/Accidents dated 11/2023, indicated The resident will remain as free from falls/accidents as is possible. The facility shall establish and utilize a systematic approach to address resident risk and environmental hazards to minimize the likelihood of accidents. 1. Identification of Hazards and Risks, and 2. Evaluation and Analysis; and 3. Implementation of Interventions. 1. A review of Resident 1 ' s Admission Record (undated), indicated Resident 1 was admitted on [DATE] with diagnoses that included Parkinson ' s disease (a movement disorder that may cause stiffness, slowing of movement and trouble with balance that raises the risk of falls), diabetes (high blood sugar levels), Chronic Obstructive Pulmonary Disease (lung disease), history of falling, difficulty in walking, and cognitive communication deficit. A review of Resident 1 ' s Quarterly Minimum Data Set (a complete clinical assessment) dated 10/2/24, indicated Resident 1 required supervision by staff when transferring in and out of the bed and the chair. Resident 1 was able to walk with supervision. Resident 1 ' s Brief Interview of Mental Status (BIMS, an evaluation of cognition [thinking, recalling, and making decisions]) indicated his cognition was moderately impaired. Section H indicated Resident 1 was frequently incontinent of urine. A review of Resident 1 ' s Fall Risk Evaluation dated 10/11/23, indicated Resident 1 was at high risk for falls. A review of Resident 1 ' s Progress Notes indicated Resident 1 had four falls since his 12/28/23 admission which were as follows: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. On 2/25/24 Resident 1 ' s nurses notes indicated Resident was found on the floor sitting and leaning against bed. Wife was standing next to him stating I was just trying to help him go to the bathroom. b. On 3/21/24 Resident 1 ' s alert charting indicated Around 10:40 am, this nurse heard yelling help help down the hallway, went to see who was calling out and found resident lying on the floor with protectors (large cushion boots, only to be worn in the bed, to protect feet from pressure injuries) on feet . Resident stated 'I was trying to walk to the closet to get a pair of pants, call light was not on.' c. On 8/21/24, Resident 1 ' s Interdisciplinary Team (IDT - group of health care disciplines that discuss resident care needs) note indicated that on 8/15/24 at 3:25 pm, CNA went to room for call light response and noted resident on the floor. He was wearing slippers. He said, ' I got up and went to the bathroom and came back and was just trying to tidy up some of the trash we had lying around and then I fell over. ' d. On 10/11/24, Resident 1 ' s nurses notes indicated He went to the bathroom by self and slipped on a wet floor that had water and urine on it. A review of Resident 1 ' s fall prevention care plan revised 10/31/24, indicated Resident 1 was at risk for falls due to having poor balance, unsteady gait and requiring assistive device for ambulation. Interventions included, but was not limited to, encourage resident to use call light for assistance, offer toileting to bathroom after meals and as needed, urinal within reach at all times. During an observation on 11/15/24 at 9:45 am, Resident 1 was observed in his room and lying in bed. Resident 1 ' s call light and walking cane were under his bed and out of his reach. There was no visible urinal next to his bed. During a concurrent observation and interview with Licensed Vocational Nurse A (LVN A) on 11/15/24 at 9:55 am, Resident 1 ' s room was observed. LVN A picked up the call light and walker from under the bed and placed them within Resident 1 ' s reach and stated, He throws things under the bed. LVN A was observed attempting to pin the call light onto Resident 1 ' s sheets but was unable to. LVN A indicated that the call light clip (a metal clip attached to the call light cord to allow call lights to be clipped onto the bedsheets and keep them within a resident ' s reach) was broken, and she would notify maintenance to get it fixed. LVN A indicated that the call light and his walking cane should be within reach and not be on the floor. During a concurrent observation and interview with Certified Nursing Assistant B (CNA B) on 11/15/24 at 2:33 pm, Resident 1 ' s room was observed. CNA B indicated that Resident 1 did not have a urinal and she had not remembered him using one. Resident 1 ' s call light was located under his covers and behind his back. CNA B attempted to clip the call light cord to the top of his bed covers but was unable to so she just laid the call light on top of the bedsheets. CNA B indicated the clip was broken. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent record review of Resident 1 ' s fall prevention care plans and interview with the Director of Nursing (DON) and Administrator on 11/15/24 at 2:59 pm, the DON confirmed that Resident 1 had not had a urinal at bedside but should have because it was on his care plan to have one within reach at all times. The DON confirmed that Resident 1 ' s call light clip was broken and needed to be fixed to keep the call light within his reach. 2. A review of Resident 2 ' s Admission Record (undated), indicated Resident 2 was admitted on [DATE] then readmitted on [DATE] after a short hospital stay from a fracture of the left leg due to a fall sustained in the facility. Resident 2 ' s diagnoses included, fracture of left femur (upper leg), need for assistance with personal cares, respiratory failure, depression, history of falling, dementia, and high blood pressure. A review of Resident 2 ' s admission MDS dated [DATE], indicated Resident 2 ' s BIMS score was 5 indicating she was severely cognitively impaired. Section GG indicated she required maximum assistance from staff with lying to sitting and sitting to standing. A review of Resident 2 ' s Fall Risk Evaluation dated 10/21/24, indicated Resident 2 was at high risk for falls. A review of Resident 2 ' s nurses progress notes dated 10/14/24, indicated Resident 2 attempted to stand unassisted from her wheelchair while wheelchair was unlocked. The wheelchair rolled backwards, and Resident 2 fell to ground. A review of Resident 2 ' s fall prevention care plan revised 10/23/24, indicated fall interventions included, but were not limited to, apply anti-roll back brakes to wheelchair. During an observation on 11/15/24 at 1:24 pm in Resident 2 ' s room, Resident 2 was sleeping in bed and there was a wheelchair next to her bed. The wheelchair did not have anti-roll back brakes on it. During a concurrent observation and interview with LVN A on 11/15/24 at 1:35 pm, Resident 2 ' s wheelchair was observed. LVN A confirmed Resident 2 ' s wheelchair did not have anti-roll back brakes attached to the wheelchair and they should be.