

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555444	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/15/2024
NAME OF PROVIDER OR SUPPLIER Sunnyvale Gardens Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1150 Tilton Drive Sunnyvale, CA 94087	

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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46552</p> <p>Based on interview, and record review, the facility failed to follow their policy and procedure (P&P) to safely secure and return personal belongings to one of one sampled resident (Resident 1) after Resident 1 was transferred to acute hospital (AH: where residents receive short term treatment for an urgent medical condition or severe illness).</p> <p>This failure had the potential for losing Resident 1's personal belongings, and negatively affect Resident 1's psychosocial wellbeing.</p> <p>Findings:</p> <p>A record review of Resident 1's face sheet (FS: a document that gives a resident's information at a quick glance) indicated Resident 1 was admitted to the facility on [DATE] and discharged to AH on 2/3/2024 following an episode of fall and did not return to facility from AH. Resident 1 had an assigned significant family member as resident representative (RP: a person authorized to act as a resident's agent).</p> <p>Review of Resident 1's inventory of personal effects (IPE) document indicated there were several personal items documented and signed by Resident 1 and facility staff upon Resident 1's admission to facility on 1/14/2024. Further review of inventory of personal effects form indicated there was no signature or date by Resident 1's RP or facility staff on discharge/move-out of Resident 1 on 2/3/2024.</p> <p>During a telephone interview with Resident 1's RP on 6/7/2024 at 11:35 a.m., RP stated facility staff were unable to locate and failed to return Resident 1's personal belongs to RP after Resident 1 transferred to AH on 2/3/2024 and did not come back to facility from AH.</p> <p>During a concurrent record review of Resident 1's inventory of personal effects document and interview with facility's social service assistant (SSA) on 6/13/2024 at 2:31 p.m., SSA acknowledged there was no signature by the Resident 1 or RP and staff to indicate Resident 1's personal belongings were returned or given after Resident 1 left the facility. SSA stated staff were unable to locate where Resident 1's personal belongings were stored in the facility. SSA also stated social service staff should have stored safely and returned all personal belongs of Resident 1 to Resident 1 and/or Resident 1's RP after Resident 1 left the facility.</p> <p>(continued on next page)</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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with facility's director of nursing (DON) on 6/13/2024 at 3:30 p.m., DON stated social service staff should have stored all personal items and returned them safely to Resident 1 or Resident 1's RP after Resident 1 left the facility to AH on 2/3/2024.</p> <p>During a review of facility's P&P titled, Release of a Resident's Personal Belongings, revised March 2017, the P&P indicated, Personal belongings of a resident transferred or discharged from our facility will be released to the resident or authorized resident representative. Personal belongings of a resident who is temporarily transferred or discharged from the facility will be inventoried and stored by the facility until the resident has returned or such items have been picked up by the resident's representative. Individuals receiving the resident's personal belongings will be required to sign a release for such items.</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44583</p> <p>Based on observation, interview, and record review, the facility failed to implement their abuse policy and procedure for one of one resident (Resident 2) when the facility did not report Resident 2's injury of unknown source.</p> <p>This failure resulted in Resident 2's fractures of left third and fourth metacarpals (broken middle and ring fingers) of unknown source not reported to required agencies (California Department of Public Health [CDPH], law enforcement agency, and Long-Term Care Ombudsman). This failure had the potential to compromise the safety of the residents in the facility.</p> <p>Findings:</p> <p>Review of Resident 2's face sheet (a document that gives a resident's information) indicated, Resident 2 was admitted to the facility with diagnoses including unspecified sequelae (after effect of a disease, condition or injury) of cerebral infarction (also called stroke), wedge compression fracture of unspecified thoracic vertebra (broken backbone that occurs when the front part of the backbone collapses giving it a wedge shape), initial encounter for closed fracture, vascular dementia (problems with reasoning, planning, judgement, memory, and other thought processes caused by brain damage from impaired blood flow to the brain), age-related osteoporosis (a bone disease that weakens bones and increases the risk of breaking them) without current pathological fracture, reduced mobility and need for assistance with personal care.</p> <p>Review of Resident 2's quarterly minimum data set (MDS, an assessment tool) assessment dated [DATE], indicated Resident 2 had memory problem with short-term memory and long-term memory and her daily decision making with task was severely impaired (never/rarely made decision). Further review indicated Resident 2 required substantial/maximal assistance (helper does more than half the effort) with sit to stand, chair/bed-to-chair transfer, and with wheelchair locomotion (the ability to move and the act of moving from one place to another) from 50 feet with two turns to 150 feet.</p> <p>During an interview with certified nursing assistant B (CNA B) on 9/6/2024 at 1:20 p.m., CNA B confirmed she was assigned to Resident 2. CNA B stated Resident 2 required assistance in moving around her room and in the facility with the use of her wheelchair. CNA B further stated, Resident 2 was unable to wheel herself in the facility.</p> <p>During an observation on 9/6/2024 at 1:26 p.m. inside the facility's dining room, Resident 2 was observed eating lunch and only required supervision with eating. Resident 2 was calm and quiet during observation but was unable to communicate due to Resident 2 was non-English speaking only.</p> <p>Review of Resident 2's Nurse's note, dated 8/28/2024, indicated, At 0928 bruise found on pts [patients] left hand.</p> <p>Review of Resident 2's Nurse's note, dated 8/30/2024, indicated, Resident 2 was transferred to the hospital for further evaluation and treatment of the non-displaced fracture of the left fourth metacarpal (broken bone in the left ring finger).</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 2's progress notes titled, IDT [interdisciplinary team, composed of members from different departments involved in resident's care] NOTE, dated 8/30/2024, indicated to address Resident 2's fracture of the left fourth metacarpal. Further review indicated the physician ordered an X-ray (a type of electromagnetic radiation that produces images of the inside of the body or objects) for Resident 2's left hand and had a result of an acute non-displaced fracture in the fourth metacarpal. It also revealed, .staff observed no falls or received report of falls or apparent injuries during their shifts .The interdisciplinary team and attending physician deemed the resident's injury as likely a spontaneous (pathological) [pathological fracture, is a broken bone that occurs when a disease weakens the bone, rather than an injury] fracture secondary to the resident's diagnosis of Osteoporosis (a disease that causes bones to become weak and brittle, increasing the risk of breaking bones) .</p> <p>Review of Resident 2's emergency room (ER) report from the hospital dated 8/30/2024, indicated, Chief Complaint: Patient presents with Swelling .for evaluation of 2-day history of left hand swelling and pain after a fall. Moderate amount of swelling as well as pain noted to the left hand .Left hand: Swelling, tenderness and bony tenderness present. Further review revealed, Diagnosis:1. Closed nondisplaced fracture of fourth metacarpal bone of left hand, unspecified portion of metacarpal, initial encounter; 2. Closed nondisplaced fracture of third metacarpal bone of left hand (broken left middle finger), unspecified portion of metacarpal, initial encounter.</p> <p>During an interview with DON on 9/6/2024 at 2:30 p.m., DON confirmed Resident 2 did not fall on or before 8/28/2024. DON stated Resident 2's fracture on left fourth finger was just a pathological fracture due to history of osteoporosis. DON also confirmed they did not report the fracture of unknown source because they found out it was a pathological fracture. DON stated they did not need to report.</p> <p>During an interview with administrator (ADM) on 9/9/2024 at 10:36 a.m., ADM stated Resident 2 did not fall on or before 8/28/2024. ADM further stated, Resident 2 only had a pathological fracture caused by osteoporosis. ADM confirmed they did not report Resident 2's fracture. ADM stated they did not need to report since Resident 2 had diagnosis of osteoporosis and Resident 2 could sustain a fracture even with a slight hit of her hand on the table.</p> <p>During an interview with licensed vocational nurse C (LVN C) on 9/9/2024 at 12:42 p.m., LVN C confirmed he was Resident 2's nurse on 8/28/2024. LVN C stated, one of the CNAs asked him to check Resident 2's left hand because of the discoloration. LVN C confirmed there was a bruise found on Resident 2's lateral side of the left hand. LVN C stated, Resident 2 did not fall on 8/28/2024.</p> <p>During a concurrent interview with ADM and DON on 9/10/2024 at 3:38 p.m., ADM and DON confirmed Resident 2 did not have any falls on August. ADM stated Resident 2 could possibly sustained the fracture while she was wheeling herself in the facility. ADM stated he did not report the fracture because the location of the fracture did not indicate an abuse but he confirmed they investigated the injury of unknown source.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's policy and procedure titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, date revised April 2021, All reports of resident abuse (including injuries of unknown origin) .are reported to local, state and federal agencies (as required by current regulations) .If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law.</p>		

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<p>F 0689</p> <p>Level of Harm - 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46552</p> <p>Based on interview and record review the facility failed to provide required supervision and assistance and failed to implement a resident's minimum data set (MDS: clinical and functional assessment tool) assessment for assistance for bed mobility, transfers, toileting, ambulation, and risk for falls care plan for transfer and ambulation assistance, to prevent a fall on 2/3/2024 for one of 2 sampled residents (Resident 1).</p> <p>These failures resulted in Resident 1's fall and subsequent transfer to acute hospital (AH: where residents receive short term treatment for an urgent medical condition or severe illness) where Resident 1 was diagnosed with left wrist fracture (broken wrist bones).</p> <p>Findings:</p> <p>Review of Resident 1's face sheet (FS: a document that gives a resident's information at a quick glance) indicated Resident 1 was admitted to the facility on [DATE] and transferred to AH on 2/3/2024 following an episode of fall. Resident 1's FS indicated Resident 1 was admitted to the facility with diagnoses including wedge compression fracture of fifth lumbar vertebra (series of small back bones broken), unsteadiness on feet (pattern of walking that is unstable), muscle wasting and atrophy (decrease in size of muscle tissue), osteoporosis (a condition in which bones become weak and brittle), arthritis (swelling and tenderness in one or more joints), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest in activities of daily living), and malignant neoplasm of bladder (bladder [body organ that stores urine] cancer). Resident 1 had an assigned significant family member as resident representative (RP: a person authorized to act as a resident's agent).</p> <p>Review of Resident 1's admission/readmission evaluation document dated 1/14/2024 indicated Resident 1 was at risk for falls due to history of falls, impaired vision, and medical problems.</p> <p>Review of Resident 1's MDS assessment dated [DATE] for Resident 1's brief interview for mental status (BIMS, an assessment to test a person's cognition level) indicated score 13 of 15 (score of 0-7: severe impaired cognition, 8-12: moderately impaired cognition, 13-15: intact cognition). Review of mobility device Resident 1 used indicated walker (a device that gives support to maintain balance and stability while walking). Review of toileting hygiene indicated Resident 1 required partial/moderate assistance [helper does less than half the effort. Helper lifts or holds trunk (body apart from hands and legs) or limbs (hands and legs) but provides less than half the effort]. Review of lower body dressing for Resident 1 indicated dependent (helper does all the effort). Review of lying to sitting on side of the bed and sit to lying on side of the bed for Resident 1 indicated dependent. Review of sit to stand and transfer from bed Resident 1 required partial/moderate assistance from care giver staff.</p> <p>Review of Resident 1's care plan for risk for falls dated 1/15/2024 indicated, Provide assist to transfer and ambulate as needed.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 1's medical doctor (MD)'s progress notes, dated 1/15/2024, 1/17/2024, 1/24/2024, 1/25/2024, and 1/29/2024, for fall risk assessment indicated, High fall risk and for plan indicated, Strict fall precautions.</p> <p>Review of Resident 1's physical therapy treatment (a branch of health care that helps with exercise, massages and various other treatments based on physical stimuli) encounter notes dated 2/2/2024 indicated, spinal precautions (prevent movement of the backbone). Review of functional status for bed mobility transfers indicated Resident 1 required supervision (assistance may be provided throughout the activity or intermittently), and for gait (walking pattern) Resident 1 needed stand by (to be there, just in case need to help) assist with walker.</p> <p>Review of Resident 1's occupational (a branch of health care that helps with physical sensory, and cognitive problems) encounter notes dated 2/1/2024 indicated fall precautions. Review of functional status for lower body dressing and toileting, Resident 1 needed moderate assistance, and toilet/commode transfers, Resident 1 required contact guard assist (one or two hands on assistance by the staff).</p> <p>Review of occupational treatment encounter notes dated 2/2/2024 indicated fall precautions. Review of functional status for lower body dressing needed minimum assistance (some assistance from staff is needed), and for toileting and transfers, Resident 1 required supervision.</p> <p>Review of Resident 1's ADL (activities of daily living) worksheet for February 2024 indicated, Resident 1 received supervision with one-person physical assist for bed mobility, transfers, and toileting during night shift (11:00 pm to 7:00 am) on 2/1/2024 and 2/2/2024.</p> <p>Review of Resident 1's nurse progress notes dated 2/3/2024 at 4:00 a.m., indicated Resident 1 was found sitting on floor leaning against the closet in room with hands on the lap at 1:00 a.m. Further review of these notes indicated Resident 1 stated, I heard voices talking while going back to bed from the bathroom, and I don't know what happened I just fall. Resident 1 denied pain upon nursing assessment. Review of continuation of nurses note at 6:00 a.m., indicated Resident 1 complained of left wrist and forearm pain and requested to go to AH. Nursing noted minimal swelling on Resident 1's left wrist and forearm area. Resident 1 was sent to AH via 911 (emergency medical personnel assess and transport resident to appropriate emergency department for clinical care) around 7:23 a.m.</p> <p>Review of nurse progress notes dated 2/1/2024 at 11:50 a.m., and 2/2/2024 at 4:25 p.m., indicated Resident 1 ambulated with walker with supervision both times.</p> <p>Review of emergency department at AH MD notes dated 2/3/2024 at 8:14 a.m., indicated, left wrist x-ray (painless test that takes pictures of inside the body) with distal radius fracture (broken one of two long bones in the forearm) as well as ulnar styloid process fracture (broken wrist bone) for Resident 1.</p> <p>Review of case manager at AH discharge planning notes dated 2/3/2024 at 12:03 pm., indicated, Daughter said that pt (patient) fell this morning while going to the restroom. Also, pt mentioned that she was calling to go to the restroom as she is supposed to have walk with walker and assistance, but no one came to help her.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of MD consult note from AH dated 2/3/2024 at 7:29 p.m., indicated, This morning around 1 am, while patient tried to use the restroom on her own, she developed a fall. Wrist X-ray showed fracture of the distal left radius and mildly displaced fracture of the ulnar styloid process.</p> <p>During an interview over the telephone with Resident 1's RP on 6/7/2024 at 11:36 a.m., RP stated, mom told me she fell after walking back from bathroom by herself, mom needed help to use the bathroom. RP also stated, Mom called for help several times, staff did not come to help her, facility staff neglected my mom's care, she had a wrist fracture from this fall.</p> <p>During a concurrent review of Resident 1's nurse progress notes dated 2/3/2024 at 4:00 a.m., and interview with facility's director of nursing (DON) on 6/7/2024 at 3:35 p.m., DON acknowledged Resident 1 did not receive supervision or assistance as needed for transfer, toileting, and ambulation. DON stated nursing staff did not implement risk for falls care plan to assist with transfer and ambulation as needed for Resident 1. DON also stated nursing staff should have provided supervision and assistance as needed for Resident 1 to prevent the fall on 2/3/2024.</p> <p>During a concurrent record review of Resident 1's ADL work sheet for February 2024 and interview over the telephone on 8/7/2024 at 2:06 p.m., with certified nursing assistance A (CNA A), assigned for Resident 1 on 2/3/2024 during night shift, when Resident had the fall, CNA A confirmed Resident 1 required supervision with set-up help from staff for bed mobility, transfers, and toileting. CNA A stated supervision with set up help means staff person required to stay in-person with Resident 1 for bed mobility, transfers, and toileting to supervise and assist as needed for Resident 1. CNA A also stated she did not recall how the fall happened for Resident 1 since it happened months ago.</p> <p>During an interview with facility's director of rehabilitation (DOR) on 8/8/2024 at 11:40 a.m., DOR confirmed Resident 1 required staff's supervision for bed mobility, transfers, and toileting. DOR stated supervision means staff person needed to be present with residents to assist in case if residents needed help with above tasks. DOR also stated staff should have helped as needed for Resident 1.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Assisting Activities of Daily Living (ADL); Supervision, dated 2001, the P&P 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:</p> <ul style="list-style-type: none"> a. hygiene (bathing, dressing, grooming, and oral care); b. mobility (transfer and ambulation, including walking); c. elimination (toileting). 		