STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555470	A. Building B. Wing	07/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wagner Heights Nursing & Rehabilitation Center	9289 Branstetter Place Stockton, CA 95209

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 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47369 Based on interview and record review, the facility failed to ensure one of four sampled residents (Resident 2) was examined by a physician at least every 30 to 60 days. This failure had the potential to result in unidentified medical conditions being untreated for Resident 2. Findings: A review of Resident 2 ' s ADMISSION RECORD, indicated she was admitted to the facility in mid-2023 with diagnoses which included malignant neoplasm of large intestine and rectum (rectal and intestinal cancer) and heart failure (chronic ocndition in which the heart does not pump blood as well as it should). During an interview on 6/26/24, at 11:22 AM, Resident 2 stated she had diabetes (a chronic disease in which the body has a shortage of insulin, a decreased ability to use insulin, or both which affects blood sugar levels) and her blood sugars were high off and on. Resident 2 further stated, I don ' t see a doctor here. About two months ago they said my doctor had been changed and I haven ' t seen him yet. A review of Resident 2 ' s clinical record, Progress Note dated 9/27/23, at 9 PM, indicated, .Type: *MD H& P [Medical Doctor History and Physical] Progress Note . LATE ENTRY .hospitalization .July 2023 .discharged to skilled nursing facility .Author:[name] Physician - MD . There were no other physician visits documented in Resident 2's Electronic Health Record (EHR). During a concurrent interview and record review on 6/26/24, at 4:09 PM, Health Information Management staff (HIM) 1, confirmed there were no physician progress notes documented in Resident 2 ' s EHR after 9/27/2023. During an interview on 7/3/24, at 11:31 AM, HIM 2 stated the HIM department created a monthly report of all residents to check the dates of the last physician visit. HIM 2 stated if a physician ' s visit was overdue, they would notify the physician via text, fax, and by placing a note in his/her binder at the facility. The HIM 2 further stated the overdue physician visits were reported in QAPI (Quality Assurance and Improvement Plan, a systematic, interdisciplinary, comprehensive, and data-driven approach to maintaining and improving safety and quality in nursing homes while involving residents and families in practical and creative problem solving) every month. (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 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/3/24, at 12:02 PM, the Administrator (ADM) stated the HIM did discuss physician visits in QAPI and stated the facility needed to notify physicians when they were out of compliance. During an interview on 7/3/24, at 11:25 AM, the Director of Nurses (DON) stated it was his expectation that the physicians would be in to see their residents every 30-60 days per the facility policy. The DON confirmed Resident 2 ' s documentation indicated she had last been visited by a physician in September of 2023. During a phone interview on 6/28/24, at 8:47 AM, the Medical Director (MDir) stated the facility residents were visited by a physician every month. The MDir further stated Resident 2 was under the care of another physician who left suddenly. The MDir stated it was unfortunate that Resident 2 had not been seen since September. The MDir further stated the purpose of the monthly visit was to make sure the resident was okay; answer any questions or concerns they may have, and review the chart. A review of a facility document titled, AHIMA ' s [American Health Information Management Association] Long-Term Care Health Information Practice and Documentation Guidelines, dated, 2014, indicated, .Role of the Attending Physician in the Nursing Home .Progress notes must be written, signed and dated each time a physician visits a resident .Per federal regulations, the resident must be seen at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter .Progress notes should provide documentation to explain medical decisions, enable effective care and should include .An evaluation of the resident ' s condition, current status and goals .Relevant information about significant ongoing, active, or potential problems including reasons for changing or maintaining current treatments or medications .

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. 47369 Based on interview and record review, the facility failed to provide medically related social services for one of four sampled residents (Resident 3) when Resident 3 ' s follow up appointments with medical specialists were not scheduled as ordered. This failure had the potential to adversely affect Resident 3 ' s health and well- being. Findings: A review of Resident 3 ' s ADMISSION RECORD, indicated she was admitted to the facility in February of 2024, with diagnoses which included fracture of the right pubis (most forward facing bone of the three hip bones), displaced (ends of the bone have come out of alignment) fracture of olecranon process (arm bone that forms the point of the elbow) with intraarticular extension of right ulna (fracture that extends into the joint of long thin bone in the lower arm), non displaced (bone fracture in which the bone retains its proper alignment)Type II DENS fracture (neck bone fracture) and contusion of scalp (a bruise under the skin of the head.) A review of Resident 3 ' s, Order Summary Report, indicated: .Aspen collar [device worn around the neck to prevent movement] Order Date 02/28/2024 . .Cast Site: RIGHT ARM Daily .Order Date 02/28/2024 . .Follow up with [name of orthopedist, (specialized physician who treats injuries and diseases of bones)] within 1 to 2 weeks .Order Date 02/28/2024 . .Follow up with [name of neurosurgeon, (specialized physician who treats injuries and diseases of the spinal cord and brain)] in 2 weeks .Order Date 02/28/2024 . During an interview on 6/26/24, at 3:10 PM, the Social Services Director (SSD) stated the nurses input residents' orders into the electronic health record (EHR). The SSD further stated the Social Services department created a daily report from the EHR system of resident appointment orders and then proceeded to schedule the appointments. The SSD confirmed there was no documentation in Resident 3 ' s EHR to indicate her follow up appointments were scheduled. During a telephone interview on 6/28/24, at 2:12 PM, the SSD confirmed there was no documentation from the orthopedist or neurosurgeon to indicate Resident 3 had been to an appointment. The SSD further confirmed there was no documentation in the facility transport book or EHR to indicate Resident 3 had attended any follow up appointments. The SSD stated the purpose of the appointments were for Resident 3 to receive follow up care for her fractures and contusion. The SSD further stated there was a risk of delayed treatment if Resident 3 did not attend her appointments. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/3/2024, at 11:25 AM, the Director of Nurses (DON) stated it was his expectation that physician orders for follow up appointments would be carried out. The DON further stated not attending the appointments could negatively impact Resident 3 ' s overall recovery from her injuries. A review of a facility policy and procedure manual titled, Social Services Positive Practice, dated, November 2017, indicated, .An integral part of the interdisciplinary team [group of healthcare professionals who assess and coordinate care] Social Services address the physical, mental, social, and emotional well being of residents in the facility .Social Services mission is to provide a standard of practice that enables residents and families to cope with everyday issues in a positive manner .As a member of a team of health care professional our purpose is to maintain, restore and deliver services .Through direct Social Services, we will strive to deliver quality care with respect for the rights and dignity of the resident and individual problems and needs of our residents .