STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555470	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/24/2025

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 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** 50977 Based on observation, interview, and record review, the facility failed to ensure a safe environment and adequate supervision for one of three sampled residents (Resident 1) with a history of falls when Resident 1 fell on [DATE], 1/11/25, 1/19/25, and 1/21/25 and no new interventions were added to Resident 1 Fall Care plan after the falls on 1/19/25 and 1/21/25. These failures had the potential for Resident 1 be injured as a result of falling. Findings: A review of Resident 1 ' s ADMISSION RECORD indicated Resident 1 was admitted to the facility with diagnoses including anxiety disorder (a feeling of fear, dread, or uneasiness), brain stem stroke syndrome (blood supply to base of brain is cut off, which may cause dizziness, weakness, blurred vision, confusion), bipolar disorder (clear shifts in a person ' s mood, energy, activity level, and concentration), and encounter for palliative (end of life) care. During a concurrent observation and interview on 1/23/25 at 3:47 PM, Licensed Nurse (LN) 1 stated that he was regularly assigned to Resident 1 who was a frequent faller, and this was the reason Resident 1 was currently sitting in front of the nursing station where LN 1 was charting. LN 1 further stated, hospice (type of end of life, comfort care) provides a sitter (one-to-one supervision) for 3 hours a day 3 days a week. LN 1 also stated that even though hospice added the 3-hour sitter Resident 1 was still experiencing falls during the evening shifts. During an interview on 1/23/25 at 4:26 PM, at nursing station 3, Assistant Director of Nursing (ADON) 1 stated the IDT (group of healthcare professionals from different disciplines who work together to provide care) meets the next day after a fall occurs to review previous fall interventions or to add new fall interventions that may help prevent a resident from falling. ADON 1 stated the IDT requested assistance from the hospice provider of Resident 1 for one-to-one supervision after the fall event on 1/6/25 which hospice provided starting 1/13/25 on Mondays, Wednesdays, and Fridays for 3-hours. When asked about the effectiveness of the one-to-one sitter provided by hospice, the ADON 1 stated that it has not been effective because she continued to fall, and a one-to-one sitter provided by the facility would be decided by the administrator. (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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555470	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/24/2025

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/24/25 10:40 AM, LN 2 stated Resident 1, Had a fall the other day at 5 PM, while aides were assisting with dinner. LN 2 further stated that Resident 1 falls usually take place during shift change and evening shift. When asked about interventions to prevent falls for Resident 1, LN 2 stated, that Resident 1 ' s medications have been adjusted but felt like the adjustments had not been effective because Resident continued to experience falls. LN 2 described the one-to-one sitter provided by hospice as, least effective because they come during day shift. During a concurrent interview and record review on 1/24/25 at 12:00 PM, Resident 1 ' s SBAR-Fall Report of Incident 8Hr-V3, was reviewed with the Director of Nursing (DON). The DON stated the IDT meets the next day after a fall to review the fall event and adjust care plans as needed. A review of Resident 1 ' s, SBAR-Fall Report of Incident 8Hr-V3, dated 1/19/25 and 1/21/25 in the IDT Recommendations section indicated, .Continue current interventions and monitor effectiveness . The DON stated Depakote (Mood stabilizing medication) was added to Resident 1's medications on 1/16/25, but since medications were only adjusted last week, we did not want to initiate new interventions before the mood stabilizer medication reached its full effectiveness. The DON confirmed Resident 1 fell on [DATE] and 1/21/25 and no adjustment had been made to Resident 1 ' s fall care plan. During an interview on 1/24/25 at 12:30 PM with the Administrator (ADM), the ADM described the 3-hour one-to-one sitter assignment provided by Resident 1 ' s hospice as, not as effective as it could have been because the sitter assignment had been provided from 8 AM to 11 AM. The ADM further stated that the request for assistance from Resident 1 ' s hospice was for the times of 7 PM to 10 PM and that he was giving hospice a window/grace period to provide that adjustment for the sitte'sr schedule (7 PM to 10 PM). When asked about one-to-one sitting assignments provided by the facility for other residents, the ADM stated, We provide a one-to-one sitter for the residents that not only frequently fall but for the residents that have shown aggressive behaviors towards other residents and staff. A review of facility policy and procedure titled, Fall Prevention and Response, revised 8/23, indicated, . Customize interventions/approaches based on actual or suspected causal factors .review any accident trends and risk factors .