STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555530	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/30/2024
NAME OF PROVIDER OR SUPPLIER Chowchilla Memorial Healthcare District		STREET ADDRESS, CITY, STATE, ZIP CODE 1104 Ventura Ave. Chowchilla, CA 93610	

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41119 Based on observation, interview and record review, the facility failed to implement a resident-centered comprehensive care plan for two of three sampled residents (Resident 1and Resident 2), when: 1. Resident 1 was left unsupervised on 4/5/24 in the shower room resulting in fall. 2. Resident 2 ambulated without assistance on 4/18/24 in the facility hallway resulting in a fall. These failures resulted in Resident 1 and 2 falling to the ground and had the potential to result in injury. Findings: 1.During a review of Resident 1's Admission Record (document containing resident demographic information and medical diagnosis) undated, the admission record indicated Resident 1 was admitted to the facility on [DATE]. Resident 1's diagnosis included cognitive communication deficit (difficulty paying attention to a conversation, remembering information). During a concurrent observation and interview on 4/30/24 at 9:50 a.m., with Resident 1 in the dining room, Resident 1 was seated in her wheelchair. Resident 1 was unable to recall how she fell on [DATE]. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool used to identify resident cognitive and physical function) assessment dated [DATE], it indicated Resident 1's Brief Interview for Mental Status (BIMS -assessment of memory and judgment) assessment score was 7 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, 00-07 indicates severe impairment, 99 severely impaired). The BIMS assessment indicated Resident 1 had severe cognitive impairment. During a review of Resident 1 ' s Progress Notes (PN), dated 4/5/24 was reviewed. The PN indicated, . Resident was found lying on her left side next to shower hose in center shower room. Approximately 2 minutes prior, resident was assisted to the toilet in the shower room, CNA [certified nursing assistant] .left resident to get skin protectant cream. Upon CNA walking back into shower room, resident found lying on the floor . (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 4/30/24 at 11:47 a.m. with Licensed Vocational Nurse (LVN) 1, Resident 1 ' s Care Plan (CP) dated 6/2/23 was reviewed. The CP indicated, .is at risk for falls R/T [related to] generalized muscle weakness .Observe frequently and place in supervised area when out of bed . LVN 1 stated Resident 1 should not have been left unsupervised in the shower room. LVN 1 stated the care planned interventions should be implemented by all staff caring for Resident 1. During an interview on 4/30/24 at 2:01 p.m. with CNA 1, CNA 1 stated she left Resident 1 unsupervised in the shower room to get a cream. CNA 1 stated she heard a sound while walking back to the shower room and upon entering the shower room, she observed Resident 1 on the ground. CNA 1 stated she should not have left Resident 1 unsupervised in the shower room. During a concurrent interview and record review on 4/30/24 at 2:16p.m. with the Administrator (ADM), the facility policy and procedure (P&P) titled Care Planning dated 04/2024 was reviewed. The P&P indicated, . Care, treatment and services are planned to ensure they are appropriate to the resident ' s needs . Care planning will be implemented through the integration of assessment findings, consideration of the prescribed treatment plan and development of goals for the resident that are reasonable and measurable . The ADM stated care planned interventions should be implemented for the safety of residents. The ADM stated CNA 1 should have asked another staff to obtain the cream. 2. During a review of Resident 2's Admission Record, undated, the admission record indicated, Resident 2 was admitted to the facility on [DATE]. Resident 1's diagnosis muscle weakness, difficulty walking, and Alzheimer ' s (affect a person ' s ability to carry out daily activities). During a concurrent observation and interview on 4/30/24 at 9:45 a.m., with Resident 2 in Resident 2 ' s room, Resident 2 was lying in bed. Resident 2 did not want to be interviewed regarding her fall. During a review of Resident 2's Minimum Data Set Assessment (MDSA) dated 3/2/24, MDSA indicated, Resident 2's Brief Interview for Mental Status assessment score was 6. The BIMS assessment indicated Resident 6 had severe cognitive impairment. During a review of Resident 2 ' s Progress Notes (PN), dated 4/18/24 was reviewed. The PN indicated, . Activities assistant .witnessed resident ambulating in the hallway with FWW [front wheel walker] .Resident was turning left to walk into the lobby and appeared to lose her balance. Resident fell on her back, walker fell over to right side .copious amounts of blood coming from back of head with lacerations noted to back of head. Resident noted to have skin tear to top of right hand, and discoloration to left elbow .Resident appeared confused, unable to say what happened . During a telephone interview on 4/30/24 at 10:31 a.m. with Activity Assistant (AA), AA stated on 4/18/24 she was doing activities with residents when she observed Resident 2 ambulating in the hallway unsupervised. AA stated Resident 2 stumbled and fell backwards. During a concurrent interview and record review on 4/30/24 at 10:51 a.m. with LVN 1, Resident 2 ' s Care Plan (CP) dated 12/12/23 was reviewed. The CP indicated, .Risk for falls .Assist Resident with ambulation and transfers, utilizing therapy (continued on next page)

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	555530	A. Building B. Wing	04/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	recommendations . LVN 1 stated Resident 1 needed assist when ambulating because she was not steady when ambulating. During a phone interview on 4/30/24 at 11:02 a.m. with Physical Therapy (PT), PT stated Resident 2 needed supervision when ambulating in the hallway. PT stated Resident 2 needed verbal cues for safety because she had confusion. During a review of Resident 2 ' s Therapist Progress & Discharge Summary dated 1/25/24, indicated, . ambulates 200 feet on level surfaces with front wheeled walker and modified independence (assistive device or extra time needed) and verbal instruction/cues .Due to safety reasons, the patient requires verbal cues for all functional mobility . During a concurrent interview and record review on 4/30/24 at 2:16p.m. with the ADM, the facility policy and procedure (P&P) titled Care Planning dated 04/2024 was reviewed. The policy indicated, . Care, treatment and services are planned to ensure they are appropriate to the resident ' s needs . Care planning will be implemented through the integration of assessment findings, consideration of the prescribed treatment plan and development of goals for the resident that are reasonable and measurable . The ADM stated care planned interventions should be implemented for the safety of residents. During a telephone interview on 5/3/24 at 2:13 p.m. with CNA 2, CNA 2 stated she was the assigned CNA for Resident 2 on 4/18/24. CNA 2 stated she was getting water on the other side of the hallway when Resident 2 fell . CNA 2 stated Resident 2 would lose balance at times when she was ambulating. CNA 2 stated whenever she observed Resident 2 walking, she would walk next to Resident 2 because she was at risk of losing her balance and falling.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41119 Based on observation, interview, and record review, the facility failed to revise and implement a person centered comprehensive care plan for one of three sampled residents (Resident 1), when Resident 1 fell on [DATE] and care plan interventions were not revised and updated. This failure placed Resident 1 ' s health and safety at risk when fall care plan interventions were not revised. Findings: During a review of Resident 1's Admission Record (document containing resident demographic information and medical diagnosis) undated, the admission record indicated Resident 1 was admitted to the facility on [DATE]. Resident 1's diagnosis included cognitive communication deficit (difficulty paying attention to a conversation, remembering information). During a concurrent observation and interview on 4/30/24 at 9:50 a.m., with Resident 1 in the dining room, Resident 1 was seated in her wheelchair. Resident 1 was unable to recall how she fell on [DATE]. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool used to identify resident cognitive and physical function) assessment dated [DATE], indicated Resident 1's Brief Interview for Mental Status (BIMS -assessment of memory and judgment) assessment score was 7 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, 00-07 indicates severe impairment, 99 severely impaired). The BIMS assessment indicated Resident 1 had severe cognitive impairment. During a review of Resident 1 ' s Progress Notes (PN), dated 4/5/24 was reviewed. The PN indicated, . Resident was found lying on her left side next to shower hose in center shower room. Approximately 2 minutes prior, resident was assisted to the toilet in the shower room, CNA [certified nursing assistant] .left resident to get skin protectant cream. Upon CNA walking back into shower room, resident found lying on the floor . During a concurrent interview and record review on 4/30/24 at 11:47 p.m. with Licensed Vocational Nurse (LVN) 1, Resident 1 ' s Care Plan (CP) dated 6/2/23 was reviewed. The CP indicated, .is at risk for falls R/T [related to] generalized muscle weakness .Observe frequently and place in supervised area when out of bed . LVN 1 reviewed Resident 1 care plans and stated there were no updated interventions after the fall on 4/5/24. LVN 1 stated care plan interventions should be updated after a fall, but was not. During an interview on 4/30/24 at 2:01 p.m. with CNA 1, CNA 1 stated she left Resident 1 unsupervised in the shower room to get a cream. CNA 1 stated she heard a sound while walking back to the shower room and upon entering the shower room she observed Resident 1 on the ground. CNA 1 stated she should not have left Resident 1 unsupervised in the shower room. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 4/30/24 at 2:20p.m. with the Administrator (ADM), the facility policy and procedure (P&P) titled Falls and Fall Risk, Managing and Prevention dated 09/2023 was reviewed. The policy indicated, . Based on previous evaluations and current data, the staff will identify interventions related to the resident ' s specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling .The IDT (Interdisciplinary Team) staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls . The ADM stated care planned interventions should be updated and revised of falls. The ADM stated the importance of the care plan was to implement interventions to keep residents safe.