STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555557	A. Building B. Wing	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pioneers Memorial Skilled Nursing Center	320 Cattle Call Dr. Brawley, CA 92227

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** 47466 Based on observation, interview and record reviews, the facility failed to provide two-person physical assistance with transferring for one of one resident (Resident 1) when Resident 1 was transferred from bed to the Hoyer lift by a staff alone. This failure had the potential to result in harm or even death. Findings: The department received a facility reported incident on 12/16/2024. It was reported that, his (Resident 1) amputee was caught during a weight measuring procedure, skin tear occurred and bleeding. A record review of the facility's Admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that include acquired absence of left leg above the knee , and difficulty walking , not elsewhere classified. A joint observation and interview on 12/17/2024 at 11:40 A.M., with Resident 1 was conducted. Resident 1 had a bandage on his left leg s/p left above the knee amputation. Resident 1 stated the treatment nurse (TXN) last Sunday told him there was bleeding on his left leg. Resident 1 stated he told the TXN he had discomfort on the sling that was used when he was weighed by the staff. Resident 1 further stated he thought it was from that incident that caused the skin tear. An interview on 12/17/2024 at 4:13 P.M., with the RNA (restorative nursing assistant) was conducted. The RNA stated she was alone when she did the transfer of resident 1 from his bed to the Hoyer lift when she weighed Resident 1. The RNA stated it was important to have two people with transfers of any resident in the facility to ensure safety and prevent accidents and falls. An interview on 12/18/2024 at 10:10 A.M., with TXN was conducted. The TXN stated she was called by Resident 1's CNA (certified nursing assistant) to his room and showed her the skin tear on Resident 1's left leg. The TXN asked Resident 1 what had happened, and Resident 1 stated he was not sure, but the sling caused him a bit of discomfort when he was weighed. The TXN stated with Hoyer lift transfers it was to her knowledge that the facility required two-person physical assistance to ensure safety and prevent accidents and falls. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555557	A. Building B. Wing	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pioneers Memorial Skilled Nursing Center	320 Cattle Call Dr. Brawley, CA 92227

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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	A record review of Resident 1's Minimum Data Set (MDS-a federally mandated assessment tool) dated 12/13/24, indicated a BIMS (brief interview for mental status) score of 14 which meant Resident 1's cognition was intact. A record review of Resident 1's MDS dated [DATE] section gg indicated Resident 1 was dependent for transfers and requires substantial maximum assistance with his trunk and limbs use. A record review of resident 1's physician orders dated 12/6/24 indicated Resident 1 was partial weight bearing. A record review of Resident 1's care plan indicated Resident 1 had limited physical mobility due to his left above the knee amputation and was dependent with two staff for transfers and ambulation. An interview on 12/18/2024 at 8:37 A.M, with the Director of Nursing (DON) was conducted. The DON stated it was important to have two person transfers with Hoyer lifts or any mechanical lift to prevent complications such as accidents and falls and ensure resident safety. A review of the facility's policy on total mechanical lift indicated, .111. at least two people are present while resident is being transferred with the mechanical lift .