STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555657	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carlmont Gardens Nursing Center	2140 Carlmont Drive Belmont, CA 94002

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 31922 Based on interview and record review, the facility failed to thoroughly investigate an allegation of abuse. A Physical Therapist (PT) reported she saw a nurse (RN 1) slapped Resident 4's hand and was yelling at him to wake him up. Failure to thoroughly investigate an allegation of abuse did not ensure residents were protected from abuse. Findings: During an interview on 06/14/2024 at 2:39 PM, the PT was asked what happened to Resident 4 on 03/20/2022. The PT stated .This happened at the end of my workday. I was walking down the hallway and I see . (Resident 4), he's sitting and there was this nurse (RN1), and she was trying to wake him up to give him his medication. She didn't gently shake his shoulder. She was slapping his hand and yelling at him to wake up. According to the .(residents) I worked with (the residents said) she (RN1) was disagreeable pushy, mean, and aggressive. When I saw this, .I called my supervisor and reported it and left a message. On 06/13/2024 at 10:00 AM during a concurrent interview and record review of the facility's abuse/neglect paperwork/folder with the Medical Record Clerk (MRC). There was no evidence the facility conducted a thorough investigation. On 6/13/24 at 3:30 PM, the Administrator was made aware that the only interview within the facility's abuse/neglect folder was with the alleged perpetrator. The Administrator was asked what her expectations were when staff conducts an abuse/neglect investigation. The Administrator stated she expected staff to interview other residents and other staff who may have knowledge of the allegation. Review of the facility's policy titled Abuse, Neglect and Exploitation, revised on 08/10/2023, indicated . Investigation of Alleged Abuse, Neglect and Exploitation .An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur . Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations .

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 - Some	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** 44477 Based on interview and record review, the facility failed to implement fall care plans for two of 3 sampled residents (Resident 1 and Resident 2) when there was no evidence of frequent monitoring. This failure had the potential to delay the identification of needs, functional and health status for Resident 1 and Resident 2. Findings: 1. Review of Resident 1's clinical record indicated, Resident 1 was [AGE] year-old female, and admitted to the facility with diagnoses including hypertension (high blood pressure), diabetes (high blood sugar), hyperlipidemia (an excess of lipids or fats in your blood). Review of Resident 1's Minimum Data Set (MDS, resident assessment tool), dated 6/10/22, indicated, Resident 1 was cognitively moderately impaired. During a concurrent interview and record review on 6/13/24 at 1:39 PM with Assistant Director of Nursing (ADON), Resident 1's Resident Incident Report dated 6/25/22, and fall care plans were reviewed. The Resident Incident Report indicated, . After few minutes of taking her routine medicines. Noted resident found facing down the floor inside in her room. Noticed bruise on the right eye and episode of nose bleeding. This nurse called 911, resident is conscious (aware of and responding to one's surroundings) but still remains in the floor while waiting with paramedics and approximately at 8:25 pm resident was sent out to XXXX (hospital name) . ADON stated, it was an unwitnessed fall, and Resident 1 was at high risk for fall. ADON stated, the nurse called 911 because Resident 1 had a bruise on the right eye, and she was transferred to the hospital right after vital signs (measurements of the body's most basic functions such as blood pressure) were checked. Review of Resident 1's fall care plan, initiated 6/28/22 indicated, . frequent monitoring of the resident . ADON stated, they didn't have the evidence of frequent monitoring when asked. He stated, frequent monitoring meant checking a resident within 2 hours as standard of practice. During an interview on 6/13/24 at 3:21 PM with ADON, ADON disputed this surveyor's finding that there was no evidence of frequent monitoring per care plan of 6/28/22, but did not show any evidence when asked. 2. Review of Resident 2's clinical record indicated, Resident 2 was [AGE] year-old male, and admitted to the facility with diagnoses including dementia (memory loss), hypertension, and diabetes. Review of Resident 2's MDS dated [DATE] indicated, Resident 2 was cognitively severely impaired. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 6/13/24 at 11:20 AM with ADON, Resident 2's Patient Incident Report and Follow-up dated 12/28/23, and Morse Fall Scale (a rapid and simple method of assessing a resident's likelihood of falling) dated 10/27/23 were reviewed. The incident report indicated, . Patient last seen at 1 am while doing routine rounds sleeping . Then at 2am CNA assign was about to give her Christmas present to him, but patient found lying down on the floor next to the bathroom on his room . Per patient statement He got up and tried to walk towards the bathroom and when he was closer to the bathroom loss his balance but he was able to hold on to the bathroom door frame and slowly falling the floor without hitting his head . no bruises, no skin breakdown was noted . ADON verified, Resident 2 fell on [DATE] at 2 AM. Review of Resident 2's Morse Fall Scale (MFS) dated 10/27/23 indicated, the scale was 75. The MFS also indicated, . High Risk 45 and higher ADON stated, Resident 2 was at high risk for fall even before the fall. During a concurrent interview and record review on 6/13/24 at 11:28 AM with ADON, Resident 2's fall care plan with initiated date of 7/17/23 was reviewed. The fall care plan indicated, . Check resident for safety every 2 hours . ADON stated, We don't have. I don't think I have this . There is no evidence . when asked if the facility had the evidence of monitoring safety every 2 hours. He stated, Yes when asked if the facility should have done 2 hours monitoring per the care plan. During a concurrent interview and record review on 6/13/24 at 11:35 AM with ADON, Resident 2's Q Shift charting (Nursing) dated 12/29/23 was reviewed. The nursing record indicated, . Patient was sent to #### (name of the hospital) . Patient c/o (complained of) pain from fall on left hip . Xray (an examination to show images of a resident's internal organs or bones) ordered and results show possible hip fracture (broken hip) . ADON stated, there was no injury at the time of Resident 2's fall on 12/28/23, but they found the fracture on X-ray. ADON stated, Resident was transferred to the hospital for fracture on 12/29/23, then came back to the facility on [DATE] after hip repair. Review of Resident 2's X-ray result titled, Patient Report dated 12/28/23 indicated, . Acute left intertrochanteric fracture (a type of broken hip) . Review of Resident 2's Discharge summary from the hospital dated 1/11/24 indicated, . ORIF (open reduction and internal fixation, a type of surgery used to stabilize and heal a broken bone) with IT (Intertrochanter, a part of the hip bone) nail on 12/30/23 . Review of the facility's policy and procedure (P&P) titled, Comprehensive Care Plans undated indicated, . It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment . Review of the facility's P&P titled, Fall Risk Assessment undated indicated, . It is the policy of this facility to . provide supervision . to prevent avoidable accidents . 4. The At Risk for Falls care plan will include interventions, including adequate supervision . in order to reduce the risk of an accident .

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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** 44477 Based on interview, and record review, the facility failed to update the fall care plan for one of 3 sampled residents (Resident 3) when there was no evidence that the fall care plan was updated after her fall on [DATE]. This failure had the potential to put the resident at risk of not receiving appropriate care. Findings: Review of Resident 3's clinical record indicated, Resident 3 was [AGE] year-old female, and admitted to the facility on [DATE] with diagnoses including acute kidney failure (sudden loss of the ability of the kidneys to excrete wastes, concentrate urine, conserve electrolytes, and maintain fluid balance, with a mortality rate of between 50% and 80%), heart failure (a condition that develops when your heart does not pump enough blood for your body's needs), and diabetes (high blood sugar). Review of Resident 3's Minimum Data Set (MDS, resident assessment tool), dated [DATE] indicated, she was cognitively intact. But her MDS also indicated, Resident 3 had dementia (memory loss) and failure to thrive (a state of decline that is multifactorial and may be caused by chronic concurrent diseases and functional impairments). During an interview on [DATE] at 2:54 PM with Assistant Director of Nursing (ADON), ADON stated, Resident 3 was on DNR (a do-not-resuscitate order, written by a health care provider. It instructs providers not to do CPR which stands for cardiopulmonary resuscitation if a patient's breathing stops or if the patient's heart stops beating) and comfort focused treatment (a patient care plan that is focused on symptom control, pain relief, and quality of life. It is typically administered to patients who have already been hospitalized several times, with further medical treatment unlikely to change matters) upon admission, then became hospice (a program that gives special care to people who are near the end of life and have stopped treatment to cure or control their disease) on [DATE], then died on [DATE]. During a concurrent interview and record review on [DATE] at 2:59 PM with ADON, Resident 3's Resident Incident Report and Follow-up-Copy dated [DATE] at 00:02 AM was reviewed. The incident report indicated, . patient was found lying on her left side on the floor inside her room approximately at 9:10pm . No signs of injury . ADON verified, it was an unwitnessed fall approximately at 9:10 PM on [DATE]. During a concurrent interview and record review on [DATE] at 3:45 PM with ADON, Resident 3's fall care plan was reviewed. The fall care plan was initiated on [DATE]. But there was no evidence that the fall care plan was updated after her fall on [DATE]. ADON stated, No when asked if the fall care plan was updated. He stated, It should be updated when asked about the facility's policy and procedure of fall. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy and procedure (P&P) titled, Fall Risk Assessment undated indicated, . It is the policy of this facility to . provide supervision . to prevent avoidable accidents . 4. The At Risk for Falls care plan will include interventions, including adequate supervision . in order to reduce the risk of an accident. 5. Monitor the effectiveness of the care plan interventions, and modify the interventions as necessary . Review of the facility's P&P titled, Care Plan Revisions Upon Status Change undated indicated, . The comprehensive care plan will be reviewed, and revised as necessary, when a resident experiences a status change . d. The care plan will be updated with the new or modified interventions .

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 31922 Based on interview and record review, the facility failed to have a Registered Dietitian (RD) working full-time or part-time at the facility from January to April 2024. Failure to have a RD working at the facility did not ensure residents were assessed appropriately to maintain the residents' weight and other nutritional parameters. Findings: During an interview on 06/12/2024 at 2:34 PM, the RD stated he had been contracted to work at the facility since 2022. The RD stated his employment at the facility .was not continuous. (I stopped working in) January (and) started back up in early April. During an interview on 06/12/2024 2:58 PM, the Administrator was asked if there was another RD covering the facility between January and April 2024. The Administrator stated .I don't want to answer those questions . Review of the facility's policy titled Nutritional Management (not dated) indicated . Facility Registered Dietitian is a registered member of the Academy of Nutrition and Dietetics, (AND) and is a staff member employed full-time, part-time, or on a consultant basis, depending on the needs of the facility. The Facility Registered Dietitian provides regularly scheduled on-premises consultation and guidance to the Administrator, .(food service director) , the residents, and other facility personnel and staff, as needed.