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	04/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Belmont Healthcare 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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that the resident representative (RR) for one of three sampled residents (Resident 1) were notified of a significant change in condition when Resident 1 experienced an unwitnessed fall with head injury. The RR was not notified until approximately more than seven hours after the incident, despite Resident 1 having impaired cognition and sustaining a documented head injury. This failure resulted in delayed awareness of Resident 1's condition by the RR, which hindered RR's timely involvement in care decisions.During a review of Brief Interview for Mental Status (BIMS) dated 01/26/2026 at 9:04 AM, the Brief Interview for Mental Status (BIMS) indicates Resident 1 has a BIMS score of 3, which means Resident 1 has severely impaired cognitive function. The BIMS score stands for Brief Interview for Mental Status, which is a short test used in nursing homes to see how well a resident's memory and thinking skills are working. A BIMS score of 3 means a resident has serious difficulty with memory or thinking. During a review of Change of Condition Fall dated 02/20/2026 at 12:52 AM, the Change of Condition Fall indicated Resident 1 had an unwitnessed fall on 02/20/2026 at 12:45 AM.During a review of Nurses Progress Note dated 02/20/2026 at 2:18 AM, the Nurses Progress Note indicated Resident 1 was found lying on their right side on the floor near the toilet and that Resident 1 had hit the right side of the head on the wall before falling to the floor and landing on the right side of the body. The Nurses Progress Note also indicated Resident 1 had a swelling on the right side of the head measuring 3 centimeters (cm). The Nurses Progress Note indicated the fall was reported to the on-call Nurse Practitioner (NP), but did not indicate that Resident 1's representative had been notified of Resident 1's fall that occurred on 02/20/2026 at 12:45 AM. Onˆcall NP means the NP is not actively working at that moment, but must be available to work if someone needs the NP.During a review of Post Fall assessment dated [DATE] at 3:25 AM, the Post Fall Assessment indicated Resident 1 had been ambulating and responding to bowel or bladder needs during the fall and the location of the fall took place in Resident 1's bathroom. The Post Fall Assessment also indicated Resident 1 had a history of falls, had impaired safety awareness, and a level of consciousness (LOC) that was alert with some forgetfulness. Resident 1 verbalized hitting the wall with the right side of their head to Registered Nurse 1 (RN 1), who had completed the assessment. The Post Fall Assessment indicated Resident Representative 1 (RR 1) was notified about Resident 1's fall on 02/20/2026 at 8:00 AM. During a review of NP note dated 02/20/2026 at 6:19 AM, the NP note indicated Resident 1 had a video call with the NP to evaluate Resident 1 for a fall with injury and that Resident 1 had hit the right side of their head resulting in a 3 cm swelling. The NP note indicated Resident 1 would stay in the facility for monitoring after the fall. During a review of Social Services Progress Note dated 02/20/2026 at 9:45 AM, the Social Services Progress Note indicated that Resident 1 was scheduled to be discharged [DATE] and Resident 1's resident representative agreed to transport Resident 1 to the emergency room (ER) according to a NP order. During a review of Nurses Progress Note dated 02/23/2026 at 10:29 PM, the Nurses Progress Note indicated it was a late entry note with effective date 02/20/2026 at 11:02 AM. The Nurses Progress Note indicated Resident 1's family member informed Registered Nurse 2 (RN 2) (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that Resident 1 had reported to the family member one episode of vomiting after the fall at approximately 9:30 AM on 02/20/2026. RN 2 notified the NP, who ordered immediate transfer of Resident 1 to the ER for further evaluation. During a review of Progress Note dated 02/20/2026 at 11:57 AM, the Progress Note indicated Resident 1 had been sent to the hospital ER at 10:10 AM as ordered by the NP for the unwitnessed fall. During a review of the Care Plan for Resident 1 dated from Resident 1's admission date of 01/23/2026 to that last revision date of 02/28/2026, the Care Plan indicated focus area, The resident has impaired cognitive function/impaired though processes related to neurological symptoms as evidenced by BIMS SCORE: 03. The focus area is associated with the intervention, Communicate with the resident/family/caregivers regarding residents capabilities and needs. The Care Plan also indicated the intervention related to falls as, Medical Doctor (MD) and Responsible Party (RP) notified was initiated on 02/25/2026, after Resident 1 was discharged from the facility on 02/20/2026.During an interview on 04/03/2026 at 10:12 AM with Resident Representative 2 (RR 2), RR 2 stated, Resident 1's RR 1 was informed about Resident 1's fall on 02/20/2026 at approximately 7:00 AM. RR 2 stated that the facility should have called 911 after Resident 1 fell and had Resident 1 sent to the hospital ER right away. RR 2 states the facility was unable to explain why the family was not notified about Resident 1's fall immediately after the fall. During an interview on 04/03/2026 at 12:03 PM with the Director of Nursing (DON), the DON confirms RN 1 did not document that the facility had notified Resident 1's family immediately after Resident 1 had an unwitnessed fall on 02/20/2026 at 12:45 PM. During an interview on 04/03/2026 at 1:46 PM with Resident Representative 1 (RR 1), RR 1 stated the facility called RR 1 at 8:20 AM on 02/20/2026, based on RR 1's personal phone record, to notify RR 1 of Resident 1's fall. Based on the documented timeline, RR 1 was notified more than seven hours after the fall occurred. RR 1 stated RR 1 had initially thought Resident 1's fall had just happened at the time of the call at 8:20 AM on 02/20/2026, but during the call RR 1 found out Resident 1's fall had happened on 02/20/2026 at 12:45 AM. RR 1 wanted the facility to have called 911 and notified RR 1 immediately after Resident 1 had a fall. RR 1 stated that the family have the right to know about Resident 1's condition and would have gone to the facility immediately if the facility would have notified the family. RR 1 stated RR 1 arrived at the facility on 02/20/2026 at around 9:00 AM after learning about Resident 1's fall. RR 1 stated that Resident 1 reported to RR 1 that Resident 1 had vomited the morning of 02/20/2026 and as a result was sent to the hospital ER by paramedics and was later admitted to the hospital.During a review of the hospital After Visit Summary dated 02/25/2026, the hospital After Visit Summary indicated Resident 1 was admitted to the hospital from [DATE] to 02/25/2026. During an interview on 04/03/2026 at 2:30 PM with the Director of Nursing (DON), the DON stated the appropriate time frame for notifying the physician and family after a fall depends on what time it is, maybe within eight hours or so. During a review of the facility's policy and procedure titled, Assessing Falls and Their Causes, dated March 2018, indicated, notify the resident's attending physician and family in an appropriate time frame and, notify the following individuals when a resident falls: the resident's family, the attending physician, the director of nursing services, and the nursing supervisor on duty.