

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555663	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/23/2024
NAME OF PROVIDER OR SUPPLIER  Lindsay Gardens Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  1011 W. Tulare Road Lindsay, CA 93247	

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)
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>38993</p> <p>Based on observation, interview, and record review, the facility failed to follow their policy and procedure when restraint removal was not documented every 2 hours for one of three sampled residents (Resident 1). This failure had the potential for Resident 1 ' s motion and exercise to be limited.</p> <p>Findings:</p> <p>During an observation on 8/23/24 at 11:30 a.m. in the hallway, Resident 1 was sitting up in a Geri chair (reclining chair on wheels) with a lap tray in use.</p> <p>During a review of Resident 1's Informed Consent For Use Of Restraints (ICFUOR) dated 5/19/23, the ICFUOR indicated, Recommended restraint: Geri chair with lap tray.Purpose for recommended restraint: comfort and safety.Recommended time/duration/usage: Q (every) 2 hrs (hours).</p> <p>During a review of Resident 1 ' s Minimum Data Set (MDS-assessment tool), dated 8/17/24, the MDS indicated, Physical Restraints.2 (Used daily) .chair prevents rising.</p> <p>During an interview on 9/10/24 at 1:54 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 1 utilized a Geri chair with a lap tray due to having multiple falls and a high fall risk. LVN 1 stated the lap tray was removed every two hours, but staff did not document when the lap tray was removed.</p> <p>During an interview on 9/10/24 at 2:01 p.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated Resident 1 utilized a Geri chair with a lap tray to help prevent falls. CNA 1 stated the lap tray was removed every two hours but was not documented.</p> <p>During a concurrent interview and record review on 9/10/24 at 2:59 p.m. with Director of Nursing (DON), Resident 1 ' s clinical record was reviewed. DON was unable to provide documentation of Resident 1 ' s lap tray being removed every two hours. DON stated when the lap tray was removed it should have been documented.</p> <p>During a review of the facility ' s policy and procedure (P&amp;P) titled Use of Restraints dated 4/17, the P&amp;P indicated, The following safety guidelines shall be implemented and documented while a resident is in restraints.The opportunity for motion and exercise is provided for a period of not less than ten (10) minutes during each two (2) hours in which restraints are employed.</p>

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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