

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555673	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/06/2024
NAME OF PROVIDER OR SUPPLIER Asbury Park Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2257 Fair Oaks Blvd. Sacramento, CA 95825	
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 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38834</p> <p>Based on observation, interview, and record review, the facility failed to promote individual care and dignity, when the staff failed to respond to three of five sampled residents (Resident 1, Resident 2, and Resident 5), who needed assistance with personal care and the staff did not answer their call lights in a timely manner.</p> <p>This failure resulted in the residents' needs not being met, they experienced discomfort, embarrassment, and felt helpless.</p> <p>Findings:</p> <p>During a phone interview with Resident 1's family member (FM) on 8/1/24 at 10:20 a.m., FM stated that his father did not receive proper staff assistance with personal care while residing in the facility. The FM stated his father had to wait for an hour or longer to have his call light answered which caused him to feel anxious and frustrated. The FM stated that his father could maintain his bladder and bowel control and make his needs known, but by the time staff responded to his calls, he had already wet or soiled himself because he could not hold it any longer. The FM added, I was on a phone with him while he yelled for help and later, I have witnessed him having his call light on but not even one person responded for a long time.</p> <p>A review of the admission record indicated the facility admitted Resident 1 earlier this year following a neck surgery.</p> <p>A review of Minimal Data Set (MDS, an assessment tool), dated 7/22/24, indicated Resident 1 was cognitively intact and did not exhibit behaviors of rejection of care.</p> <p>A review of the initial nursing assessment, dated 7/15/24, indicated Resident 1 was assessed as always continent for bowel and bladder. A review of the MDS bowel and bladder assessment completed on 7/22/24, indicated that the resident was frequently incontinent for bladder and bowel.</p> <p>A review of the care plan dated 7/15/24 indicated Resident 1 was at risk for altered activities of daily living (ADL's, - activities done every day such as eating, personal hygiene, bathing, and toileting) related to immobility and surgery. Resident 1's goal indicated his needs would be met. One of the care plan intervention directed staff to provide assistance with ADLs.</p> <p>(continued on next page)</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 555673
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<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Resident 1's care plan titled 'At risk for altered skin integrity,' and initiated on 7/15/24 indicated the following interventions, Keep clean and dry as possible. Minimize skin exposure to moisture .provide incontinence care as indicated.</p> <p>During an interview with Resident 5 on 8/1/24 at 3 p.m., Resident 5 was observed laying in his bed. Resident 5 was alert and oriented and was responding appropriately. When asked about the care he received, the resident stated, Call light response is not good. Have to wait, sometimes 30 minutes or longer [for staff] to help me. I need lots of help; need help to get out of bed . need them to empty my urine bottle, you see it's almost full. Next time I have to use it, I might spill it in my bed.</p> <p>A review of Resident 5's MDS dated [DATE] indicated the resident was cognitively intact.</p> <p>During an observation on 8/1/24, at 3:12 p.m., the call light outside Resident 2's door was on and the resident was calling, I need help, someone help me. The Department continued observation of facility staff responding to resident's call light and call for help.</p> <p>During an observation and interview on 8/1/24, at 3:15 p.m., A certified Nursing Assistant (CNA 1) was observed walking in the hall near where Resident 2 had call light on and was calling for help. CNA 1 stated she was making rounds and was checking if any of the residents assigned to her needed help. CNA 1 stated that the call lights should be answered immediately or as soon as the light was noted to be on. After the interview, CNA 1 did not enter the resident's room and continued walking in the hall past the room where Resident 2 had call light on and was calling for help.</p> <p>During a continued observation on 8/1/24, at 3:20 p.m., Resident 2 was observed standing in the doorway facing the hall. The resident was wearing pajama top and had no clothes from waist down. Resident 2 had her incontinence briefs with a visible blue line indicating the brief was wet. Due to being soaked with urine, the briefs were halfway down to the resident's knees. Resident 2 looked anxious and tearful and continued yelling, I need help, I need help. Resident 2 was visibly distressed and had tears in her eyes when she stated, I have to go to the bathroom. Have been waiting for over an hour and nobody comes to help me. Do you know how hard it is to hold your bowel? Observed CNA 2 entering the resident's room and offering to assist her.</p> <p>During an interview with CNA 2 on 8/1/24, at 3:25 p.m., CNA 2 was observed leaving Resident 2's room. CNA 2 stated that he assisted the resident to the bedside commode and the resident requested to send a female staff to assist her back to bed. CNA 2 explained that Resident 2 was not assigned to him, but he saw that she needed assistance and stopped to help her. CNA 2 validated that Resident 2's brief was soaked with urine and it looked like her brief had not been changed for an extended period. CNA 2 added that it was humiliating for the resident to stand in the doorway with no pants or clothing exposed to other residents and visitors.</p> <p>During a continued observation on 8/1/24, at 3:30 p.m., a call light above Resident 2's room was on and the resident was calling in loud voice for help. A moment later, Resident 2 was overheard on the phone explaining that she needed someone to come and wipe her bottom. Resident 2 stated, I can't get up by myself, I'm afraid that I will fall and hurt myself. I waited for over an hour to be put on commode and now waiting to have someone helping me and wiping .It hurts sitting for so long on that thing. Observed three staff walked by the resident's room but none of them stopped to check why the resident was calling for help and offer assistance.</p> <p>(continued on next page)</p>		

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<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation on 8/1/24, at 3:34 p.m., Licensed Nurse (LN 1) entered Resident 2's room. Resident 2 stated, I need someone to help me, to wipe me. I've been sitting here for too long. LN 1 informed the resident that he will get a CNA to help her and left the room without helping the resident.</p> <p>During an interview with LN 1 on 8/1/24, at 3:40 p.m., LN 1 confirmed that Resident 2 was very upset that she could not get help to the commode and assistance back to bed for an extended period. LN 1 stated that the resident should not have been waiting longer than 5 minutes to get toileting assistance. While interviewing LN 1 near Resident 2's room, observed CNA 3 entering her room and offered to assist her, almost 30 minutes after the resident was noted calling for help.</p> <p>During a concurrent observation and interview on 8/1/24, at 3:59 p.m., Resident 2 was sitting on the edge of her bed wearing the pajama top and brief, no pants. Resident 2 was alert and answered all questions appropriately. Resident 2 pointed to her call light that was hanging on her side rail and stated, This is useless, nobody pays attention to it .Nobody comes and checks on me or my roommate. They ignore us. Not sure why - because we are elderly, or this is their practice. Resident 2 was visibly upset and added that earlier today she waited for longer than an hour to get to the bedside commode. Resident 2 stated the urge to move her bowels was really bad, I was very uncomfortable, had my light on, and was calling for help . Finally somebody came and put me on the commode .then I was waiting, and nobody came to wipe me and put me back to bed .I am not supposed to get up by myself, I fell at home and hurt my shoulder. During a continued interview, Resident 2 stated that she could feel when she needed to urinate or have a bowel movement and wanted to use the bathroom or bedside commode, but the staff put the briefs on her and did not change them for a long time. Resident 2 added, It is so uncomfortable to hold it for an hour. I feel helpless and embarrassed.</p> <p>A review of the admission record indicated that the facility admitted Resident 2 in the summer of 2024 with multiple diagnoses including difficulty in walking and dislocation of right shoulder during a recent fall.</p> <p>A review of Resident 2's initial nursing assessment (NA), dated 7/31/24, indicated that the resident was alert and oriented, required one person assistance with personal hygiene, bathing, and transferring and was at increased risk for falls. Resident 2's ADL care plan indicated she was at risk for altered ADLs related to limited mobility and the goal indicated that the resident will have needs met. The interventions directed staff to provide assistance with ADLs as resident required. Resident 2's skin care plan indicated the resident was at risk for altered skin integrity due to her poor mobility and the interventions directed staff to keep the resident clean and dry as possible and to minimize skin exposure to moisture. The NA indicated Resident 2 was always continent for bowel and bladder and was at risk for constipation.</p> <p>During an interview on 8/1/24, at 4:10 p.m., CNA 3 stated Resident 2 was on her assignment. CNA 3 stated she came to work one hour late today. When asked who attended to her residents, CNA 3 stated, I hope other staff did, the nurses or other CNAs could answer her call lights. CNA validated that the resident was very upset and in tears when she went to help the resident from the commode, cleaned her, and assisted her back to bed. CNA 3 stated the resident did not ask for help to put on her pajama bottoms and she did not offer it.</p> <p>(continued on next page)</p>		

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