

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555682	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/09/2024
NAME OF PROVIDER OR SUPPLIER  Marysville Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  1617 Ramirez Street Marysville, CA 95901	

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 - Actual harm  Residents Affected - Few	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41715</b></p> <p>Based on interview and record review, the facility failed to ensure residents received supervision to prevent falls for one of four residents sampled for falls (Resident 1). Resident 1 was assessed as high risk for falls and the Interdisciplinary team (IDT) (a facility group composed of a physician, a registered nurse, a social worker and additional appointed facility staff) did not revise Resident 1's fall care plan interventions based on Resident 1's fall risk factors and resident-centered needs to include increased supervision following 14 falls between 8/7/24 and 9/13/24.</p> <p>These failures resulted in Resident 1 having avoidable falls which resulted in hospitalization on [DATE] for bleeding in her brain, and caused bruising to the bridge of her nose, left eye, a laceration (a cut or tear in the skin and underlying tissues that can be caused by blunt force trauma), a raised lump to the left temporal region (behind the ear), and a chipped front tooth on 9/13/24.</p> <p>Findings:</p> <p>A review of the facility policy, Managing Falls and Fall Risk, dated 3/2018, indicated fall risk factors included lower extremity (legs) weakness, medication side effects, and neurological disorders. The policy indicated the staff will implement a resident-centered fall prevention plan to reduce the risk factors of falls for each resident with a history of falls.</p> <p>During a review of Resident 1's face sheet (a document with demographic, personal and medical information) dated 9/19/24, the record indicated Resident 1 was originally admitted to the facility on [DATE]. Resident 1's diagnoses included Huntington's disease (a chronic, inherited, and incurable brain disorder that causes the gradual breakdown of nerve cells in the brain. Symptoms include clumsiness, balance issues, and involuntary movements), traumatic subdural hemorrhage (a brain injury that occurs when a blood vessel tears and leaks blood into the space between layers of the brains lining, usually caused by a severe head injury, such as a blow to the head or a fall), muscle weakness and unsteadiness on feet.</p> <p>During a review of the clinical record for Resident 1, the Minimum Data Set (MDS) (assessment of healthcare and functional needs) dated 6/4/24, indicated Resident 1 had short- and long-term memory impairment. The MDS document indicated Resident 1 was severely impaired in decision making during activities of daily living and required supervision with mobility and transfers. The MDS document indicated Resident 1 was taking medications in two high-risk drug classes, antipsychotic and antidepressant medications.</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
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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the facility's Incidents by Type log for falls, indicated Resident 1 sustained 14 falls in the 50-day period from 8/1/24 through 9/19/24. Six of the falls were unwitnessed.</p> <p>A review of the facility policy, Care Planning-Interdisciplinary Team, dated 3/2022, indicated the Interdisciplinary Team (IDT) included the resident's physician, a registered nurse, a certified nurse's assistant, food and nutrition services staff, the resident or their representative as practicable, and other staff as necessary. The IDT is responsible for the development of comprehensive (all inclusive), resident-centered (a practice in which patients actively participate in their own medical treatment in close cooperation with their health professionals) care plans based on resident assessments.</p> <p>During a review of the clinical record for Resident 1, the Progress Notes dated 8/1/24 through 8/16/24, indicated the following.</p> <p>An IDT fall note dated 8/7/24 at 9:30 am, indicated Resident 1 had a witnessed fall onto her bottom and then fell back and hit her head on the floor at 5:50 am. After further investigation the IDT determined Resident 1 did not hit her head. The IDT noted fall risk factors including Huntington's disease, a history of falling with traumatic brain injuries, muscle weakness, and high-risk medications. The IDT recommended interventions to prevent further falls were to Reach out to family for more visits more frequently, therapy to do post-fall evaluation. Continue to educate staff for frequent checks.</p> <p>A review of the Therapy Post-Fall Evaluation dated 8/7/24 at 4:24 pm, indicated Patient has had multiple falls, may benefit from one-on-one supervision</p> <p>An IDT fall note dated 8/9/24 at 9:30 am, indicated CNA (Certified Nurse Assistant) reported to nurse that Resident 1 had an unwitnessed fall on 8/8/24 at 1:30 pm. Resident 1 was sitting in an upright position on the floor. The CNA told the nurse After assisting [Resident 1] back to bed, when I came out from room, I immediately heard sound and turned back around. I found [Resident 1] sitting on the floor. IDT recommended interventions to prevent further falls were medication adjustments.</p> <p>An IDT noted dated 8/13/24 at 10:14 am, indicated staff heard a noise at 6:05 am and went to Resident 1's room. Resident 1 was found sitting on the floor at the side of her bed. Resident 1 had a 1.5 cm (centimeter, a unit of measure) abrasion (a partial thickness wound caused by friction to the skin) with bruising to the left knee, a 3.2 cm by 1 cm abrasion with bruising to the right knee, a 3 cm abrasion to the left elbow, and a 1.7 cm laceration to the left eyebrow. The root cause analysis (a method for identifying the underlying causes of problems and developing corrective actions) indicated that due to Resident 1's medical condition, she does not remember to ask for assistance, got up on her own, lost balance and was found on the floor. IDT recommended interventions to prevent further falls were therapy to do a post-fall evaluation and soft/soothing music.</p> <p>A review of the Therapy Post-Fall Evaluation dated 8/13/24 at 11:12 am, indicated Patient may benefit from one-on-one supervision at all times, frequent visual checks</p> <p>An IDT note dated 8/14/24 at 9:33 am, indicated Resident 1 was found on the floor in the hallway outside her room by nursing staff at 8:03 pm. IDT recommended interventions to prevent further falls were to attempt to obtain insurance authorization for sensory integration techniques (therapies such as deep pressure, weighted vests, and swinging).</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>An IDT note dated 8/16/24 at 10:12 am, indicated a CNA informed the nurse about Resident 1's fall. Per CNA Resident 1 was walking and lost her balance and sat on the floor. IDT recommended interventions to prevent further falls were therapy to do a post-fall evaluation, hip protectors (a specialized form of pants or underwear with pads designed to prevent hip fractures following a fall) and encourage one-on-one activities.</p> <p>A review of the Therapy Post-Fall Evaluation dated 8/16/24 at 7:31 am, indicated the above fall occurred on 8/15/24 at 10:30 am. The recommendations from therapy were Patient would benefit from one-on-one supervision.</p> <p>An IDT note dated 8/19/24 at 7:55 am, indicated Resident 1 was at the Nurse's Station in a wheelchair 8/16/24 at 6:05 am. The nurse turned her back to Resident 1 and Resident 1 got out of her wheelchair. The nurse turned around and saw Resident 1 lose her balance and fall onto her bottom. IDT recommended interventions to prevent further falls were therapy to do a post-fall evaluation and a urinalysis (a medical test that examines urine to check for a variety of conditions, including urinary tract infections).</p> <p>A review of the Therapy Post-Fall Evaluation dated 8/19/24 at 8:50 am, indicated Patient would benefit from one-on-one supervision.</p> <p>An IDT note dated 8/19/24 at 8:13 am, indicated Resident 1 was assisted to the floor on 8/18/24 at 8:06 am. The nurse saw Resident 1 walking in the hallway and assisted her to walk. The nurse turned to ask someone to grab her a pair of socks. When the nurse looked away, Resident 1 started falling backwards and was lowered to the floor. As Resident 1 was being lowered to the floor, her jerking movements caused her to hit the back of her head against the wall. The ambulance arrived at 8:36 am and Resident 1 was taken to the emergency room .</p> <p>A review of the Therapy Post-Fall Evaluation dated 8/19/24 at 9:03 am, indicated Patient could benefit from one-on-one supervision.</p> <p>An IDT note undated, indicated that the IDT met to review a fall on 8/19/24 at 2:20 pm. Resident 1 got up from bed, started walking, lost her balance, stepped backwards and hit her head. MD ordered Resident 1 to be sent to the emergency room for further evaluation. The ambulance arrived at 2:37 pm. At 6:30 pm the acute hospital notified the facility that Resident 1 was being admitted to the hospital due to a hemorrhage (bleeding) in her brain.</p> <p>During a review of acute care hospital records for Resident 1, the Emergency Department progress notes dated 8/19/24, at 8:56 p.m., indicated Resident 1 was brought in by ambulance from the facility following a fall and striking her head on the ground. The note indicated that Resident 1 has had multiple falls recently as the care home she is in has been unable to provide one on one watch over the patient and the patient is left alone and tries to get out of bed and falls. Resident 1 was transferred to a higher level of care for treatment of her injuries.</p> <p>During a review of the clinical record for Resident 1, the Progress Notes dated 9/4/24 through 9/13/24, indicated the following.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>An IDT note dated 9/4/24 at 9:26 am, indicated Resident 1 was found on her back with her feet pointing toward the bed and her head toward the door on 9/4/24 at 6:15 am. IDT recommended interventions to prevent further falls were therapy to do a post-fall evaluation and to have a physician evaluate Resident 1's medications.</p> <p>An IDT note dated 9/6/24 at 9:50 am, indicated on 9/5/24 at 8:45 am Resident 1's roommate shouted for help. A CNA went into the room and found Resident 1 on the floor. Resident 1 was lying on her back on the floor next to her bed. IDT recommended interventions to prevent further falls were Continue current plan of care.</p> <p>An IDT note dated 9/13/24 at 8:19 am, indicated Resident 1's roommate shouted for help on 9/13/24 at 6:10 am. Resident 1 was found lying on her stomach with her face against the oxygen concentrator (a machine used to provide supplemental oxygen from the environment) with blood on the floor. Resident 1 had a 1 cm by 0.3 cm laceration with bruising to the bridge of her nose, a 1 cm by 0.2 cm laceration to the left cheek, a raised lump to the left temporal region, bruising to the left eye and a chipped front tooth. IDT recommended interventions to prevent further falls were therapy to do a post-fall evaluation, physician to reevaluate Resident 1's medications, and keep the television on for a diversion.</p> <p>During an interview on 9/19/24 at 1:15 pm, Resident 2 stated she witnessed Resident 1 fall on 9/13/24. Resident 1 got out of bed and fell to the floor. Resident 1's head and nose were bleeding and there was too much blood on the floor. Resident 2 stated that she frequently takes care of Resident 1 because the staff don't watch her. Resident 2 stated, There was nobody on the floor (unit). I had to look around for someone to tell that she fell .</p> <p>During an interview on 9/19/24 at 1:18 pm, CNA A stated [Resident 1] gets up out of nowhere. We try to supervise her as much as possible, but she is unpredictable. [Resident 1] has had numerous falls. Anytime [Resident 1] would start to dangle her feet off the side of the bed, [Resident 2] would alert us.</p> <p>During an interview on 9/19/24 at 1:20 pm, Licensed Vocational Nurse (LVN) B stated that Resident 2 would alert staff if she thought Resident 1 was going to fall.</p> <p>During an interview on 9/19/24 at 1:47 pm, family member (Fam) C stated [Resident] 1 has had many, many falls, they don't supervise her She had repeated falls and got a massive brain bleed from one of them. Recently she fell and hit her face. They didn't tell me her face and nose were bruised I told [the facility] if you don't want her to fall the only way to stop it is to get a sitter (one-on-one supervision). The Social Services Director told me I was free to hire a sitter. The clinic that [Resident 1] goes to for Huntington's disease offered to come to the facility to help give them recommendations to stop these falls, but the facility didn't take them up on the offer.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 9/26/24 at 12:30pm, the Huntington's disease clinic Social Worker (SW) stated it is usual for Huntington's disease patients to have falls, but there are ways we know to mitigate that. SW stated that her concern was the number of falls that were unobserved. SW stated that showed that Resident 1 needed more supervision. SW stated that the facility kept changing Resident 1's care plan and then changing it back without evaluating the effectiveness of what they were doing. Every fall seemed to be met with a medication review. Resident 1 should have been moved to a room within eyesight of staff at all times due to her uncontrolled movements and urge to get up. Resident 1 should have had a scheduled toileting program (help the resident ambulate to the bathroom every three to four hours, or according to the individualized program) so she didn't fall in the morning, for instance. SW stated that she tried to give the facility advice and offered to come there in person to do an in-service for free, but the facility never followed through.</p> <p>During an interview on 9/19/24 at 2:30 pm, the Social Services Director (SSD) reviewed Resident 1's care plan. SSD confirmed that the current interventions were not enough. SSD stated that she was trying to get the family to help get a sitter. The CNAs can't help her, they have to go to other rooms. It seems to be a financial issue that we don't hire sitters.</p> <p>During an interview on 9/19/24 at 2:15 pm, the Director of Nursing (DON) reviewed Resident 1's care plans. DON stated We don't have one-on-one sitters in this building We don't have the staff to do that. DON stated Resident 1 was not appropriate for the facility due to her need for supervision.</p> <p>During an email conversation on 10/10/24, at 11:19 am the administrator stated We will hire a specific position for a sitter for residents like this. We've also assigned an extra CNA to that resident hall to make sure we have an extra set of eyes. At 12:03 pm, the administrator stated, The one-on-one sitter was a suggestion from rehab, and we discussed in IDT we wouldn't be able to provide a sitter 24/7.</p>		