STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555713	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/07/2024
NAME OF PROVIDER OR SUPPLIER: Meadowood A Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 3110 Wagner Heights Road Stockton, CA 95209	

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 50161 Based on observation, interview, and record review, the facility failed to ensure measures were planned and implemented to prevent injury from a fall for one of two sampled residents (Resident 2), when: 1. Resident 2 was at high risk for falling and his care planned interventions did not include measures adequate to prevent an injury if a fall occurred; and, 2. Staff left Resident 2's bed in a high position after Resident 2 fell on [DATE], and his revised care plan directed the bed was to be kept low. These failures resulted in Resident 2 sustaining an injury from a fall on 7/2/24 and increased the risk of further falls resulting in serious injury. Findings: 1. Review of Resident 2's Physician Order Report indicated Resident 2 was admitted to the facility with a diagnosis of aftercare following hip hemiarthroplasty (a partial hip joint replacement) and severe dementia (disorder of the brain that results in declined cognition causing individuals to lose the ability to think and appropriately respond to information). Review of Resident 2's Minimum Data Set (comprehensive assessment of a patient's health status and care needs), dated 6/25/24, indicated .Brief Interview for Mental Status [BIMS- a brief screener that aids in detecting cognitive impairment] .BIMS Summary Score .03 [13-15: cognitively intact 8-12: moderately impaired 0-7: severe impairment] . Review of Resident 2's John Hopkins Fall Risk Assessment Tool (a standardized assessment of fall risk. A score of less than 6 points indicates low risk, a score of 6-13 points indicates moderate risk, and a score of more than 13 points indicates high risk), dated 6/19/24, indicated a score of 17 and that Resident 2 was at high risk for falling. Review of Resident 2's Physical Therapy PT Evaluation & Plan of Care dated 6/20/24, indicated, . Precautions: posterior hip precautions, fall risk .Safety Awareness .Impaired .Reason for Skilled Services . Patient requires skilled PT [physical therapy] services to minimize falls . (continued on next page)

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 - Few	Review of Resident 2's clinical record, Care Plan History with a date range of 6/19/24-6/30/24 indicated a care plan, .POTENTIAL FOR FALLS AND INJURY DUE TO: weakness and unsteady gait . was created on 6/20/24. The long-term goal indicated, RESIDENT WILL NOT EXPERIENCE SIGNIFICANT INJURY FROM A FALL . Interventions included, .FREQUENT VISUAL CHECKS .NOTIFY PHYSICIAN IF ANY FALLS OR INJURIES .OBSERVE FOR EXTERNAL FALL RISK FACTORS SUCH AS .ENVIRONMENTAL . Review of Resident 2's physician progress note dated 6/21/24, indicated, .Recently admitted due to fall, rt [right] femur neck fx [thigh leg fracture near the hip joint] .PLAN .Monitor mental state .fall precaution . Review of Resident 2's clinical record, Event Report, dated 7/2/24 at 8:50 p.m., indicated .FALL EVENT . Writer was called by CNA [Certified Nursing Assistant] because pt [patient] was on the floor. When entering the room writer noticed pt was laying on left side of the bed and was on his left side in fetal position .Upon assessment writer also noticed that right leg was positioned inwards. Resident had previous femur neck fx [fracture] with surgical intervention. Staples are intact to left hip Md [physician] was notified as well with orders to get xray to right hip .received xray . Notified [physician's name] and received an order to send pt to ER [emergency room] .paramedics came to facility @ [at] appox. 2355 [11:55 p.m.] and transfer pt via gurney to [name of hospital] . Review of Resident 2's Radiology Interpretation, dated 7/2/24 indicated, .IMPRESSION .Complete dislocation of the right hip. Orthopedics consultation recommended . Review of Resident's 2 hospital Discharge Summary *Final Report* dated 7/15/24, indicated, .In ED [emergency department] hip x-ray reveals dislocation of the femoral [relating to femur or thigh] component . Orthopedic consulted for operative repair . In a concurrent interview and record review on 7/30/34, at 2:38 p.m., LN 2 stated Resident 2 now had a true low bed and mats on either side of the bed due to his history of falls. LN 2 stated a true low bed went down almost to the floor whereas regular beds were two to three feet off the ground in their lowest position. LN 2 stated Resident 2 had a fall from his bed with reinjury here at facility. LN 2 reviewed Resident 2's clinical record and stated Resident 2's readmission to the facility was on 7/15/24 following right hip revision. In an interview and record review on 7/30/24, at 4:58 p.m., with the DON, the DON stated Resident 2 was admitted into the facility on [DATE] and fell in the facility on 7/2/24. The DON confirmed Resident 2 had a fall risk assessment completed in June of 2024 which placed him at high risk for falls. The DON stated prior to readmission from the hospital, Resident 2 had a regular bed. The DON stated he now had the special bed as well as fall mattresses on both sides of his bed to prevent reinjury from a fall. In an interview on 7/30/24, at 6:52 p.m., LN 4 stated Resident 2 was confused and would try to get out of bed. LN 4 stated she made sure Resident 4's bed was always low, but CNAs would leave Resident 2's bed in a higher position. LN 4 stated she would remind the CNAs at the beginning of her shift, but she would still need to remind them again later. LN 4 stated she expected staff to put the bed in its lowest position for residents with fall risks. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 8/7/24, at 12:34 p.m., LN 7 stated residents with dementia or confusion were more at risk for falls because they forgot instructions. LN 7 stated she would make sure the bed was in low position for a resident with dementia, and that fall mats were placed. LN 7 reviewed Resident 2's care plan initiated 6/20/24 and stated it did not include the use of fall mats or lowered bed prior to his fall on 7/2/24. In a concurrent interview and record review on 8/7/24 at 1:21p.m., PT 1 stated cognition was the biggest risk factor for falls due to the resident not having safety awareness, coordination, weakness, sensation, and ability to follow commands. PT 1 stated yesterday he found Resident 2 on the floor of his room with his upper body on the floor mattress and his lower body on floor. PT 1 stated floor mats helped reduce impact and lessened injury. PT 1 reviewed Resident 2's PT treatment notes and confirmed he conducted a PT fall risk assessment for Resident 2 on 6/20/24. PT 1 stated, .We base interventions on resident assessment, and this resident should have had fall mats in place due to his cognition, weakness, lack of range of motion, and potential for reinjury. PT 1 stated he would have expected Resident 2's bed to be in the lowest position. In a concurrent interview and record review on 8/7/24, at 3:36 p.m., the DON stated a fall risk care plan provided a guide to staff on how to care for residents. The DON confirmed Resident 2 was at high risk for falling and his care plan to address the risk, dated 6/20/24, did not include fall mats as an intervention. The DON stated nursing interventions would also include a bed in low position. The DON stated Resident 2 did have a fall, he was reinjured, and if he had fall mats in place, they could have cushioned him. In an interview on 8/8/24, at 3:42 p.m., via phone call, FM 3 stated somehow Resident 2 fell and reinjured himself at the facility. FM 3 stated the facility called her around 9:30 p.m. on 7/2/24 and stated Resident 2 was going back to the hospital. FM 3 stated the staff member told her they were not exactly sure how he fell or where he fell , they just said they were sending him back to the hospital. FM 3 stated Resident 2's surgeon wanted mattresses on the floor to prevent injury from falls. FM 3 stated the surgeon put something on Resident 2's legs to prevent another injury and surgery. FM 3 stated Resident 2's bed was left in high position when she would visit. 2. Review of Resident 2's clinical record, Care Plan, initiated on 7/16/24 indicated, POTENTIAL FOR FALLS AND INJURY .MATTRESS ON FLOOR .LOW BED . During a concurrent observation and interview on 7/30/24, at 2:07 p.m., PT 1 and Occupational Therapist (OT) 1 exited Resident 2's room. Upon entering Resident 2's room with CNA 3, Resident 2 was laying in his bed and the bed was in a high position. CNA 3 placed the bed in a low position and stated this happened often. CNA 3 stated keeping the bed low was especially important for Resident 2 because he already had injuries. CNA 3 stated the last time Resident 2 had a fall he was reinjured, and she thought they had to redo his surgery. In an observation and interview on 7/30/24, at 2:16 p.m., outside of Resident 2's room, with OT 1 and PT 1, OT 1 stated they were doing therapy due to Resident 2's hip replacement of the right side. OT 1 confirmed Resident 2 was laying in his bed and the bed was left in a high position when OT 1 and PT 1 left Resident 2's room. OT 1 stated the risk to the resident of leaving the room and the resident's bed in a high position was reinjury and pain, and stated this would be a major setback for Resident 2. PT 1 stated part of resident education was keeping the bed in low position and explaining the risk of falls and reinjury. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation on 7/30/24, at 2:25 p.m., in Resident 2's room, Resident 2 was observed sleeping in his bed with braces on both lower legs. It was observed Resident 2's bed was very low to the floor and there were two floor mats on either side of his bed. During an interview on 7/30/24, at 7:20 p.m., the DON stated the true low bed went down further then a regular bed and Resident 2 received a true low bed after he returned from the hospital due to safety and his risk for reinjury in the event of another fall. The DON stated her expectation of staff was for Resident 2's bed to be kept in the lowest position. Review of a facility P&P titled Fall Prevention Program, revised 5/25/21, indicated, .Residents will be provided an environment which will reasonably maximize safety while maintaining an optimal level of independence .Residents are assessed for falls using the Minimum Data Set (MDS) .Fall risk care plans will be updated by nursing to reflect the potential problem .and individualized interventions . Review of a facility P&P titled Interdisciplinary Team / Care Plan Process, revised 12/15/21, indicated, .The care plan is developed by an interdisciplinary team which includes .Attending physician .Licensed nurse who has responsibility for the resident .Nursing assistants responsible for resident care .Dietary Manager / Registered Dietician .Social Services worker responsible for the resident .Therapists (speech .) .Consultants (as applicable) .Others as appropriate or necessary .In interdisciplinary assessment team, in coordination with the resident and his/her family or representative, develops and maintains a comprehensive care plan for each resident .The comprehensive care plan has been designed to .Incorporate identified problem areas . Identify the professional services that are responsible for each element of care .Prevent declines in the resident's functional status and/or functional levels .Enhance the optimal functioning of the resident .

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	555713	A. Building B. Wing	08/07/2024
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. 50161 Based on observation, interview, and record review, the facility failed to ensure dental care was provided for one of two sampled residents (Resident 1) when Resident 1 had an unwitnessed fall on 7/4/24, which resulted in missing front teeth, and no oral assessment and/or follow-up dental care was provided. This failure led to Resident 1 experiencing pain, difficulty eating, potentially contributed to his weight loss, and had the potential to negatively affect his psychosocial well-being and quality of life. Findings: Review of Resident 1's Observation Report indicated Resident 1 was admitted to the facility with Parkinson disease (progressive disorder which affects the nervous system and the parts of the body controlled by the nerves) and need for assistance with personal care. Review of Resident 1's Minimum Data Set (MDS, an assessment tool), dated 6/13/24, indicated, .Section L-Oral/Dental Status .D. Obvious or likely cavity or broken natural teeth [unmarked] .E. Inflamed or bleeding gums or loose natural teeth [unmarked] F. Mouth or facial pain, discomfort with chewing [unmarked] G. Unable to examine [unmarked] .Z .None of the above were present [marked] . Review of Resident 1's Physician Order Report dated 6/7/24, indicated .MAY HAVE DENTAL EVALUATION AND CARE PRN [As Needed] . Review of Resident 1's nursing progress note, dated 7/4/24, indicated, .1:15 PM House keeper called me and reported [Resident 1] on the floor, found him lying on left side position in the hallway near in [sic] room XXX , remain alert and verbally responsive , we assisted back to wheelchair and stated he didn't passed out, and stated propelling his wheelchair and fell down on the floor, bumped his forehead on ground, noted redness on forehead and skin tear right FA [forearm] and right hand re open, and left hand skin tear left knee, noted blood from his mouth, AND at 145 PM 2nd neuro checked and I asked him how he fell and stated he feel dizzy and v/s bp [blood pressure] 96/56 . MD ordered to sent to ER [emergency room] .e [electronically] Signed by [Licensed Nurse (LN) 1] . During an interview on 7/29/24, at 11:41 a.m., Certified Nurse Assistant (CNA) 1 stated she did not witness Resident 1's recent fall at the facility, but assisted LN 1 to get Resident 1 back into his wheelchair after the fall. CNA 1 stated she had observed Resident 1 had scratches, skin tears, was bleeding from the mouth, and was missing his two front teeth. CNA 1 further explained Resident 1 had all his front teeth when she had assisted Resident 1 to brush his teeth the morning before the fall occurred. CNA 1 stated she told LN 1 that Resident 1 was now missing his front teeth after the fall occurred. CNA 1 stated she looked for Resident 1's teeth on the ground in the hallway but could not find them. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 7/30/24, at 12:35 p.m., in Resident 1's room, Resident 1 stated he had his front teeth, but had lost them in a fall. Resident 1 stated the fall was in June or July, or in the summertime. Resident 1 stated his bottom teeth and his front teeth hurt. LN 1 then entered Resident 1's room. Resident 1 opened his mouth, and it was observed Resident 1 had all his lower bottom front teeth and was missing his top two or three front teeth. During a follow-up interview on 8/7/24 at 12:59 p.m., LN 1 confirmed Resident 1 had no upper front teeth when she performed a mouth check on 7/30/24 at 12:35 p.m. in his room. In an interview on 7/30/24, at 12:40 p.m., LN 1 stated Resident 1 had a fall in the hallway in July. LN 1 stated housekeeping called her over to let her know Resident 1 was on floor. LN 1 further explained she found Resident 1 on his left side on the floor after falling from his wheelchair. LN 1 stated Resident 1 was bleeding from his mouth and had bleeding skin tears on his arms. LN 1 stated she checked Resident 1's mouth at the time and was not sure where the bleeding was coming from. LN 1 stated she did not remember if Resident 1 had front teeth prior to the fall. LN 1 stated she did not let the doctor know Resident 1 might have lost his teeth during the fall because she was not sure if he had his teeth prior or not. LN 1 stated if a resident had teeth and they were to get knocked out during a fall, she would inform the doctor and they would send the resident to the hospital. LN 1 stated they would do this in case the resident swallowed their teeth and so the doctor can check their mouth. LN 1 stated Resident 1 was transferred to the hospital by her, due to the resident complaining of feeling dizzy. LN 1 stated after Resident 1 fell , she called Family Member (FM 1) and stated she forgot to ask FM 1 if Resident 1 had front teeth prior to the fall. LN 1 explained it would have been an important question to ask FM 1 as this information could have helped with Resident 1's treatment. During an interview on 7/30/24, at 4:15 p.m., FM 1 stated he received a phone call from the nurse regarding Resident 1 having an unwitnessed fall from his wheelchair, but the nurse did not mention Resident 1's mouth bleeding or his teeth status. FM 1 stated Resident 1 lived at a board and care home prior to being admitted to the facility and stated his prior caregiver was FM 2. FM 1 stated Resident 1 lived with FM 2 for two years and she would know if Resident 1 had his front teeth or not prior to being admitted to the facility. During an interview on 7/30/24, at 4:32 p.m., FM 2 stated she had taken care of Resident 1 for the last two years providing care such as brushing his teeth and assisting with meals. FM 2 stated Resident 1 had a full set of teeth, including his front upper teeth, prior to being admitted to the facility. During an interview on 8/22/24, at 9:08 a.m., via phone, Speech Therapist (ST) 2 confirmed she performed the initial evaluation for Resident 1. ST 2 explained a speech therapist was designated to evaluate residents swallowing and an evaluation checked swallowing, choking risks, aspiration risk, and the oral cavity. ST 2 stated she would note if a resident had teeth, or dentures, or was missing teeth. ST 2 explained it would be important to specify exactly what teeth were missing as it could impact chewing. ST 2 stated she did not recall Resident 1's front teeth missing and if Resident 1 had his front teeth missing, she would have noted that in her speech assessment report. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/30/24, at 7:20 p.m., the DON stated if a resident was to have a fall, then the expectation was for the nurse to notify the RP (representative party) and physician to determine if the resident needed to be transferred to the hospital or needed a higher level of care. The DON stated the expectation was for the nurse to inform the doctor if the resident had his normal teeth and was bleeding from the mouth. The DON stated if the nurse was not sure if the resident had his front teeth or not prior to fall the nurse would need to tell the doctor the possibility that the resident had lost their teeth. The DON explained if this was not communicated to the doctor that the resident lost his teeth during a fall or there was a possibility, then the risk to the resident could be chewing problems, pain, speech issues, and could affect the resident's psychosocial well-being. The DON explained, the resident could need a speech consult and a dental consult. The DON stated the expectation for the nurses if they were unsure of the residents' mouth status after a fall was to check with the RP, the resident, and the CNA as they work with them and brush their teeth, so the information obtained could be given to the doctor. During a concurrent interview and record review on 8/7/24, at 3:36 p.m., Resident 1's electronic health record (EHR) was reviewed with the DON. The DON stated if a resident was bleeding from their mouth after a fall than an assessment must be completed to check the resident's mouth because the bleeding could be a cut or could be from the teeth. The DON stated the risk to the resident when an oral assessment did not occur could result in affecting the treatment course and could result in weight loss if a resident hit their mouth or lost their teeth, resulting in pain. Review of Resident 1's EHR, the DON confirmed Resident 1 did have weight loss after the fall, and there was an IDT (Interdisciplinary Team) meeting held on 7/10/24 to address Resident 1's weight loss. The DON stated Resident 1's diet was changed at that time and confirmed there was no documentation of a physical assessment of Resident 1's mouth in the EHR. The DON stated it would have been important to perform a physical assessment of Resident 1's mouth. The DON explained an oral assessment would be done to see if there was anything going on in Resident 1's mouth which could impact his food intake or cause mouth discomfort. The DON stated the risk to Resident 1's mouth not being properly assessed or checked would be continued loss of weight, weakness, and the resident's functional level could be impacted. During an interview on 8/14/24, at 2:24 p.m., via phone call with the Medical Director (MD), regarding Resident 1, the MD stated the nurse must assess the resident and he would listen to what the nurse tells him in terms of the resident's assessment. The MD stated Resident 1's teeth probably were knocked out when Resident 1 fell , and the nurse needed to inform him of that information. The MD stated lost teeth would have been an emergency and Resident 1 should have had his teeth and mouth pain evaluated by a doctor. The MD explained the nurse should have informed the ambulance of Resident 1's condition and the expectation was the nurse would call the ER (emergency room) to let them know of the resident's condition otherwise they would not be sure of why resident was there. The MD explained, when the nurse shares all the information then all the resident problems get addressed.