STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555737	A. Building B. Wing	06/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayshire San Dimas Post-Acute	1740 S San Dimas Ave San Dimas, CA 91773

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37198 Based on observation, interview, and record review, the facility failed to ensure call lights were within reach for two of three sampled residents (Residents 2 and 3). This deficient practice had the potential to result in the delay of care for Residents 2 and 3 when Residents 2 and 3 were unable to reach their call lights to call staff for assistance. Findings: a. During a review of Resident 2's Admission Record (AR), the AR indicated, the facility admitted Resident 2 on 5/21/2024, with diagnoses of viral pneumonia (an infection of the lung caused by a virus) and chronic obstructive pulmonary disease (a condition caused by damage to the airways or other parts of the lung that blocks airflow and makes it hard to breathe) with acute exacerbation (a sudden worsening of symptoms that lasts for several days). During a review of Resident 2's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 5/28/2024, the MDS indicated, Resident 2 was understood by others and had the ability to understand others. The MDS indicated, Resident 2 required substantial/maximal assistance (helper lifted or held trunk or limbs and provided more than half the effort) with oral hygiene, toileting hygiene, showering/bathing self, lower body dressing, putting on/taking off footwear, and personal hygiene. During a concurrent observation and interview on 6/26/2024 at 12:30 pm with Resident 2, Resident 2 was sitting up in a recliner chair in the corner of the room eating lunch. Resident 2's call light was attached to the bed and not reachable by Resident 2. Resident 2 stated staff (unidentified) who assisted her to the recliner chair did not ask her if she had a call button. b. During a review of Resident 3's AR, the AR indicated, the facility admitted Resident 3 on 5/10/2024, with diagnoses that included acute kidney failure (when the kidneys are suddenly not able to filter waste products from the blood) and fractures of second cervical vertebra (bone in the neck area of the spine that allows rotation of the head), pelvis (the area below the abdomen that contains the hip bones, bladder, and rectum), sacrum (large, triangle-shaped bone in the lower spine), humerus (upper arm bone), and left arm. (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 3's MDS dated [DATE], the MDS indicated, Resident 3 was understood by others and had the ability to understand others. The MDS indicated, Resident 3 was dependent (helper did all the effort) with toileting hygiene, showering/bathing self, upper body dressing, lower body dressing, and putting on/taking off footwear. During a concurrent observation and interview on 6/26/2024 at 12:40 pm, in the presence of the Director of Staff Development (DSD), Resident 3 was sitting in her wheelchair away from the bed with the bedside table in front of her. Resident 3 stated her call light was by the bed. Resident 3 stated she was not able to call for assistance since the call light was by the bed. During an interview on 6/26/2024 at 2:47 pm with Certified Nursing Assistant (CNA) 1, CNA 1 stated sometimes the call lights were not long enough for the residents to reach so the residents were supposed to have a bell if the call light was not working or if not reachable. CNA 1 stated the residents should always have their call light close to them in case of an emergency. During an interview on 6/26/2024 at 3:04 pm with the DSD, the DSD stated it was important for call lights to be within reach of the residents in case the residents needed assistance. During a review of the facility's policy and procedure (P&P) titled, Answering the Call Light, revised in 9/2022, the P&P indicated, the facility ensured timely responses to the resident's requests and needs. The P&P indicated, the facility ensured that the call light was accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor.

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prepare residents for a safe transfer or discharge from the nursing home. 37198 Based on interview and record review, the facility failed to ensure a safe and orderly discharge from the facility for one of three sampled residents (Resident 1) as indicated in the facility's policy and procedure (P&P) titled, Transfer or Discharge, Preparing a Resident for. This deficient practice resulted in Resident 1 being discharged from the facility without the needed services ordered by the physician. This had the potential to put Resident at risk for injury, harm, and/or rehospitalization . Findings: During a review of Resident 1's Admission Record (AR), the AR indicated, the facility originally admitted Resident 1 on 4/19/2024, and readmitted Resident 1 on 5/10/2024, with diagnoses that included fractures of shaft of left tibia (big bone between the knee and ankle, shinbone), left lower leg, and lower end of left tibia, and an open wound on left ankle. During a review of Resident 1's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 5/10/2024, the MDS indicated, Resident 1 was understood by others and had the ability to understand others. The MDS indicated, Resident 1 was dependent (helper did all the effort) with showering/bathing self, lower body dressing, putting on/taking off footwear and required substantial/maximal assistance (helper lifted or held trunk or limbs and provided more than half the effort) with oral hygiene, toileting hygiene, and personal hygiene. During a review of Resident 1's Social Services Progress Note (SSPN) dated 6/3/2024, timed at 1:51 pm, the SSPN indicated, the Social Services Director (SSD) was going to arrange home health (medical services provided at home to treat a chronic health condition or help one recover from an illness, injury, or surgery) and order a wheelchair for Resident 1. During a review of Resident 1's Physician's Order (PO) dated 6/4/2024, timed at 9:51 am, the PO indicated, Resident 1 had an order to discharge to home on 6/4/2024 with home health physical therapy (PT- therapy used to preserve, enhance, or restore movement and physical function impaired or threatened by disease, injury, or disability)/occupational therapy (OT- therapy intervention that uses everyday life activities to promote health, well-being, and ability to participate in the important activities in your life) and Registered Nurse (RN) for safety evaluation. During a review of Resident 1's Progress Note (PN) dated 6/4/2024, timed at 9:48 am, the PN indicated, Resident 1 was discharged home with family member via private care. During an interview on 6/26/2024 at 10:28 am with Resident 1, Resident 1 stated she had not received her wheelchair and there was no home health agency that showed up at Resident 1's home since she was discharged from the facility on 6/4/2024. (continued on next page)

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/26/2024 at 2 pm with the SSD, the SSD stated there should have been a follow up phone call to Resident 1 to confirm that the home health services ordered by Resident 1's physician were provided, and that the wheelchair was delivered. The SSD was unable to provide documentation that a specific home health agency was arranged and confirmed prior to Resident 1's discharge from the facility on 6/4/2024. During an interview on 6/26/2024 at 3:19 pm with RN 1, RN 1 stated it was important to follow up with Resident 1 after discharge for safety reasons because if Resident 1 who was not stable needed an equipment like a walker or a wheelchair, Resident could be at risk for injury. During a review of the facility's P&P titled, Transfer or Discharge, Preparing a Resident for, revised in 9/2016, the P&P indicated, the residents were prepared in advance for discharge. The P&P indicated, when a resident was scheduled for transfer or discharge, the business office notified nursing services of the transfer or discharge so that appropriate procedures were implemented. The P&P indicated, nursing services was responsible for obtaining orders for discharge or transfer, as well as the recommended discharge services and equipment.