| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555737 | A. Building<br>B. Wing | 11/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Bayshire San Dimas Post-Acute | 1740 S San Dimas Ave<br>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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Reasonably accommodate the needs and preferences of each resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37662<br><br>Based on interview and record review, the facility failed to ensure timely care was provided for eight of 11 sampled residents (Residents 4, 2, 3, 5, 6, 7, 8, and 10).<br><br>This deficient practice resulted in the delay of care for Residents 4, 2, 3, 5, 6, 7, 8, and 10 and had the potential for other residents to not receive timely assistance for basic and/or emergent needs.<br><br>Findings:<br><br>1. During a review of Resident 4's Admission Record (AR), the AR indicated, Resident 4 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), tachycardia (heart rate over 100 beats per minute), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest).<br><br>During a review of Resident 4's Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 8/27/2024, the MDS indicated, Resident 4's cognitive skills for daily decision-making were cognitively intact. The MDS indicated, Resident 4 required substantial/maximal assistance (helper does more than half the effort) for oral hygiene, toileting hygiene, showering/bathing self, and personal hygiene. The MDS indicated, Resident 4 required substantial/maximal assistance for rolling left and right (the ability to roll from lying on back to left and right side and return to lying on back on the bed).<br><br>During an interview on 11/5/2024 at 10:14 AM with Resident 4, Resident 4 stated the call light response time could vary from right away to staff not showing up at all. Resident 4 stated Resident 4 will press the call light again after waiting 20 minutes and not receiving staff assistance.<br><br>2. During a review of Resident 2's AR, the AR indicated, Resident 2 was admitted to the facility on [DATE] with diagnoses that included acute kidney failure (sudden decline in the functioning of the kidneys), unspecified, acute respiratory failure (ARF- a condition where the respiratory system is unable to exchange oxygen and carbon dioxide properly) with hypoxia (low levels of oxygen in your blood), other abnormalities of gait and mobility, and personal history of urinary tract infections (UTI- an infection in the bladder/urinary tract).<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of Resident 2's MDS, dated [DATE], the MDS indicated, Resident 2's cognitive skills for daily decision-making were cognitively intact. The MDS indicated, Resident 2 was dependent (helper does all the effort) for toileting hygiene, showering/bathing self, lower body dressing, and putting on/taking off footwear. The MDS indicated, Resident 2 was dependent in rolling left and right.<br><br>During an interview on 11/5/2024 at 10:41 AM, Resident 2 stated the facility was short staffed and had waited in a soaked diaper for three and a half hours. Resident 2 stated Resident 2 was informed multiple times that a staff member would come, but the staff kept walking by. Resident 2 stated Resident 2 went to the doorway to get the staff members' attention and to inform them that Resident 2 needed assistance.<br><br>3. During an observation on 11/6/2024 at 11:04 AM, Certified Nursing Assistant 1 (CNA 1) was observed on the phone while in a random resident's room.<br><br>During an interview on 11/6/2024 at 11:09 AM with the Director of Nursing (DON), the DON stated the importance of answering a call light timely was to identify the needs of the resident. The DON stated the residents may need pain medication, water, changing, or basic needs. The DON stated if the resident was not changed on time, the resident's skin integrity would result in skin breakdown. The DON stated staff was not allowed to be on the telephone while working and that staff had been informed. The DON stated if a staff member was on the phone while working the staff member would be neglecting their duty.<br><br>During a concurrent observation and interview on 11/6/2024 at 11:31 AM, CNA 1 was observed on the phone in the nurse's station. CNA 1 stated CNA 1 knows they are not supposed to be on the phone while in the resident's room.<br><br>4. During a review of Resident 10's AR, the AR indicated the facility originally admitted Resident 10 on 10/25/2024 with diagnoses that included UTI, type 2 Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), muscle wasting and atrophy (weakening, shrinking, and loss of muscle), and pressure ulcer of the right buttock/sacral region, Stage 2 (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence).<br><br>During a review of Resident 10's History & Physical (H&P) dated 10/28/2024, the H&P indicated Resident 10 has the capacity to understand and make decisions.<br><br>During a review of Resident 10's MDS, dated [DATE], the MDS indicated Resident 10's cognitive skills for daily decision-making were intact and required setup or clean-up assistance with eating and substantial/maximal assistance with oral hygiene, toilet hygiene, shower/bathe self, dressing and putting on and taking off footwear.<br><br>(continued on next page) |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 11/6/2024 at 11:10 AM with Resident 10, Resident 10 stated, It takes some time for the staff to answer the call light. Resident 10 was asked, How long does it take for staff to respond to the call light? Resident 10 stated, I call a second time when it is long, 30 to 45 minutes; one hour is definitely too long. Resident 10 stated she has not waited for an hour because by then she is calling out for help. Resident 10 stated the delays to answer the call light occur during the 3 p.m. to 11 p.m. shift because there is not enough staff. Resident 10 stated, They [The facility] are short-staffed and we are the ones affected because we have to wait, and we are calling because we need to go to the bathroom or there is something that is urgent and it needs to be addressed.<br><br>5. During an interview on 11/6/2024 at 12:18 p.m. with Family Member 2 (FM 2), FM 2 stated, The facility is short-staffed during the 3 p.m. to 11 p.m. shift and call lights are not answered. I know because I go visit my mom [Resident 3] during that time. FM 2 stated, The staff are stretched, and it falls on the CNAs and LVNs (Licensed Vocational Nurses) to try and take care of the residents. Some CNAs have 12 residents to care for and they don't always answer the call lights. I can hear the other resident calling out for help. FM 2 stated, They [facility] use a lot of registry [nurses] because they have lost some really good CNAs due to the heavy resident workloads. FM 2 stated, Last week during the 3 p.m. to 11 p.m., I wasn't able to visit my mom [Resident 3] and she told me about the call light not being answered. FM 2 stated, The problem with the staff not answering the call light is ongoing and there are not enough staff during the 3 p.m. to 11 p.m.to take care of the residents. I brought the staffing issue up with the DON, but she believes they can take care of all the residents with the staff they have. FM 2 stated, I am concerned about my mom's [Resident 3's] safety because she is prone to sundowning [a group of symptoms in the late afternoon and early evening, which includes confusion, trouble sleeping, anxiety, wandering, and hallucinations] and she may try to get up by herself, if no one answers her call light, and then she is at risk of falling.<br><br>6. During a review of the facility's One to One Room-Based Resident Council (RC), notes, dated 10/2/2024, the RC indicated:<br><br>a. Resident 5 indicated that Resident 5 feels like call lights are ignored.<br><br>b. Resident 6 indicated that there is no response when the light is pushed. Resident 6 indicated staff stated, We'll be right there, or we'll be there after seeing another patient.<br><br>c. Resident 7 indicated there was no sense of urgency and no acknowledgment of call lights.<br><br>d. Resident 8 indicated staff responds to call lights but always seems to be in a hurry.<br><br>7. A review of the facility's Census and Direct Care Service Hours Per Patient Day (DHPPD) indicated the following Actual hours per patient day:<br><br>10/21/2024 Actual DHPPD 3.816<br><br>10/22/2024 Actual DHPPD 3.766<br><br>10/23/2024 Actual DHPPD 3.570<br><br>10/24/2024 Actual DHPPD 4.035<br><br>(continued on next page) |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 10/25/2024 Actual DHPPD 4.124<br><br>10/26/204 Actual DHPPD 3.913<br><br>10/28/2024 Actual DHPPD 3.727<br><br>10/29/2024 Actual DHPPD 3.894<br><br>10/31/2024 Actual DHPPD 4.099<br><br>A review of the facility's Census and Direct Care Service Hours Per Patient Day (DHPPD) indicated the following CNA hours per patient day (minimum is 2.4 CNA DHPPD):<br><br>10/21/2024 Actual CNA DHPPD 2.188<br><br>10/22/2024 Actual CNA DHPPD 2.030<br><br>10/23/2024 Actual CNA DHPPD 2.060<br><br>10/24/2024 Actual CNA DHPPD 1.957<br><br>10/25/2024 Actual CNA DHPPD 2.079<br><br>10/26/2024 Actual CNA DHPPD 2.174<br><br>10/28/2024 Actual CNA DHPPD 1.851<br><br>10/29/2024 Actual CNA DHPPD 2.263<br><br>10/31/2024 Actual CNA DHPPD 2.366<br><br>During a review of the facility's approved waiver for Title 22 of the California Code of Regulations section 72329.2(a), the waiver indicated, the approval date was from 7/1/2024 to 6/30/2025.<br><br>During a review of the facility's policy and procedure (P&P), titled, Accommodation of Needs, revised 1/2020, the P&P indicated, the facility's environment and staff behaviors are directed towards assisting the resident in maintaining and/or achieving safe independent functioning, dignity, and well-being.<br><br>During a review of the facility's P&P, titled, Answering the Call Light, revised 9/2022, the P&P indicated, the purpose of this procedure was to ensure timely responses to the resident's requests and needs.<br><br>During a review of the facility's Certified Nursing Assistant (CNA) Job Description (JD), dated 11/2016, the JD indicated CNAs were responsible for providing assistance with Activities of Daily Living and assistance with routine daily nursing care needs and services in accordance with resident's assessment and service plan. The JD indicated CNAs would respond timely to resident's requests for services. |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45553<br><br>Based on observation, interview, and record review, the facility failed to supervise (observe/watch) one of three sampled residents (Resident 1), who was at risk for elopement (leaving the facility without notice, leaving a safe area unsupervised without notice and permission) as indicated in the facility's policy and procedures (P&P), titled, Safety and Supervision of Residents, and Wandering and Elopements, by failing to:<br><br>1. Ensure Resident 1 did not leave the facility unsupervised on 10/17/24.<br><br>2. Ensure Laundry Attendant 1 (LA 1) identified and reported Resident 1 was seen standing by the storage room located in the<br><br>Assisted Living (AL, housing facility for people with disabilities or for adults who cannot live independently) side of the facility's premise on 10/17/24.<br><br>As a result, Resident 1 eloped from the facility, fell outside of the facility, sustained facial trauma (experiencing very stressful, frightening, or distressing events) injury with multiple mandibular (jawbone) fractures (cracks/breaks), and was transported to General Acute Care Hospital 1 (GACH 1).<br><br>Findings:<br><br>During a review of Resident 1's Admission Record (AR), the AR indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included Senile degeneration of brain (gradual decline in cognitive function, such as memory loss, impaired thinking, and difficulty with daily activities), essential hypertension (high blood pressure), dementia (a progressive state of decline in mental abilities), anxiety (a feeling of fear, dread, and uneasiness), and Type 2 diabetes mellitus (high blood sugar).<br><br>During a review of Resident 1's Nursing Admission (NA) dated 10/16/24, the NA indicated Resident 1's cognition/mental status was intermittently confused. The NA indicated Resident 1 was oriented to person and place. The NA indicated Resident 1'smemory/recall ability was current to season, and that Resident 1 was in a nursing home. The NA indicated Resident 1 required setup or clean-up assistance (helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity) with eating, oral hygiene. The NA indicated Resident 1's elopement risk factors included 1) mobility: propels self/requires some assistance; 2) two or more medications (psychotropics [a drug or other substance that affects how the brain works and causes changes in mood], Mood Stabilizer [a class of medications used to treat mood disturbances]), 3) conditions (dementia, depression [a serious mental illness that involves a prolonged low mood or loss of interest in activities], other type of mental health illness): 2 or more present. The NA indicated Resident 1's total score was 10. The NA indicated a total score of 10 or greater was considered an elopement risk.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During a review of Resident 1's History and Physical (H&P), dated 10/17/24 (completed prior to Resident 1 eloping on 10/17/24), the H&P indicated, Resident 1 did not have the capacity to understand and make decisions due to dementia.<br><br>During a review of Resident 1's care plan (CP) titled, Elopement Care Plan: Is at Risk for Wandering and/or Elopement Related To: Disoriented to Place, Dx (diagnoses) of dementia, senile degeneration of [the] brain, initiated on 10/17/24 (created prior to Resident 1's elopement on 10/17/24), the CP indicated Resident 1's safety would be maintained through the review date. The CP's interventions indicated for facility staff to distract Resident 1 from wandering by offering pleasant diversions, structured activities, food, conversation, television, and books. The CP further indicated for the facility staff to identify patterns of wandering, intervene as appropriate, and to monitor Resident 1's location throughout the shifts (shift-based staffing, a method of scheduling employees in shifts, rather than traditional 9 to 5 schedules and to ensure around the clock coverage).<br><br>During a review of Resident 1's Situation, Background, Assessment and Recommendation (SBAR, structured communication framework that helps teams share information about the condition of a resident) Note, dated 10/17/24, the note indicated Resident 1 left the facility and fell outside of the facility (exact location was not indicated) on the pavement of the community.<br><br>During a review of Resident 1's Interdisciplinary Team (IDT, a team of health care professions who work together to establish plans of care for residents))-Post Accident/Fall Evaluation dated 10/18/24 timed at 10:30 a.m., the evaluation indicated Resident 1 was at a high risk for falls with a score of 15 (total score of 10 or above represents a high risk for falls). The root cause analysis indicated Resident 1 had a diagnosis of dementia and wandering (alert and with confusion).<br><br>During an observation on 11/4/24 at 10 a.m., Resident 1's room was located at the end of the hallway next to an exit door. The exit door was unlocked and led to an adjoining connector space (transition area) to the AL side of the facility. The connector space had another exit door on the left side that was unlocked and led to the outside of the building.<br><br>During an interview on 11/4/24 at 10:45 a.m. with Licensed Vocational/Minimum Data Set (MDS - a federally mandated resident assessment tool) Nurse (MDS 1), MDS 1 stated Resident 1 was taken to the hospital on 10/17/24 after Resident 1 was picked up by the Fire Department and EMTs (emergency medical technicians) for sustaining a fall/fracture that occurred after Resident 1 eloped from the facility. MDS 1 stated Resident 1 was never returned or readmitted to the facility after Resident 1 eloped on 10/17/24.<br><br>During an interview on 11/4/24 at 11:20 a.m. with Certified Nursing Assistant 6 (CNA 6), CNA 6 stated, Resident 1 had a lot of movement; he walked everywhere.<br><br>During an interview on 11/4/24 at 11:35 a.m. with CNA 7, CNA 7 stated, Resident 1 was ambulatory, very confused, nice man, eager to leave [and] go home to his wife. CNA 7 stated, We all knew that Resident 1 was at risk [for elopement] and we were told [by licensed nurses] to watch [Resident 1's whereabouts] this resident.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During a concurrent observation and interview on 11/5/24 at 10:40 a.m. with Maintenance Supervisor 1 (MS 1), MS 1 stated, the exit door adjacent to Resident 1's room led to a transition space to the AL side. MS 1 stated within that transition space was another exit door that led to the outside of the building and led to the trash area and the open parking lot. MS 1 stated, the door could be easily pushed open from the inside, but the door is locked from the outside. MS 1 stated the door was used as a service entrance door to deliver food/drinks to the kitchen on the AL side. MS 1 stated the exit door has an alarm, but the alarm was deactivated daily from 8 a.m. to 8 p.m. due to the in and out activities from staff. MS 1 stated housekeeping and laundry staff from the AL side moved freely from the AL facility side to the skilled nursing facility (SNF) side using the transition space. MS 1 stated staff from the SNF must watch the residents and ensure residents from the SNF did not go through the exit door to the outside of the facility unsupervised.<br><br>During an interview on 11/6/2024 at 8:40 a.m. with CNA 1, CNA 1 stated CNA 1 was assigned to care for Resident 1 on 10/17/24. CNA 1 stated Resident 1 had dementia and wandered around [the facility]. CNA 1 stated Resident 1's room was located next to an exit door. CNA 1 stated a huddle (a short, stand-up meeting where a team discusses patient safety and care goals) was conducted every morning. CNA 1 stated there should be a plan [in place] for residents that wandered and had dementia. CNA 1 stated CNA 1 did not know the plan for Resident 1. CNA 1 stated the only intervention for residents that wandered who had dementia was to conduct hourly checks (visual monitoring). CNA 1 stated Resident 1 walked through the door located next to Resident 1's room and went to the local gas station. CNA 1 stated Resident 1 walked across the street from the SNF and fell .<br><br>During an interview on 11/6/24 at 9:36 a.m. with Director of Nursing (DON), the DON stated before the DON left to attend a meeting, on 10/17/24 (unable to recall the time), next door at the AL facility, and she told all staff to watch/supervise Resident 1. The DON stated when she left the SNF side, Resident 1 was sitting on the sofa in the dining room watching television. The DON stated the DON was gone from the facility for the meeting and by the time the DON came back to the SNF side, the Fire Department was at the facility and informed the RN Supervisor (RN 1) what happened to Resident 1 (Resident 1's fall).<br><br>During a concurrent observation and interview on 11/6/2024 at 9:47 a.m. with LA 1, LA 1 stated LA 1 worked for the SNF and the AL facility. LA 1 stated LA 1 transported laundry to and from AL facility and SNF. LA 1 stated the transition space and the exit door located next to Resident 1's room was used frequently by laundry staff. LA 1 stated the exit door located next to Resident 1's room remained unlocked. LA 1 stated on 10/17/24 (LA 1 could not recall the time the encounter occurred), LA 1 saw Resident 1 standing outside of the storage room door located inside the AL side. LA 1 stated LA 1 did not know who Resident 1 was and LA 1 did not report this incident to any nursing staff because Resident 1 looked like a visitor. LA 1 stated Resident 1 told her, Have a nice day. LA 1 found out later that Resident 1 had eloped from the facility.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During an interview on 11/6/2024 at 9:56 a.m. with Restorative Nursing Assistant 1 (RNA 1), RNA 1 stated every staff member was responsible for the whereabouts of residents (in general) that wandered. RNA 1 stated on 10/17/24, RNA 1 was watching Resident 1 while Resident 1 was in the dining room. RNA 1 stated RNA 1 was with Resident 1 until almost 1 p.m. RNA 1 stated RNA 1 instructed Resident 1 to stay in the dining room because RNA 1 was going to help another resident (unidentified). RNA 1 stated that was the last time RNA 1 saw Resident 1. RNA 1 stated facility staff were looking for Resident 1, but the facility staff did not find Resident 1. RNA 1 stated Resident 1 was found on a street by an unknown individual and was sent to the hospital. RNA 1 stated it was the facility's practice for staff to divert (redirect) residents who wandered in the facility and remind them of their room location.<br><br>During a review of the Los Angeles County Fire Department record dated 10/17/24, the record indicated the unit was notified by the dispatch staff (staff who relay work orders and information to field staff using phones or 2-way radios on 10/17/24 at 1:31 p.m. and the EMT arrived at the scene (on 10/17/24) at 1:36 p.m. where Resident 1 was found sitting on the curb, down the hill from the facility, and complained of face pain (pain rate was not indicated). The record indicated a passerby stated she witnessed Resident 1's fall while Resident 1 was walking down a hill and away from the facility. The record indicated Resident 1 was transported to General Acute Care Hospital 1 (GACH 1).<br><br>During a review of General Acute Care Hospital 1's (GACH 1) Emergency Department (ED) record, admitted [DATE], the ED record indicated Resident 1 presented to the ED after a fall and on arrival Resident 1 had notable trauma to the face. The ED record indicated CT (computed tomography scan, medical imaging technique used to obtain detailed internal images of the body) imaging was obtained of Resident 1's head and face. The CT imaging revealed multiple mandibular fractures. The ED record medical decision making indicated Resident 1 had evidence of possible intracranial (within the cranium [bones that form the head]) injury due to the CT of the head showed a left-sided occipital lobe (visual processing area of the brain, located at the back of the head) petechial hemorrhage (tiny round brown, purple spots due to bleeding under the skin). The ED record indicated cardiac (heart) monitoring was initiated due to the potential for rapid decompensation (a system or structure's functional decline after it has been compensating for a defect or stressor) of Resident 1's clinical condition. The ED record indicated Resident 1 was transferred from GACH 1 to GACH 2.<br><br>During a review of GACH 2's Encounter Report dated 10/17/24, the report indicated Resident 1 fell while leaving Resident 1's care facility. The report indicated Resident 1 struck Resident 1's face on the pavement/ground and Resident 1 sustained multiple mandibular fractures and a chin laceration (cut. The report indicated Resident 1 had a small contrecoup injury (a brain injury that occurs when the brain moves within the skull and hits the opposite side of the head from the initial impact).<br><br>During a review of the facility's P&P, titled, Safety and Supervision of Residents, revised 7/2017, the P&P indicated the facility strives to make the environment as free from accident hazards as possible. The P&P indicated resident safety and supervision and assistance to prevent accidents are facility-wide priorities. The P&P indicated systems approach to safety included, resident supervision being a core component of the systems approach to safety. The type of frequency of resident supervision is determined by the individual resident's assessed needs and identified hazards in the environment. The P&P indicated resident risks and environmental hazards included, unsafe wandering.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555737 | A. Building<br>B. Wing | 11/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Bayshire San Dimas Post-Acute | 1740 S San Dimas Ave<br>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 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During a review of the facility's policy and procedure (P&P) titled, Wandering and Elopements, revised 3/2019, the P&P indicated, the facility would identify residents who were at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. |