STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555768	A. Building B. Wing	03/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayshire Yorba Linda Post-Acute	17803 Imperial Highway Yorba Linda, CA 92886

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** 48844 Based on interview, medical record review and facility P&P review, the facility failed to develop a plan of care to reflect the individual care needs for one of two sampled residents (Resident 1). * The facility failed to develop the care plan problem and interventions to address Resident 1's behavior of getting up from the wheelchair. This posed the risk of not providing appropriate, consistent, and individualized care to the resident. Findings: Review of the facility's P&P titled Care Plans, Comprehensive Person-Centered revised 12/2016 showed for a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. Medical record review for Resident 1 was initiated on 3/4/25. Resident 1 was originally admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 1's Admission Initial Evaluation dated 2/14/25, showed the resident was a fall risk and exhibiting the following behaviors: easily distracted, altered perception/awareness, disorganized thoughts, restlessness/lethargy and forgetfulness/confusion. Review of Resident 1's Change in Condition Evaluation dated 2/16/25, showed the resident was up in the wheelchair at the nursing station, and later the CNA found the resident sitting on the floor. Review of Resident 1's IDT Post Accident/Fall dated 2/17/25, failed to show the interventions to address Resident 1's behavior of getting up from the wheelchair and how to prevent the resident from further fall incidents. Review of Resident 1's MDS Section C - Cognitive Patterns dated 2/21/25, showed a BIMS score of 3, suggesting severe cognitive impairment. Review of Resident 1's Order Summary Report dated 2/21/25, showed to be up in the wheelchair two times a day with assistance. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident 1's medical record failed to show the care plan problem and interventions were developed for Resident 1's behavior of getting up from the wheelchair and how to prevent the resident from further fall incidents. On 3/4/25 at 1120 hours, an interview was conducted with LVN 1. LVN 1 stated Resident 1 had episodes of trying to get up from the wheelchair. On 3/24/25 at 1502 hours, an interview and concurrent medical review was conducted with the DON. The DON confirmed there was no care plan and its interventions were developed to address Resident 1's behavior of getting up from the wheelchair and how to prevent the resident from further fall incidents.