STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555836	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbol Residences of Santa Rosa	300 Fountaingrove Parkway Santa Rosa, CA 95403

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** 38335 Based on observation, interview, and record review, the facility failed to develop and implement a person-centered care plan with measurable objectives and appropriate interventions for one resident (Resident 1), that addressed fall precautions when the resident developed an L3 fracture (a fracture of the third vertebra in the lumbar spine) of unknown origin. This failure put Resident 1 at risk for additional injuries and falls and had the potential to cause pain and Resident 1's safety to go unmonitored. Findings: During an interview on 7/22/24 at 10:15 a.m., the DON (Director of Nursing) stated she followed-up on Resident 1's abdominal pain by sending the resident to the hospital where an X-ray and blood test confirmed Resident 1 had an L3 fracture and Osteoporosis (a bone disease that develops when bone mineral density and bone mass decreases, or when the structure and strength of bone changes. This can lead to a decrease in bone strength that can increase the risk of fractures (broken bones). The DON stated she looked back in the medical records and found a bone density test that was performed in 2015 and confirmed Resident 1 was diagnosed with Osteoporosis. While in the facility the DON was asked if Resident 1 had any falls , she stated the resident had No falls. During a review of the clinical record for Resident 1, the Admission Record (demographic information), indicated Resident 1 was admitted on [DATE], with a medical diagnosis that included: Age-related Osteoporosis without current pathological fracture, Dysphagia (a condition that affects your ability to produce and understand spoken language), Aphasia (a language disorder that affects a person's ability to communicate due to damage to the brain's language centers) following unspecified cerebrovascular disease (damage to the blood supply to the brain), and Hemiplegia and Hemiparesis (hemiplegia refers to complete paralysis, while hemiparesis refers to partial weakness on one side of the body) following cerebral infarction (or brain infarction, is the death of brain tissue caused by a prolonged decrease in blood flow to the brain) affecting right dominant side and difficulty in walking not elsewhere classified. (continued on next page)

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	During an interview on 7/22/24 at 11:00 a.m., the Director of Rehabilitation stated Resident 1 had therapy 5 times per week, (Physical, Occupational, and Speech Therapy). He stated the resident had a stroke (when blood flow to the brain is blocked or there is sudden bleeding in the brain) and as part of her plan for therapy a Hemi walker (a small mobility aid that helps people with limited or no dexterity in one hand or side of their body, walk) was used for working on gait and endurance. When asked if Resident 1 had any falls since her admission to the facility, the director of rehab stated the resident had no falls in the facility. When asked if the resident's therapy is care planned and if the CNAs and staff know how to properly continue treatment and follow a plan of care for this resident he stated Yes. When asked how the plan of care was communicated to the staff, he stated the CNAs were shown and told what to do. Review of Resident 1's care plan indicated Resident 1 had an unwitnessed fall in her room on 6/16/24 and did not show specific interventions or monitoring to prevent falls from occurring. This fall could have potentially caused the L3 fracture and pain, but there was no documemtation to support this finding. During an observation and concurrent interview on 7/22/24 at 11:30 a.m., Resident 1 was observed sitting in a wheelchair in the activity room. When attempting to interview Resident 1 she could not verbalize or form words or sentences to questions asked; movement was weak to her right side. When asking the resident if she had pain, she attempted to answer the question, but words were scrambled and incomprehensible. She shook her head No. A review of Resident 1's Minimum Data Set 3.0 (MDS- a standardized assessment and screening tool) dated June 8, 2024, did not show a complete assessment for level of cognition (mental process of thinking and understanding) was conducted the assessment form was missing data points and did not include a Brief Interview for Mental Status (BIMS) summary score in-order to confirm if Resident 1 was able or unable to make herself understood or if she was able to understand others. A review of Resident 1's fall assessment evaluation dated June 9, 2024, was also incomplete with missing data points and showed no risk level for falls or interventions to assist the resident with ambulation and transfers. During an interview on 7/22/24 at 11:45 a.m. the Charge Nurse was assigned to take care of Resident 1 and was asked what interventions were in place to help prevent falls for the resident. She stated all residents had gait belts that Physical Therapy (PT) used when walking residents, we bring fall risk residents to the nurse's station or to the activity room to keep a watch on them. When asked if the interventions were care planned, she stated she would have to look at the care plan. Review of the care plan did not show specific interventions for fall risk were listed in the care plan nor were any updates made to the care plan post hospitalization . When asking the charge nurse how she kept residents safe from falls she stated we do frequent checks and keep the residents at the nurse's station. When asked if the monitoring of falls was documented in the progress notes or on the Treatment Administration Record (TAR), she stated it usually was. When reviewing the TAR and care plan no interventions or monitoring was listed for Resident 1. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/22/24 at 12:00 noon, the DON was asked how residents were kept safe from falls. She stated we post signs at the bedside that lets staff know how to move residents out of bed. When asked what interventions were put in place to monitor Resident 1 for falls, she stated she would have to look at the care plan. Review of Resident 1's care plan showed no specific interventions were listed on the care plan to prevent falls for Resident 1. The DON stated to the charge nurse that monitoring interventions for falls should be added to the care plan for Resident 1. The DON showed a copy of the Safety-First sign posted on the wall next to Resident 1's bed with instruction that indicated, resident transfers required, moderate and maximum assist and when standing pivot transfer to the left, right side is weak. A review of the facility's policy and procedure titled, Care Plans- Comprehensive Person-Centered with a revision date of December 2016, indicated: 8. The comprehensive, person-centered care plan will: a. Include measurable objectives and timeframes; h. Incorporate risk factors associated with identified problems; . m. Aid in preventing or reducing decline in the resident's functional status and/or functional levels .13. Assessment of residents are ongoing and care plans are revised as information about the resident and the resident's condition change.