STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555901	A. Building B. Wing	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Anberry Transitional Care	1000 West Yosemite Avenue Merced, CA 95341

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44708 Based on interview, and record review, the facility failed to meet professional standards of quality for one of three residents (Resident 1) when Resident 1 was admitted with a pressure ulcer (a localized area of skin damage and underlying tissue that develops when prolonged pressure is applied to the body) of the sacral region (the area of the lower back and pelvis) and Resident 1 required to be turned and repositioned every two hours. Resident 1's care plans did not indicate Resident 1 be turned and repositioned every two hours and Resident 1's medical records did not indicate Resident 1 was turned and repositioned every two hours. This failure resulted in incomplete and inaccurate documentation of when Resident 1 was turned and repositioned and had the potential to result in the worsening of Resident 1's pressure ulcer and the potential of developing new pressure ulcers resulting in the death of Resident 1 on [DATE] with a diagnosis of septic shock (a life-threatening condition that occurs when an infection triggers a widespread inflammatory response that leads to dangerously low blood pressure and organ damage). Findings: During a review of Resident 1's Admission Record (AR), the AR indicated, Resident 1 was admitted on [DATE] and with a history of Hemiplegia (paralysis of one side of the body) and Hemiparesis (weakness on one side of the body) following cerebral infarction (loss of blood flow to part of the brain) affecting left non-dominant side and Pressure Ulcer of sacral region unspecified stage. During a review of Resident 1's Brief Interview for Mental Status (BIMS; an assessment of a resident's cognitive status; the ability to remember, concentrate, learn new things, and/or make decisions that affect their everyday life), dated [DATE], Resident 1's BIMS score was 12 (a score of 0 to 7 indicated severe impairment, 8 to 12 indicated moderate impairment, and 13 to 15 indicated minimal to no impairment). During a review of Resident 1's Minimum Data Set (MDS; process for clinical assessment of all residents of long-term care nursing facilities), dated [DATE], the MDS indicated, Resident 1's functional abilities was dependent (Helper does all the effort. Resident does none of the effort to complete the activity) on toileting hygiene (the ability to maintain cleanliness after voiding or bowel elimination) and 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). (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's Clinical Admission (CA), (undated), the CA indicated, . 72. Skin Issue. 73. Location . h. Coccyx (a small triangular-shaped bone located at the bottom of the spine) . Open wound . 77. Length (cm; centimeter; unit of measurement) 4 . 78. Width (cm) 0.5 . During a review of Resident 1's Wound Consultation (WC), dated [DATE], the WC indicated, . Wound Location: Coccyx a Stage 4 (full-thickness skin and tissue loss with exposed or directly palpable fascia; a thin, fibrous connective tissue that surrounds and supports all the structures in the body, muscle, tendon, ligament, cartilage, or bone) Type: Pressure. L (length in cm) 6 x (by) W (width in cm) 7 x D (depth in cm) UTD (unable to determine) . Plan: Implement pressure relieving measures and offloading as tolerated. - offload/reposition . Specialty Devices: Bed - Group 2: Low Air loss Mattress (a medical-grade mattress designed to prevent and treat pressure injuries by distributing weight, minimizing heat and moisture buildup, and promoting airflow through tiny air holes in the mattress surface) . During a review of Resident 1's WC, dated [DATE], the WC indicated, . Wound Location: . coccyx. L 9.5 x W 6.5 x D 3.4. R (right) heel L 4.4 x W 4.9 x D 0.1. L (left) trochanter (a bony prominence located at the upper end of the femur; thigh bone) L 1.5 x W 2.3 x D 0.4. L elbow L 0.3 x W 0.3 x D 0.1 . Plan: Offload/Reposition . Devices: Low Air loss Mattress . During a review of Resident 1's Progress Notes (PN), dated [DATE], the PN indicated, . Upon assessment patient was . nonresponsive to physical stimuli or verbal communication . Patient's BP (blood pressure) was noted to be dropping while oxygen was increasing . 1st (first) EMT (emergency medical technician) arrived at 0655 (6:55 a.m.) . and 3 EMT's departed facility in 1 (one) truck with patient at 0715 (7:15 a.m.) . During a review of Resident 1's hospital Final Report (FR), dated [DATE], the FR indicated, . Admission Information: admitted : [DATE] 10:35 (p.m.) . Hospital Course: . In the ED (Emergency Department) here patient was noticed to be hypotensive (low blood pressure) with blood pressure of 57 x 48, hypoxic (low oxygen level) with O2 (oxygen) sats (saturation) in 60s and GCS (Glasgow Coma Scale; a neurological assessment tool used to evaluate a person's level of consciousness) 4 (a score of 1 indicating no response up to a score of 15 indicating fully responsive). Patient was intubated (a tube inserted into the lungs to assist with breathing) . Patient was then treated aggressively in the ICU (Intensive Care Unit) with a working diagnosis of septic shock likely from his urinary/infected decubitus ulcer (a skin lesion that develops when prolonged pressure on an area of the body restricts blood flow, leading to tissue damage) . Despite aggressive measures patient went into multiorgan failure became anuric (absence or significantly low production of urine) needing emergent Quinton catheter (a tunneled, double-lumen, flexible silastic catheter used for long-term central vascular access) and starting of dialysis (a medical procedure that removes waste products and excess fluid from the blood when the kidneys have failed) . But despite all the efforts patient's condition continued to deteriorate and later at night patient coded (when a person experience a cardiac or respiratory arrest and require immediate, life-saving resuscitation efforts) . Patient was pronounced dead on , d+[DATE] ([DATE]) at 01:12 am (1:12 a.m.) . During a review of Resident 1's Interdisciplinary Team (IDT; a group of staff members consisting of nursing, dietary, rehabilitation, social services, activities, and administration who meet regularly to discuss incidents that occurred involving the well-being of residents and staff) Review, dated [DATE], the IDT Review indicated, . IDT Recommendations. 1. Nursing to monitor and provided wound tx (treatment) as ordered . Reposition q (every) 2 hrs (hours) and prn (as needed) . (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's IDT Review, dated [DATE], the IDT Review indicated, IDT Recommendations. 1. Turning and repositioning - care plan updated . During a review of Resident 1's IDT Review, dated [DATE], the IDT Review indicated, IDT Recommendations. 1. Turning and repositioning - care plan updated - wound vac (a device that applies gentle suction to a wound to promote healing) to be placed [DATE] to sacrum . During a review of Resident 1's Care Plan Report (CPR), dated [DATE], the CPR indicated, Wound Management. admitted with bruising. admitted with open area to coccyx . Interventions: Monitor ulcer for signs of infection. Notify provider if no signs of improvement on current wound regimen. Provide wound care per treatment order. During a review of Resident 1's CPR, dated [DATE], the CPR indicated, Documented Pressure on admission . Interventions: Encourage Resident to frequently shift weight. Evaluate skin for areas of blanching or redness. Notify family of new onset finding. Notify provider if no signs of improvement on current wound regimen. Provide skin care per facility's guidelines and PRN as needed. Provide wound care per treatment order. During a review of Resident 1's CPR, dated [DATE], the CPR indicated, Upon my admission, I have an ADL (Activities of Daily Living; dressing, toileting, washing, feeding, mobility, and transferring) self-care performance deficit r/t (related to) HEMIPLEGIA AND HEMIPARESIS FOLLOWING CEREBRAL INFARCTION AFFECTING LEFT NON-DOMINANT SIDE. Goal: I am dependent on help to perform all of my ADLs and require staff assistance to meet all of my ADL needs . Interventions: Assist and meet ADL needs. Encourage to assist with ADLs as able. Encourage to attend/participate in therapy. Observe for decline in ADL function. Observe for improvement in ADL function. During a review of Resident 1's Roll Left and Right (RLR), dated [DATE] through [DATE], the RLR indicated, Resident 1 required substantial to dependent assistance. The times Resident 1 was rolled left and right indicated Resident 1 was not rolled left and right every two hours. On [DATE], the record indicated Resident 1 was rolled left and right at 1:36 a.m., 9:35 a.m., 8:37 p.m., and 11:48 p.m. On [DATE], the record indicated Resident 1 was rolled left and right at 3:54 a.m., 1:59 p.m., and 7:41 p.m. During an interview on [DATE] at 12:59 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated she was assigned to Resident 1 on [DATE]. LVN 1 stated Resident 1 was immobile (incapable of moving or being moved) and was turned and repositioned every 2 hours. LVN 1 stated lying in one position longer than two hours will cause skin injuries. During an interview on [DATE] at 1:11 p.m. with Certified Nursing Assistant (CNA), CNA stated she was assigned to Resident 1 on [DATE]. CNA stated Resident 1 was dependent on transfer and required the use of a hoyer lift (a mechanical device used to safely transfer individuals with limited mobility from one place to another) and was turned and repositioned every two hours. CNA stated Resident 1 was incontinent (unable to control bowel and bladder) and was toileted every two hours. CNA stated lying in one position longer than two hours will cause skin injuries. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 1:26 p.m. with LVN 2, LVN 2 stated she was the Treatment Nurse (a nurse assigned to provide wound care to residents with wounds). LVN 2 stated Resident 1 was incontinent and required the use of a hoyer lift. LVN 2 stated Resident 1 required wound care and turning and repositioning every two hours. LVN 2 stated turning and repositioning was required every two hours to alleviate pressure points on the body to prevent skin break down and to let wounds heal. During an interview on [DATE] at 1:40 p.m. with the Director of Nursing (DON), the DON stated Resident 1 had impaired mobility, was incontinent of bowel and had an indwelling foley catheter (a tube inserted into the bladder to collect urine). The DON stated staff was required to check Resident 1's briefs (adult diaper) and turn and reposition Resident 1 every two hours. The DON stated it was the standard of practice to prevent skin break down and promote wound healing by turning and repositioning residents with wounds every two hours. The DON stated Resident 1's care plan did not specify how often Resident 1 should be turned and repositioned and should have. The DON stated there was no documentation that Resident 1 was turned and repositioned every two hours and should have. The DON stated the facility recently added turning and repositioning every two hours as a task for CNAs to complete for residents who required turning and repositioning every two hours to reflect that care was provided as indicated. The DON stated complete and accurate documentation was a requirement. During an interview on [DATE] at 1:45 p.m. with the Administrator (ADM), the ADM stated Resident 1 was unable to articulate (verbally express) his needs. The ADM stated Resident 1's spouse visited Resident 1 every day and she was his advocate (a person who supports and defends the interests of a patient). The ADM stated Resident 1 had skin breakdown and required two people to assist with transfer. The ADM stated it was standard of practice to turn and reposition immobile residents every two hours to avoid skin breakdown and promote wound healing. The ADM stated documentation of turning and repositioning every two hours should be complete and accurate to reflect the care provided. During an interview on [DATE] at 11:09 a.m. with the Medical Doctor (MD), the Medical Doctor stated he specialized in wound care. The MD stated the standard of practice to turn and reposition residents with pressure ulcers was every two hours to relieve pressure to the injured area, to promote wound healing and prevent the formation of pressure ulcers. The MD stated care plans should indicate offloading devices and repositioning every two hours. The MD stated documentation should be complete and accurate to reflect the required care ordered and provided. During a review of the facility's policy and procedure (P&P) titled, Wound and Skin Management, dated [DATE], the P&P indicated, Purpose: To maintain and/or improve tissue tolerance to pressure in order to prevent injury and/or infection and to assure that skin breakdown, and/or the potential for skin breakdown, is identified on admission and weekly thereafter as needed . Prevention: 1. The IDT, licensed nurses and CNAs are to ensure the following preventative measures are implemented for residents at risk for skin breakdown: . c. Ensure the resident is turned and repositioned as needed in bed and/or chair, if the resident can't do so independently . Intervention: 1. All staff are to take preventative measures for residents at risk for skin breakdown . During a review of the facility's P&P titled, Turning and Repositioning Patients, dated [DATE], the P&P indicated, Purpose: To prevent skin breakdown and contractures while providing the patients with appropriate circulation and comfort. Policy: It is the policy of this facility that patients will be repositioned throughout the day as needed for their physical and medical wellbeing. Procedure: . 2. Patients are to be repositioned routinely based on their needs . (continued on next page)

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