STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056405	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERRITOS VISTA HEALTHCARE CENTER	17836 WOODRUFF AVENUE , BELLFLOWER, California, 90706

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during the investigation of three complaints. Complaint Number: CA00968705, CA00970296 and CA00971206 The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility. Four deficiencies were identified for complaint number CA00968705.	F0000	Disclaimer: The signing of this plan of correction is not an admission or agreement by this statement of deficiencies and plan of correction. In fact, this plan of correction is submitted exclusively to comply with state and federal law. This plan of correction constitutes my written credible allegation of compliance for the deficiencies noted.	
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights.	F0550	F 550 Immediate Corrective Action The signage at the receptionist desk was immediately removed. On 7/9/25 the Administrator gave a 1-1 in-service to Receptionist 1 and Receptionist 2 regarding the policy for resident rights specifically regarding visitation. Identification of Others at Risk Social Services Director visited with residents on 7/10/25 to ensure they are able to have visitors with no restrictions. No other residents were identified with the same deficient. Process to Prevent Recurrence On 7/9/25 the DSD gave an in-service to staff regarding the policy for resident rights specifically regarding visitation.	7/20/25

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 reverse for further 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
[signature]	Administrator	8/1/25

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F0550 SS = D	Continued from page 1 The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, The facility failed to respect residents' right to receive visitors without limitation. This failure has the potential to disrupt resident's psychosocial well-being, cause emotional distress, and negatively affect the quality of care provided. During an interview on 7/8/2025 at 7:25 a.m. with Receptionist 1, Receptionist 1 stated that they recommended two visitors per resident to prevent the room being crowded. During a concurrent observation and interview on 7/8/2025 at 12:38 p.m. with Receptionist 2 at the facility entrance, observed one signage on the receptionist's desks stating, only two people allowed in residents room per visit. Receptionist 2 stated that the facility limits visitors to two people per visit and the facility remained the sign on the receptionist's desk for several years. During an interview on 7/9/2025 at 1:18 p.m. with Family Member (FM) 1, FM 1 stated that there are two visitor limit guidelines at this policy, but the facility does not follow their own policy, he saw a bunch of people celebrating one resident's birthday. During a concurrent observation and interview on 7/9/2025 at 1:25 p.m., observed that the facility did not post the 'two people allowed' sign on the	F0550	The Social Service designee will visit residents randomly weekly for six weeks and to discuss whether they had any concerns with visitation. All findings will be reported to the Administrator. Monitoring Performance The Activity Designee will discuss monthly at resident council for three months whether residents had any concerns with visitation. All findings will be reported to the Administrator. Findings will be reported to the QA committee for further review and recommendations, monthly, for 3 months or until substantial compliance is achieved.	

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F0550 SS = D	Continued from page 2 receptionist's desk on the observation date. Receptionist 2 stated that, for some reason, the visitor limit sign was not present on that date. During an interview on 7/9/2025 at 2:28 p.m., Resident 1 stated that he heard from his family that up to two people can visit him at the same time. During an interview on 7/9/2025 at 2:48 p.m. with the Social Service Director (SSD), the SSD stated that residents have the right to unlimited visitors, the signage on the reception desk was incorrect and inconsistent posting of the sign could affect resident's psychosocial well-being. The SSD stated if rooms are too small for visitors, the facility can provide alternative spaces like the patio or activity room. During the interview on 7/10/2025 at 1:10 p.m. with the Administrator (ADM), the ADM stated that they can have unlimited visitors, and this is the residents' right. The ADM stated if a room becomes overcrowded or issues arise, alternatives like activity room or patio can be provided instead of limiting visitor numbers. The ADM stated that failing to honor it could upset residents, lead to complaints, affect quality of care, or cause emotional distress and depression. During the review of the facility's policy and procedure(P&P), titled Residents' rights, no dated, the P&P indicated that This facility shall encourage visiting by family members and friends of all residents residing in the facility, In addition, cheerful and comfortable visiting areas are provided in which the residents may welcome and converse freely with their visitors.	F0550	F604 Corrective action: On 7/11/25, the physician's order for to use of abdominal binder for Resident 2 was discontinued and carried out. An individualized care plan to address use of abdominal binder was developed on 07/10/2025 for Resident #2. An in service to the MDS nurses was done by the Regional MDS nurse on 07/9/2025 to discuss completion of care plan for residents with abdominal binder order, individualized to address resident needs, clinical conditions, and medical necessity for use. Identification of others	7/20/25
F0604 SS = D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1),483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical . . . restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2).	F0604		

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F0604 SS = D	Continued from page 3 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical . . . restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to follow facility's own restraint policy for one of three sample residents (Resident 2) by not: a. trying alternatives prior to use of abdominal binder b. completing the informed restraint consent. c. monitoring every 30 minutes while on use. d. developing a care plan for abdominal binder (a supportive garment that wraps around the abdomen and provides compression and support) restraint (limiting or controlling something, whether it's a person's actions, emotions, or physical movement). These deficient practices have the potential to place the residents at risk for unnecessary prolonged use of restraints and can lead to a decline in physical functioning, and residents not being treated with respect and dignity with the use of restraints. During a review of Resident 2's Admission Record, the Admission Record indicated the facility admitted Resident 2 on 5/9/2025 with diagnoses including chronic	F0604	On 7/11/25 the DON/ADON conducted a chart audit and reviewed residents with current orders for abdominal binder/ physical restraints to ensure that less restrictive interventions attempted or tried other alternative options prior to applying a physical restraint. No other residents were identified with the same deficient practice. The Medical Records designee conducted a health records audit on 7/11/25 to ensure residents with an abdominal binder/ physical restraint have a complete informed restraint consent. No other residents were identified with the same deficient practice. On 7/11/25, the DON/ADON and Medical Records designee reviewed MAR/TAR record on residents with current order for abdominal binder/ physical restraint to ensure residents are monitored every 30 minutes while abdominal binder is in use. No other residents were identified with the same deficient practice. The Lead MDS nurse completed an audit on residents who currently have an abdominal binder/physical restraint order and were reviewed to ensure individualized care plan for abdominal binder/ physical restraint use is addressed/updated. No other residents were identified for this deficient practice Process to prevent recurrence: An in service to all licensed nurses was conducted by the DON on 7/11/25 to discuss trying alternatives prior to use of applying an abdominal binder/ physical restraint. An in service to all licensed nurses was conducted by the DON on 7/10/25 to discuss completion of informed restraint consent when a resident has an order for an abdominal binder/ physical restraint. Also, must monitor every 30 minutes.	

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F0604 SS = D	Continued from page 4 obstructive pulmonary disease (COPD-a common lung disease that makes it hard to breath), dysphagia (difficulty swallowing), type two diabetes mellitus (a condition where the body does not use insulin properly, and our blood sugar levels become too high) and dysphagia (difficulty swallowing) with gastrostomy (a surgically created opening into the stomach, often for the purpose of inserting a feeding tube). During a review of Resident 2's "History and Physical" (H&P), dated 5/11/2025, the H&P indicated, Resident 2 did not have the capacity to understand and make decisions. During a review of Resident 2's Minimum Data Set (MDS-a resident assessment tool), dated 5/15/2025, the MDS indicated Resident 2's cognitive (functions your brain uses to think, pay attention, process information, and remember things) skills for daily decision making was moderately impaired. The MDS indicated Resident 2 was dependent (helper does all of the effort) with eating, oral hygiene, toileting hygiene, upper body dressing, lower body dressing, putting on/ taking off footwear, and personal hygiene. During a review of Resident 2's Order Summary Report, as of 7/8/2025, the Order Summary Report indicated there was an order, created on 5/9/2025, support and safety device, may apply abdominal binder to minimize the risk of resident pulling out life sustaining gastrostomy tube (a flexible tube inserted through the abdominal wall into the stomach) and prevent potential injury, and may release during activities of daily living. During a review of Resident 2's Restraint-Physical initial evaluation, dated 5/10/2025 at 00:22 a.m., the restraint evaluation indicated that no alternatives attempted to reduce risk of harm to Resident 2 were attempted prior to the application of the restraint. During a review of Resident 2's Informed Consent, dated 5/10/2025, the informed consent indicated that the proposed treatment was applying abdominal binder. The informed consent form did not have a physician's signature. During a review of Resident 2's medical records, there	F0604	An in service to all licensed nurses was conducted by the DON on 7/9/25 to discuss completion of care plan for residents with abdominal binder order, individualized to address resident needs, clinical conditions, and medical necessity for use. The Medical Records designee will conduct a weekly audit for six weeks and monthly thereafter for three months to ensure there is an informed restraint consent completed for residents with an Abdominal binder/ physical restraint. She will also check the MARS/TARS to ensure the residents are being monitored every 30 minutes. All findings will be reported to the DON. The DON/ADON will ensure care plan for abdominal binder use is addressed for all residents with current abdominal binder order/ physical restraints. Furthermore, the MDS nurses will review/ update restraint care plans quarterly and as needed, per protocol Monitoring performance The DON/ADON will review residents with current order for abdominal binder application several times a week for six weeks and weekly thereafter for 3 months to ensure that less restrictive interventions were attempted and/or other alternative options prior to abdominal binder/ physical restraint. The Director of Nursing will discuss findings at our Quality Assurance and Improvement Committee monthly for evaluation and further action. The DON/ADON and Medical Records designee will check resident records MAR/TAR weekly for six weeks and monthly thereafter for 3 months to ensure that residents are being monitored every 30 minutes.	

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F0604 SS = D	Continued from page 5 was no care plan addressing Resident 2's abdominal binder restraint. During an observation on 7/7/2025 at 4:40 p.m., in Resident 2's room, Resident 2 was wearing an abdomen binder. During a concurrent interview and record review on 7/8/2025 at 10:51a.m., with Licensed Vocational Nurse (LVN) 2, the informed consent, dated 5/10/2025was reviewed. LVN 2 stated that Resident 1 had the abdominal binder as a restraint and staff should obtain the restraint informed consent. The informed consent regarding the abdominal restraint on 5/10/2025 was incomplete due to the absence of the physician's signature and date. LVN 2 stated that Staff should monitor Resident 2 while the restraint binder in use to ensure that it is fastened properly, not too constrictive or tight, and that the skin is not affected. LVN 2 stated that there was no documented monitoring while the abdominal restraint was in use. During a concurrent interview and record review on 7/8/2025 at 2:51p.m., with 20Registered Nurse (RN)1, Resident 2's Restraint-Physical initial evaluation, dated 5/10/25 at 12:22 a.m., was reviewed. RN 1 stated Staff did not attempt alternative interventions prior to the initial use of abdominal binder on 5/10/2025 at 00:00, to reduce or avoid the use of restraint. RN 1 stated Resident 2 had COPD which causes difficulty breathing, and staff did not monitor or assess Resident 2 every 30 minutes while the abdominal binder restraint was in use. RN 1 stated that staff should monitor and assess comfort, tolerance, breathing difficulties, and proper application, and no such record was found. RN 1 stated that there was no specific care plan regarding the abdominal binder restraint. RN 1 stated that failure to follow the restraint policy could lead to resident neglect, unrecognized distress, or actions against residents' will. During an interview on 7/10/2025 at 11:34 a.m., with the Assistant of Director of Nursing (ADON), the ADON stated that staff had to obtain the informed consent prior to apply restraint, should first try less restricting alternatives, such as 1:1 companionship, medication review, or engaging in activities. The ADON stated use of restraints should be the last resource. The ADON stated that the personalized Care plan should be developed and reflect Resident 2's need for	F0604	The Director of Nursing will discuss findings at our Quality Assurance and Improvement Committee monthly for evaluation and further action. The Regional MDS nurse shall conduct chart audits monthly for 3 months with focus on care plan for residents with current restraint order/s and will provide a report of findings to the Administrator/QA committee for review and further recommendations	

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F0604 SS = D	Continued from page 6 abdominal binder restraint. ADON stated that staff should observe the resident at least every 30 minutes while the restraint in use, as Resident 2's multiple comorbidities could cause discomfort and dignity issues if not properly monitored. During a review of the facility's policy and procedure (P&P) titled, Use of restraint, dated 2017, the P&P indicated that, Restraints shall only be used for the safety and well-being of the residents and only after other alternatives have been tried unsuccessfully. The ongoing re-evaluation for the need for restraints will be documented. Orders for emergency restraints shall be signed by the physician within forty-eight 48 hours. A resident placed in a restraint will be observed at least every thirty (30) minutes by nursing personnel and an account of the resident's condition shall be recorded in the resident's medical record. Care plans for residents in restraints will reflect interventions that address not only the immediate medical symptoms), but the underlying problems that may be causing the symptom (s), care plans shall also include the measures taken to systematically reduce or eliminate the need for restraint use. Documentation regarding the use of restraints shall include the length of effectiveness of the restraint time; and observation, range of motion and repositioning flow sheets.	F0604	F 641 Corrective action: A. Resident #2's Admission/Medicare 5 day assessment with an Assessment Reference Date (ARD) of 05/15/2025 has been modified on 07/10/2025 to correct coding for Section P0100D. Other Restraint, to code use of the abdominal binder. This assessment was transmitted and accepted on 07/11/2025 accordingly. B. In service was done by the Regional MDS consultant re: Section P coding accuracy on 07/9/2025. Identification of Others at Risk The Lead MDS nurse did a chart audit on 7/10/25 and reviewed residents with current order for Abdominal binder on use to check if they were correctly coded on the MDS assessment/s: Section P. A copy of this audit was provided to the DON/ Administrator for review. One other resident was identified for this deficient practice and MDS assessment was modified accordingly.	7/20/25
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.	F0641		

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F0641 SS = D	Continued from page 7 §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on interview, and record review, the facility failed to ensure the assessment entries on the Minimum Data Set (MDS- a resident assessment tool) related to restraints and alarms was accurately documented for one of two sample residents (Resident 2). This deficient practice had the potential to negatively affect Resident 2's plan of care and delivery of necessary care and services. During a review of Resident 2's Admission Record, the Admission Record indicated the facility admitted Resident 2 on 5/9/2025 with diagnoses including chronic obstructive pulmonary disease (COPD-a common lung disease that makes it hard to breath), and dysphagia (difficulty swallowing) with gastrostomy (a surgically created opening into the stomach, often for the purpose of inserting a feeding tube). During a review of Resident 2's MDS, dated 5/15/2025, The MDS indicated Resident 2 was dependent (helper does all the effort) with eating, oral hygiene, toileting hygiene, upper body dressing, lower body dressing, putting on/ taking off footwear, and personal hygiene. The MDS, Section P, indicated Resident 2 did not have restraints (limiting or controlling something, weather it's a person's actions, emotions, or physical movement) During a review of Resident 2's Restraint-Physical Initial evaluation, dated 5/10/2025, the restraint evaluation indicated that staff initiated an abdominal	F0641	Measures to prevent recurrence: The Lead MDS nurse will ensure all residents with (new) abdominal binder order that meet the definition of restraint are coded accurately. The Regional MDS consultant shall perform random chart audits, focusing on coding Section P accurately, monthly for three months and present inaccuracy findings to the DON and the Administrator for corrective actions. Monitoring Performance The Director of Nursing will present a recapitulation of findings of the random monthly audits at the Monthly Quality Assessment and Assurance Committee meeting for review with corrective actions, as indicated.	

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F0641 SS = D	Continued from page 8 binder restraint on Resident 2 on 5/10/2025 at 00:00. During a concurrent interview and record review on 7/8/2025 at 2:22 p.m., with Registered Nurse (RN) 2, RN 2 stated that Resident 2 wore the abdominal binder, she did not mark it as a restraint on the MDS section P because she did not consider it a restraint. RN 2 stated that accurate entries on the MDS were important because they reflect the care provided to residents; If not assessed accurately, the facility cannot identify the correct status of the patient. During a concurrent interview and record review on 7/8/2025 at 2:51p.m., with Registered Nurse (RN)1, RN 1 stated that abdominal binder used for Resident 2 was considered a restraint, and the MDS coordinator should mark it as a restraint on the MDS. During an interview on 7/10/2025 at 11:34 a.m. with the Assistant Director of Nursing (ADON), the ADON stated that Resident 2's abdominal binder was a restraint, Accurate assessment is important and should be accurately documented in the system, as MDS serves as the basis of care planning, billing purposes, and ensuring that the patient receives the appropriate quality of care of the patient's need. During a review of the facility's policy and procedure (P&P) titled, certifying accuracy of the resident assessment, undated, indicated, any person who completes any portion of the MDS assessment, tracking form, or correction request form is required to sign the assessment certifying the accuracy of that portion of that assessment. During a review of the facility's P&P titled, Resident assessment, undated, indicated that comprehensive assessment includes completion of the Minimum Data Set (MDS); All persons who have completed any portion of the MDS resident assessment form must sign the document attesting to the accuracy of such information.	F0641		
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care	F0684		

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F0684 SS = D	Continued from page 9 Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Facility failed to assess comprehensively one of three sampled residents (Resident 2) by not assessing and monitoring Resident 2's toenail detachment status after it began bleeding for five days. This failure had the potential to delay necessary medical intervention, leading to complications such as infection, pain, or further injury. During a review of Resident 2's Admission Record, the Admission Record indicated the facility admitted Resident 2 on 5/9/2025 with diagnoses including chronic obstructive pulmonary disease (COPD-a common lung disease that makes it hard to breath), dysphagia (difficulty swallowing), type two diabetes mellitus (a condition where the body does not use insulin properly, and our blood sugar levels become too high), the admission record also indicated that long term use of anticoagulants (blood thinners). During a review of Resident 2's "History and Physical" (H&P), dated 5/11/2025, indicated, Resident 2 did not have the capacity to understand and make decisions. During a review of Resident 2's Minimum Data Set (MDS- a resident assessment tool), dated 5/15/2025, indicated Resident 2's cognitive (functions your brain uses to think, pay attention, process information, and remember things) skills for daily decision making were moderately impaired. The MDS indicated Resident 2 was dependent (helper does all the effort) with eating, oral hygiene, toileting hygiene, upper body dressing, lower body dressing, putting on/ taking off footwear, and personal hygiene. During a review of Resident 2's Order Summary Report, as of 7/8/2025, the Order Summary Report indicated there was an order, dated 5/9/2025, to administer one table of apixaban (a blood thinner) oral tablet 2.5 milligram (unit does) through gastrostomy tube(a tube inserted thought the abdominal wall into the stomach)	F0684	F 684 Immediate Corrective Action Upon notification the RN Supervisor immediately assessed the toenail of Resident 2 and notified the Physician and family. The treatment nurse was informed and assessed the resident. On 7/9/25, the DON gave a 1-1 in service to RN 1 regarding ensuring to assess and monitor residents after they have a change of condition and ensure not to delay necessary medical intervention, pain, or further injury. On 7/9/25, the DON gave a 1-1 in-service to LVN 1 regarding ensuring to assess and monitor residents after they have a change of condition and ensure not to delay necessary medical intervention, pain, or further injury. Identification of Others at Risk The Director of Nursing and Medical Records conducted a health records review on 7/9/2025 to ensure all residents with a change of condition were assessed and monitored and follow up was completed. No other residents were identified with the same deficient. Process to Prevent Recurrence On 7/9/25, the DON gave an in-service to Licensed nurses regarding ensuring to assess and monitor residents after they have a change of condition and ensure not to delay necessary medical intervention, pain, or further injury. Medical Records will audit change of condition assessments daily for six weeks and weekly thereafter for three months to ensure compliance. All findings will be reported to the DON.	7/20/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056405	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0684 SS = D	Continued from page 10 two times a day for atrial fibrillation (a condition where the upper chambers of the heart beat irregularly and rapidly). During a review of Resident 2's COC (change of condition-any significant alteration in a patient's physical, mental, emotional, or functional status)/interact assessment form (SBAR-situation, background, assessment and recommendation), dated 5/20/2025, the COC assessment form indicated that Resident 2's daughter reported RN 1 that her toe was bleeding, RN 1 noted dried blood underneath the fifth toe (pinky toe) of left foot. During an observation on 7/8/2025 at 10:10 a.m. in Resident 2's room, observed no toenail on Resident's left 5th toe. During a concurrent interview and record review on 7/8/2025 at 2:51 p.m. with Registered Nurse (RN) 1, COC assessment form (SBAR), dated 5/20/2025 was reviewed, RN 1 stated that Resident 2's left toe started to bleed on the day, RN 1 assessed the resident and MD made aware with order to have treatment nurse assess and evaluate. RN 1 stated that Resident 2's toenail was already detached and gone completely upon RN 1's return to work 6 days later. RN 1 stated that the treatment nurse, Licensed Vocational Nurse (LVN)1 assessed Resident 2 after the toenail was fully removed. RN 1 stated this was a delayed intervention and not consistent with quality care. During a concurrent interview and record review on 7/8/2025 at 4:43 p.m. with the Director of Nursing (DON), Resident 2's COC assessment form and nursing progress notes, dated from 5/20/25 to 5/25/2025 were reviewed. The DON stated that there was no documentation regarding the status of toenail's detachment, after the initial COC assessment. During an interview on 7/9/2025 at 1:32 p.m. with Licensed Vocational nurse (LVN) 1, LVN 1 stated, her role included monitoring and assessing any skin issues. LVN 1 stated that Resident 2 had diabetes and was at risk of bleeding. When Resident 2 experienced bleeding on her toe, assessing and monitoring were important. LVN 1 stated that there was no follow-up treatment documentation regarding the bleeding on her toe.	F0684	Monitoring Performance The DON or designee will randomly check residents change of condition assessments several times a week for six weeks and weekly thereafter for three months to ensure to ensure licensed nurses have assessed and monitored after the residents change of condition.	

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F0684 SS = D	Continued from page 11 During an interview on 7/10/2025 at 11:34 a.m. with the Assistant Director of Nursing (ADON), the ADON stated that when the patient is diabetes, was on a blood thinner, and began bleeding on the toe area, it could indicate a diabetic foot complication. Staff should assess, monitor and document the source of bleeding, circulation, and signs of infection for at least 72 hours or longer to allow early intervention. The ADON stated that there was no documentation regarding circulation, infection signs, or, bleeding source, and there was no treatment nurse's documentation. The progress of the toenail coming off was not assessed for several days. And 6 days later, it detached and finally fell off after then seen late by podiatrist after the toenail had gone. The ADON stated that proper documentation and timely communication are essential. During a review of the facility's policy and procedure (P&P) titled, Change of Condition, revised 1/24/2017 indicated that documentation of change in condition shall be performed by the licensed Nurse accordingly. Documenting for at least 72hours or longer if condition change warrants. During a review of the facility's P&P titled, Charting and Documentation, revised 07/2017, indicated that Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. The P&P indicated that Documentation of procedures and treatments will include care-specific details, including: the assessment data and/or any unusual findings obtained during the procedure/treatment. During a review of the facility's P&P titled, change in a Resident's Condition or Status, revised 2/2021, indicated that If a significant change in the resident's physical or mental condition occurs, a comprehensive assessment of the resident's condition will be conducted. During a review of the facility's P&P titled, Change of Condition, revised 1/24/2027, indicated that documentation of change in condition shall be performed by the licensed nurse accordingly: documenting for at least 72 hours or longer if condition change warrants.	F0684		