F550, 483.10 (a) Resident Rights:
On 8/19/24 between 12:27 p. m. and 12:34 p.m., a surveyor observed the lunch meal service in the C - Unit dining room. A surveyor observed Certified Nursing Assistant #3 (CNA#3) standing over Resident #42 while feeding him/her. In addition, the CNA did not engage in any conversation with the resident while feeding him/her.
On 8/20/24 at 8:15 a.m. a surveyor observed CNA#1 in Unit C dining room, standing over a resident while aiding him/her feeding. A surveyor observed CNA #2 in the hallway at the nurse's station, standing over a resident while aiding him/her with feeding

F 550 483.10 (a) Facility Plan of Correction:

- 8/19/24, 8/20/24, on spot correction was provided to staff members. Staff member immediately remedy practice
- SJRR/ Fallbrook Commons will provide all staff education regarding dignity and the residents dining experience. Education will include review of resident rights and specifically target areas of dignity r/t dinning. Education will be provided verbal as well written communication. Staff will be required to sign they understand the education provided
- Nurse Manager or designee will Audit five (5) dining experiences each week each unit. Weekly Audits will continue for a period of 3 months or until 100% compliance is reached. The Nurse Manager or designee will then reduce audits and conduct random audits to maintain facility compliance.
- Fallbrook Commons will be in substantial compliance by 10.06.2024

F577, 483.10 (g) (10)(11) Right to Survey Results/ Advocate Agency info
On 8/22/24 at 9:05 a.m. a surveyor went to the main lobby to review the book that contained the Latest Survey Results, and the book was empty.

F577, 483.10(g) (10)(11) Facility Plan of Correction:

- As discussed with the Surveyor at the time this information was presented, the information was likely removed as we are transitioning to move to a new facility. The survey results are required to be submitted to the insurance companies.
- The last 3 years of survey's were immediately acquired and placed into the survey book and the book returned to the lobby as required.
- The facility will provide education to staff regarding the presence of the survey results. This education will be provided via written memo style.
- The facility receptionist/ shift supervisor will check the survey book 2x daily for the presence of the required documentation. The audit sheet will be kept with the survey book. If they note any missing documentation the staff will notify Director or Nursing or designee.
- Fallbrook Commons will be in Substantial Compliance by 9.13.24

F578, 483.10 (c)(6)(8)(g)(12)(i)-(v)Request/ Refuse/ Discontinue treatment; Formulate Advanced Directives
Based on record review, and interviews, the facility failed to inform and provide written information concerning the right to formulate an advance directive for 4 of 16 residents reviewed for advanced directives. (#62, #65, #40, #21)

F 578, 483.10 (c)(6)(8)(g)(12)(i)-(v) Facility Plan of Correction:

- Social Service department has given Advanced directive information to resident's #62, #65, #40, #21. We will adopt using a new Advanced Directive form from NCA (NC4011 Advanced Directive Acknowledgment).
- All resident's records will be audited to ensure presence of Advanced Directive notice, if records are found to not contain the information, the information will be provided at this time.
- Social Services will add the NCA form Advanced directive Acknowledgement to all new admit packets. Social services will review with resident at time of admission and will scan completed form into the medical record, labeled "Advanced Directive".
- Social Service or designee will audit all new admission weekly to ensure Advanced directive form completed.
- SJRR/ Fallbrook Commons will be in substantial compliance by 10.06.24

F582, 483.10(g)(17)(18)(i)-(v) Medicaid/Medicare Coverage/ Liability Notice
Based on record reviews and interview, the facility failed to ensure the Notice of Medicare Provider Non-Coverage (CMS-10123-NOMNC) form was provided for 2 of 3 sampled residents whose Medicare Part A Skilled services were discontinued. In addition, the facility failed to ensure the Skilled Nursing Facility Advance Beneficiary Notice (CMS-10055-SNF ABN), which included appeal rights and liability of payment was provided for 2 of 2 sampled residents who remained in the facility after Medicare Part A benefits ended.

F 582, 483.10(g)(17)(18)(i)-(v) Facility Plan of Correction:

- Residents noted to have not received form(s) CMS-10123 and CMS-1005, will be issued for as late documentation and noted in the medical record.
- Social Service will audit any discharges occurring in the last 60 days, if evidence of CMS-10123 (NOMC) not found, Social Services or designee will complete the form indicating that the form was given late with appropriate date. Once complete document will be uploaded into EHR.
- Facility will create and implement check list to include NOMC and ABNs are discussed weekly during Utilization Review meetings.
- Social services or designee will create audit tool to be utilized to ensure all mandatory forms are completed and present in the medical record. Audits will be completed weekly.
- SJRR/ Fallbrook Commons will be in substantial compliance by 10.06.24

F600, 483.12 (a)(1) Freedom from Abuse, Neglect and Exploitation
On 6/11/24, the Division of Licensing and Certification received from the facility a Reportable Incident Form which indicated an allegation of abuse of a resident (Resident #91) by Certified Nursing Assistant #4. (CNA #4) While CNA #4 was providing 1:1 care to Resident #91.

F 600, 483.12 Facility Plan of Correction:

- Incident in question occurred on 6.10.2024 and was reported @ approx. 3:00. CNA#4 was immediately sent home pending an investigation. Clinical Laision RN present and assessed resident (bruising not present). Assignments on the unit changed to accommodate resident #91 needs. Requested staff who witnessed the event to write statements. Email sent to CNA#4 agency (staff was from a contracted company), advised that due to the nature of the alleged complaint we would need to terminate her contract effective immediately. On 6.11.24 Nurse Manager was able to take pictures and slight bruising noted, the incident was reported to Division of Licensing and Certification as allegation of abuse, with results of termination of employee from facility. CNA #4 had completed facility training against abuse.
- Employee's contract was terminated effective immediately d/t severity of allegations (6.11.24)

- Facility will implement approach for res #91, that staff providing 1:1 will have periodic breaks to reduce fatigue and stress. Nurse Manager or designee will implement book to sign off from caregiver to caregiver. Book will contain a copy of Greg's care plan, as well as the Preventing resident abuse, neglect, and exploitation. Book will be in place by 9.13.24
- Facility seeking placement for resident that would better accommodate his needs (ICF/IDD).
- All staff will be provided additional training on preventing resident abuse, neglect, and exploitation. Education will be provided via written communication in small groups. Staff will be required to sign off on the policy.
- SJRR/ Fallbrook Commons will be in Substantial compliance by 10.06.24

F623, 483.15 (c)(3)-(6)(8) Notice of requirement before Transfer/Discharge
Based on record reviews and interviews, the facility failed to issue a written transfer/discharge notice to a resident or their legal representative for a facility-initiated transfer/discharge for 5 of 5 sampled residents transferred/discharged to an acute care facility. (#75, #40, #65, #78 and #88)

F 623, 483.15(c)(3)-(6)(8) Facility Plan of Correction:

- Facility will complete late documentation of transfer/discharge notice. Late entry will be placed in the EHR for residents #75, #40, #65, #78, #88.
- Facility will audit all resident discharge occurring in the last 60 days for appropriate transfer/ discharge notice. If a resident record is noted to not contain one, social service will provide a late entry and will document in the EHR.
- Education will be provided to all nursing staff regarding transfer/discharge form. Nursing staff will be educated via oral communication as well as written process. Nursing staff to initiate transfer/discharge form with any transfers, Nursing staff will make a copy of the form to be sent to responsible party by social services. If a resident in unable to sign the form will still be initiated and sent with the resident. The form will be uploaded into the EHR.
- Social Service will send the transfer/discharge form to the responsible party, as well as fax a copy to the ombudsman on the next business day, documentation will indicate that the form has been sent to both parties.
- Social Services will review each previous day discharges and note if appropriate documentation is contained in the medical record. This will review will occur during AM meetings.
- Facility will be in substantial compliance by 10.06.24

F625, 483.15 (d)(1)(2) Notice of Bed Hold Policy
Documentation in Resident (#75, #40, #65, #78 and #88) clinical record indicated that he/she transferred to an acute care hospital. The clinical record lacked evidence that the facility issued a written bed hold notice to the resident, a family member, or legal representative

F 625, 483.15(d)(1)(2) Facility Plan of Correction:

- Facility will complete late documentation of notice of Bed Hold Policy. Late entry will be noted in the EHR for residents (#75, #40, #78, #88).
- Facility will audit all facility transfers to acute care hospital x60 days for appropriate notice of bed hold policy. If resident record found not to have notification, Social Services will make late entry.
- Education will be provided to all nursing staff that notice of Bed Hold policy must accompany resident each time they are transferred to acute facility. Education that nursing will initiate form make a copy and Social services

will send form to responsible party. The form will be uploaded into EHR, as well a note documenting that the form was sent. Staff will be educated via written and oral communication

- Social Services will review previous day discharges/ transfers to ensure all appropriate notifications have been completed. This review will be incorporated into facility AM meeting.
- Facility will be in substantial compliance by 10.06.24

F645, 483.20 PASARR (k)(1)-(3) Screening for MD & ID
Based on record reviews and interview, the facility failed to ensure that 1 of 5 residents reviewed with a specialized mental health diagnosis, whose stay went beyond the expected 30 days, had been referred to the appropriate state-designated authority for Pre-Admission Screening & Resident Review Level II (PASRR) evaluation and determination (Residents #55).

F645, 483.20(k)(1)-(3) Facility Plan of Correction:

- Facility will submit to state for PASARR determination for resident #55.
- Social Services or designee will audit all record for presence of PASARR documentation. Documentation will be uploaded into EMR. If any records are found out of compliance social services will submit to have PASARR completed.
- Social services will audit and track all new admissions for presence of PASARR, if addition assessments are required social services will request. Social services will track PASARR and need each week at Utilization Review meetings, Social Services will alert MDS with any change in PASARR status.
- Facility will be in substantial Compliance by 10.6.24

F657, 483.21(b)(2)(i)-(iii) Care Plan Timing and Revision
Based on interviews and record review the facility failed to review and revise the care plan by an interdisciplinary team (IDT), that included but is not limited to, the attending physician, a registered nurse, and Certified Nurses Aid (CNA) with responsibility for the resident, a member of nutrition services and to the extent possible, include the participation of the resident and/or resident's representative, after each Minimum Data Set (MDS) assessment for 16 of 29.

F657, 483.21(b)(2)(i)-(iii) Facility Plan of Correction:

- IDT documentation and care plan for residents (#13, #18, #30, #31, #40, #54, #55, #62, #65, #67, #71, #75, #78, #88, #93, #95). It will be noted by any department to be a late entry with date completed.
- Social Services will audit all records having IDT meetings going back 60 days. If documentation is not complete, late entries will be completed.
- Facility will begin using IDT form with sign in sheet attached, form indicating persons present will be uploaded into EHR.
- Families will continue to be notified in writing of IDT with date and time. Copy of the letter as well as note stating it was sent will uploaded into medical records. Social Services or designee will invite the resident to attend the meeting and document in the medical record that notification occurred.
- Social Services will write narrative recap note of the meeting.
- IP/QAA Nurse will audit the records of each resident having IDT's weekly on Friday. If above noted documentation not present, they will notify social services and Director of Nursing.
- Facility will be in substantial compliance by 10.06.24

F661, 483.12(c)(2)(i)-(v) Discharge Summary
Based on interview and record review, the facility failed to develop a discharge summary which included a recapitulation of the resident's stay for 1 of 1 resident reviewed for discharge (Resident #105).

F661, 483.12 483.12(c)(2)(i)-(v) Facility Plan of Correction:

- Facility will implement use of NCA tool IDT "Recapitulation of Resident Stay". Resident discharge date will be discussed at UR. When discharge date set, Nurse Manager will start Recap of stay form, form will be placed at nursing station to be completed by all appropriate disciplines.
- Nurse Manager or designee will copy form, (1) copy will be given to the resident as part of their discharge instructions, the form will be uploaded into the medical record.
- Nursing /ancillary staff will be educated on the "new process, and form", Education will be oral as well as written.
- IP/QAA nurse will audit the presence of the form when resident discharged from facility.
- Facility will be in substantial compliance by 10.06.2024

F664, 483.25 Quality Care
Based on record review and interview, the facility failed to ensure that physician's orders were followed for 1 of 33 sampled residents (#9). Resident #9's Physician Order Summary sheet dated 4/9/24 indicated the resident was to be weighed weekly on Tuesday and Thursday for Congestive Heart Failure. There was no evidence in the resident's clinical record to indicate the resident was weighed on 4/18/24, 5/23/24, 6/6/24, 6/11/24, 7/11/24, 7/18/24 and 7/25/24.

F664, 483.25 Facility Plan of Correction:

- Nurse Manager or designee for each community has completed audit of Provider orders regarding weights, Nurse Manager or designee will ensure that the weight is able to be captured into the Medical record by CNA/Nurse.
- Nurse Manager or designee will provide education to all staff regarding obtaining the information as ordered, as well as facility weight policy (NCA policy). Education will be provided written as well as oral.
- Nurse Manager or designee will audit the records weekly to ensure unit is compliant with obtaining information as ordered by the facility. Audits will occur weekly x3month or until 100% compliance reached. Nurse managers will then perform periodic audits to maintain compliance.
- Facility will be in substantial compliance by 10.06.24

F695, 483.25(i) Respiratory/ Tracheostomy Care and Suctioning
Based on observations, record reviews, facility policy, and interviews, the facility failed to provide a sanitary environment to help prevent the development and transmission of disease and infection related to respiratory care for 4 of 4 residents reviewed for respiratory care (#30, #60, #93 and #70

F695, 483.25(i) Facility Plan of Correction:

- Facility immediately changed and dated O2 tubing/nebulizer equipment for residents #30, #60, #93, #70
- Nurse Manager for all unit completed an audit to ensure all O2 tubing was labeled dated, off the floor, nebulizer equipment was rinsed and stored correctly.

- Facility will implement the use of O2 plastic bags to store O2 equipment when not in use and prevent contamination, bags will be dated as well as tubing and changed weekly.
- Nurse Manager or designee will provide education to all nursing staff regarding Oxygen policy, label and dating tubing as well as use of O2 bags.
- Nurse Manager or designee will audit O2 tubing weekly to ensure compliance with policy.
- Facility will be in Substantial compliance by 9.13.2024

F699, 483.25(m) Trauma Informed Care
Based on record review and interview, the facility failed to identify a resident's history of Post-Traumatic Stress Disorder (PTSD)/trauma to determine what trigger(s) might cause re-traumatization and failed to revise the care plan to include trauma informed care for 1 of 5 sampled residents reviewed for trauma. (#60)

F699, 483.25(m) Facility Plan of Correction:

- Social Service will complete trauma screen for resident #60, and update care plan to reflect that resident has preference for no male care givers. Completed by 9.13.2024
- Facility will conduct audits for all residents to screen for hx of trauma and update care plan appropriately
- Facility will implement new trauma informed screening tool, to be completed upon admission to the facility and reviewed with IDT meetings
- Social services or designee will provide education to nursing staff regarding trauma informed care and process to follow, education will be provided written and well as verbal.
- Facility will discuss all new admits at morning meeting to ensure trauma screen completed and care plan updated accordingly
- Facility will be in substantial compliance by 10.06.2026

F755, 483.45(a)(b)(1)-(3) Pharmacy Services/ procedures/pharmacist records
Based on facility policy, observations, record review and interviews the facility failed to ensure controlled drug records are in order and an account of all controlled drugs is maintained to enable reconciliation and failed to ensure that two people who are authorized to administer medications signed the controlled substance cycle count once daily for 1 of 1 Omnicell (automated medication dispensing cabinet) reviewed

F755, 483.45(a)(b)(1)-(3) Facility Plan of Correction:

- Facility's policy regarding the use of the Omnicell will be eliminated/ discontinued.
- Facility will use Omnicare's policy exclusively "automated medication dispensing"
- Nurse Manager or designee will provide education to all staff authorized to utilize the Omnicell, via written and verbal communication
- Facility will be in substantial compliance by 10.06.2024

F761, 483.45 (g)(h)(1)(2) Label/Store Drugs and Biologicals
Based on facility policy, observation, interview, and record review the facility failed to ensure biologicals were stored at appropriate temperatures in 2 of 2 refrigerators observed (Unit A, #1 and #2 refrigerators)

F61, 483.45(g)(h)(1)(2) Facility Plan of Correction:

- Facility will audit all temperature logs for the medication refrigerators on the units.

- Facility will provide education to all staff the Unit refrigerator need to be monitored 1x daily and vaccine refrigerator will be monitored 2x daily. Education will be provided written as well as verbal.
- Nurse Manger or designee will audit daily to ensure the temperature is monitored and documented x3 months or until 100% compliance is reached. Nurse Manager or designee will then conduct random periodic audits.
- Facility will be in substantial compliance by 10.06.24

FB12, 483.60(i) Food Procurement, Store/Prepare/Serve-Sanitary
Based on observations and interviews, the facility failed to serve and store food in a sanitary manner during 1 of 2 observations.

FB12, 483.60(i) Facility Plan of Correction:

- Unlabeled items noted in the reach in refrigerator as well on the cart were immediately disposed of.
- Facility has entered a contract with Heavenly cleaning company to clean kitchen and other facility areas until SJRR closes on 9.20.2024 and all residents are moved to Fallbrook commons.
- Kitchen staff will be educated on appropriate dating of any food via written and oral communication
- Person (s) in charge of dinning services or designee will conduct audits of food and dates daily x 1 month or until 100% obtained. Audits will then reduce to 2x weekly
- Facility will be in substantial compliance by 10.06.2024

FB68, 483.75(g)(1)(i) -(iii)(2)(i), 483.80(c) QAA committee
Based on interviews and reviews of the attendance from the facility Quality Assurance meetings, the facility failed to ensure the Quality assessment and assurance (QAA) committee consisted of the required members.

FB68, 483.75483.75(g)(1)(i) -(iii)(2)(i), 483.80(c) Facility Plan of Correction:

- Fallbrook Commons will hold QAA meeting on 10.03.2024, Facility will ensure that, Administrator, Director of Nursing, Medical director, Infection preventionist, pharmacist and 3 other members are present.
- QAA meetings will be held on a quarterly basis moving forward from 10.3.2024
- Facility will be in substantial compliance by 10.06.2024