STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055201	A. BUILDING _____ B. WING _____	03/23/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
STOCKTON NURSING CENTER	4545 SHELLEY COURT STOCKTON, CA 95207

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 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide adequate supervision for one of 3 sampled residents (Resident 1) with wandering and intrusive behavior when the facility did not identify and implement specific interventions to stop his wandering behaviors. This failure resulted in Resident 1's wandering into Resident 2's room where Resident 1 sustained injury to his nose, and Resident 1's behavior also caused other residents in the facility to feel anxious and upset. Findings: Resident 1 was admitted to the facility in the summer of 2019 with [DIAGNOSES REDACTED]. During an observation on 1/31/20 at 9:50 a.m., Resident 1 was rolling in his wheelchair in the hall. Resident 1 wheeled past his room and continued moving down the hall. Resident 1 was noted to have a dry scab in the middle of his nose. Resident 1 smiled when his name was called, mumbled incoherently, and was unable to carry out a meaningful conversation. When Resident 1 was asked regarding the incident in which he received injury to his nose, he attempted to respond to a question, but the speech was unintelligible and responses were irrelevant. During a review of Resident 1's most recent Minimum Data Set (MDS, a comprehensive assessment) with an assessment reference date of November 28, 2019, indicated Resident 1 required supervision to limited assistance in his daily functions, including transfers. According to the assessment, Resident 1 moved around in his wheelchair independently. During a review of Resident 1's document titled, Wandering Assessment, dated 8/21/19, the assessment indicated he was disoriented, did not understand his surroundings, was independently mobile, and had a known history of wandering. Resident 1 scored 11 and the assessment categorized him to be at high risk for wandering. Review of Resident 1's plan of care initiated on 8/22/19, indicated Resident 1 had episodes of being nervous and anxious which was manifested by his wandering around the facility. The care plan's interventions were to call and address resident by his name, touch/hold resident's hand, and to avoid things that make me more anxious. The care plan did not identify the things that made Resident 1 anxious and failed to contain specific interventions how to avoid things that increased Resident 1's anxiety. The care did not include frequent visual checks and did not list any preventative measures addressing Resident 1's wandering and interventions to assure resident's safety. During multiple observations throughout the day on 1/31/20, Resident 1 was observed rolling around in his wheelchair in two different stations and was noted making attempts to enter other residents' rooms. There was no staff in the halls to redirect him away or engage in any activities and he continued to wheel himself around. Numerous clinical notes by nurses from 12/1/19 to 1/31/20 indicated Resident 1's restlessness, [MEDICAL CONDITION], increased anxiety, reeducation for use of call light, and resident's cognitive status and behaviors needed supervision. Review of facility's Interdisciplinary Team (IDT) report dated 1/21/20, indicated that on 1/20/20 Resident 1 had unwitnessed incident when he wandered into another resident's room and had a physical altercation with another resident (Resident 2). The report indicated a nurse heard someone yelling in another resident's room and when she entered the room, Res (resident) 1 was observed sitting on the WC (wheelchair) with skin abrasion + (plus) small serous drainage (thin, watery plasma drainage) on the nose bridge. The report indicated Resident 1 was not able to provide description of the alleged incident secondary to his dementia. The IDT report did not provide any recommendations and did not indicate what precautions and specific interventions were put in place after the altercation incident to monitor Resident 1's wandering behaviors and safety. During a concurrent observation and interview on 1/31/20 at 10:45 a.m., Resident 2 stated he remembered the incident with Resident 1. Resident 2 explained that he was watching his TV on that day when Resident 1 rolled into his room and started touching his TV and other belongings on the dresser. Resident 2 stated, I called for help, I yelled loudly and nobody came. Resident 2 stated he told Resident 1 a few times to stop touching his things and leave the room, but he did not. Resident 2 stated he became anxious that he could not get out of bed by himself and could not stop Resident 1 from touching his things. Resident 2 continued, I didn't plan to hurt him (Resident 1) . I tossed water pitcher on the curtain and thought it will scare him (Resident 1) and he leaves. The pitcher bounced off the curtain and hit him in the face, his nose had a small scratch. Resident 2 further stated that Resident 1 was frequently coming to his room and touching his and his roommate's belongings and even taking food from their tables. Resident 2 stated every time Resident 1 rolled in his room, he felt extremely anxious. Resident 2 continued, They (facility) don't watch him (Resident 1), he goes everywhere he wants and nobody stops him .others (residents) come here too and touch our belongings. I don't like them touching my stuff .it's annoying, I get stressed out, get all anxious, and get trouble breathing when I'm anxious .They need to watch them better. Resident 2 was asked if he reported to staff about Resident 1 coming into his room and how he felt about it. Resident 2 stated he reported to different staff multiple times, but Resident 1 continued coming to his room. Review of Resident 2's clinical record indicated he was admitted to the facility with [DIAGNOSES REDACTED]. Review of facility's assessment of Resident 2's cognition indicated he scored 10 out of 15 on the Brief Interview for Mental Status (BIMS, an assessment tool) which indicated he had mild cognitive impairment. The MDS assessment, dated 10/13/19, indicated Resident 2 was dependent on 2 or more staff for transfer to or from the bed. During an interview on 1/31/20 at 11 a.m., with Resident 3, he was asked if he experienced any trouble with other residents and if he was bothered by other residents wandering in his room. Resident 3 stated it was annoying a when confused resident wandered in his wheelchair to his room and touched his things. Resident 3 stated staff was aware about such behaviors, when you start yelling, nurses will come and get them away, but staff do not watch them and they (Resident 1) go whenever they want to. Resident 3 stated he did not want other residents coming to his room and touching his things and he told the staff many times, but they still continued coming. Review of Resident 3's clinical record indicated he was admitted to the facility in mid-summer of 2019. Resident 3's facility's assessment of his cognition dated 11/24/19 indicated he had no cognitive impairment. During an interview on 1/31/10 at 9:30 a.m., with a Certified Nursing Assistant (CNA 1), CNA 1 stated Resident 1 was up all day wheeling himself around the entire facility and got lost frequently. CNA 1 stated Resident 1 was confused all the time. CNA 1 stated she was aware of Resident 1's intrusive behaviors when he went into other residents' room and touched their things. When CNA 1 was asked what she did when she saw Resident 1 going into other residents' room, CNA 1 stated she took him out of the room and redirected him to other activities. CNA 1 stated that even with frequent redirection, Resident 1 still continued rolling into other residents' room. CNA 1 added further that she did not think Resident 1 understood anything when staff educated him not to go into other residents' rooms and that happened because he was confused. During an interview on 1/31/10 at 10 a.m., with CNA 2, she stated Resident 1 did not know where his room was and had tendency to go to other rooms and touch other residents' belongings. CNA 2 stated Resident 1 required constant re-orientation and redirection due to his confusion. CNA 2 was asked how other residents responded to his wandering behavior and she stated some alert and oriented residents complained about him and were upset. CNA 2 stated the interventions to prevent or intervene with Resident 1's intrusive behavior were frequent checks and redirection. During an interview on 1/31/10 at 10:10 a.m., with Licensed Nurse 1 (LN 1), LN 1 was asked if she was aware of Resident 1's wandering

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

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F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) and intrusive behaviors. LN 1 stated yes, Resident 1 was known to have behaviors of wandering into other resident rooms and touching their things and agreed that it was not safe for Resident 1. LN 1 was asked what care plan interventions were in place for Resident 1's wandering and intrusive behaviors to protect Resident 1 and other residents and she stated staff could not make Resident 1 stop wandering because it was his behavior. LN 1 stated she was not sure if there was care plan for wandering, but staff provided frequent visual checks to minimize Resident 1's going into other residents' rooms. When LN 1 was asked how the facility ensured the frequent visual checks were effective to protect Resident 1 and other residents, when he continued to wander into other rooms, causing some residents to feel anxious and upset, LN 1 was unable to answer. During a concurrent interview and record review on 1/31/20 at 11:55 a.m., with Director of Nursing (DON), the DON confirmed that Resident 1's wandering had been an ongoing issue. When the DON was asked if Resident 1 had adequate supervision to prevent his wandering and intrusive behaviors, the DON stated, we can't restrain him (Resident 1) from going around in the facility, he has rights to go where he wants to, except other residents' rooms and we monitor him to prevent those incidents. During the review of the facility's policy and procedure titled, Safety and Supervision of Residents, dated 2018, indicated, Our .resident safety and supervision and assistance to prevent accidents are facility-wide priorities .Our individualized, resident-centered approach to safety addressees safety .for individualized residents .The care plan may target interventions to reduce individual risks .including adequate supervision .Resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessed needs.