STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555855	A. BUILDING _____ B. WING _____	**06/30/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BAYWOOD COURT HEALTH CENTER	**21966 DOLORES STREET CASTRO VALLEY, CA 94546**

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 0655 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, for one of three residents (Resident 1) the facility failed to develop and implement a comprehensive, person-centered care plan for incontinence care based on their comprehensive assessments. This failure resulted in incontinence care not being delivered to Resident 1, which risked Resident 1 developing complications from incontinence including skin breakdown. Findings: During a review of Resident 1's medical record, the record indicated the resident was admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. During a review of Resident 1's Minimum Data Set (MDS, an assessment tool used to guide care), dated 2/24/20, the MDS indicated Resident 1 had a Brief Interview for Mental Status (BIMS, a tool used to assess mental function score of 7, meaning the resident was severely cognitively impaired. Further review of the MDS indicated Resident 1 was always incontinent of bladder and frequently incontinent of bowels. During an interview on 3/6/20, at 2:04 p.m., with Family Member 1 (FM 1), FM 1 stated she visited Resident 1 in the morning on 2/22/20 and returned later that afternoon. FM 1 stated Certified Nursing Assistant 1 (CNA 1) came into Resident 1's room at 8:00 p.m. to change Resident 1. FM 1 stated when CNA 1 changed Resident 1, Resident 1 was wet and had dried feces stuck to her skin. During an interview on 3/20/20, at 10:43 a.m., with CNA 1, CNA 1 indicated went to check on Resident 1 and changed her. CNA 1 also stated Resident 1's brief was full of dried feces, which were stuck to Resident 1's skin. During a concurrent interview and record review on 3/5/20, at 12:10 p.m., with the Director of Nursing (DON), DON stated that on 2/22/20, there was no care plan for incontinence in Resident 1's medical record. During a review of the facility's policy and procedure (P&P) titled, Bowel and Bladder, dated 9/12, the P&P indicated, It is the policy of (facility's name) that each resident who is incontinent is identified, assessed, and provided appropriate treatment and services to achieve or maintain as much normal urinary function as possible .(Upon admission the facility will) Complete a B&B (bowel and bladder) assessment .Establish a plan of care for incontinence/training (and) communicate plan to line staff.
F 0690 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1) received necessary bowel and bladder incontinence care. This failure put Resident 1 at risk for developing complications from incontinence, including skin breakdown. Findings: During a review of Resident 1's medical record, the record indicated the resident was admitted to the facility with multiple [DIAGNOSES REDACTED]. During a review of Resident 1's Minimum Data Set (MDS, an assessment tool used to guide care), dated 2/24/20, the MDS indicated Resident 1 had a Brief Interview for Mental Status (BIMS, a tool used to assess mental function score of 7, meaning the resident was severely cognitively impaired. Further review of the MDS indicated Resident 1 was always incontinent of bladder and frequently incontinent of bowels. During an interview on 3/6/20, at 2:04 p.m., with Family Member 1 (FM 1), FM 1 stated she visited Resident 1 in the morning on 2/22/20 and returned later that afternoon. FM 1 stated Certified Nursing Assistant 1 (CNA 1) came into Resident 1's room at 8:00 p.m. to change Resident 1. FM 1 stated when CNA 1 changed Resident 1, Resident 1 was wet and had dried feces stuck to her skin. During an interview on 3/20/20, at 10:43 a.m., with CNA 1, CNA 1 indicated that late in the shift Certified Nursing Assistant 2 (CNA 2) asked CNA 1 to care for Resident 1, in exchange for caring for one of CNA 2's residents. CNA 1 stated CNA 2 told her that CNA 2 had not been in Resident 1's room at all during the shift because FM 1 did not like her. CNA 1 stated she went to check on Resident 1 and changed her. CNA 1 also stated Resident 1's brief was full of dried feces, which were stuck to Resident 1's skin. CNA 1 indicated it took a while to get Resident 1 cleaned up, and she reported the incident to the charge nurse. During a review of entries for Vitals Taken/Urine, Bowel Movement in Resident 1's electronic medical record, the review showed CNA 2 made an entry on 2/22/20, at 4:42 p.m., indicating Resident 1 had a small amount of urine when CNA 2 changed Resident 1's brief. Further review showed CNA 2 made an entry on 2/22/20, at 6:30 p.m., also indicating Resident 1 had a small amount of urine when CNA 2 changed Resident 1's brief. During an interview on 3/5/20, at 12:20 p.m., with CNA 2, CNA 2 stated she checked Resident 1 every two hours. CNA 2 stated she looked at the brief but did not open it. CNA 2 also stated she was not sure why she documented that she changed Resident 1's brief when she did not. During a concurrent interview and record review on 3/5/20, at 12:10 p.m., with the Director of Nursing (DON), DON stated the facility practice was to change incontinent patients every two hours, or more frequently as needed. During a review of the facility's policy and procedure (P&P) titled, Bowel and Bladder, dated 9/12, the P&P indicated, It is the policy of (facility's name) that each resident who is incontinent is identified, assessed, and provided appropriate treatment and services to achieve or maintain as much normal urinary function as possible.

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.