STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056362	A. BUILDING _____ B. WING _____	**03/19/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MESA VERDE POST ACUTE CARE CENTER	**661 CENTER STREET COSTA MESA, CA 92627**

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 0558 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Reasonably accommodate the needs and preferences of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and medical record review, the facility failed to ensure the call light was within reach for one of two sampled residents (Resident 1). This deficient practice had the potential for Resident 1's needs to go unmet and resulted in Resident 1 needing to call out for staff or rely on his roommate for assistance. Findings: On [DATE]20 at 0854, at 1007, and at 1217 hours, Resident 1 was observed lying in bed with their call light out of reach. Resident 1's call light was observed on the floor, between the resident's bed and the privacy curtain separating Resident 1 and their roommate's bed. Medical Record review for Resident 1 was initiated on [DATE]20. Resident 1 was readmitted to the facility on [DATE]. Review of the MDS dated [DATE], showed, Resident 1 had severe cognitive impairment. On [DATE]20 at 1415 hours, an observation and concurrent interview was conducted with Resident 1 and his Responsible Party. Resident 1 was observed lying in bed. Resident 1's call light was again on the floor. Resident 1's Responsible Party stated Resident 1's call light was often not within his reach. The Responsible Party stated Resident 1 had to yell and scream to get help or ask his roommate to press the call light for him. When the resident was asked if he could press his call light, the resident stated, Where was it? On [DATE]20 at 1437 hours, an interview and concurrent observation was conducted with CNA 3. CNA 3 stated Resident 1 did not use the call light, he screamed. CNA 3 verified Resident 1's call light was on the floor and not in the resident's reach.

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.