STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555802	A. BUILDING _____ B. WING _____	**09/28/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COUNTRY CREST POST ACUTE	**50 CONCORDIA LANE OROVILLE, CA 95966**

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 observation, interviews and record review the facility failed to provide adequate supervision and assistance to ensure safety for one of two sampled residents, (Resident 1), when Resident 1 was found on the floor in her bathroom. This failure resulted in Resident receiving a back injury due to the fall requiring hospitalization for pain management. Findings: Review of Resident 1's medical chart indicated Resident 1 was readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The record indicates that Resident 1 is alert and understands but is unable to respond. Resident 1's medical record contained a Care Plan, for Patients at High Risk for Falls with a revised date of 9/18/18. The care plan listed the following risk factor, weakness, history of [MEDICAL CONDITION] and stroke. The following interventions were listed; call light within reach, tab alarm in wheelchair, grab bars, bed alarm, toilet every two hours, transfer pole, fall pads on both sides of the bed, encourage not to get up without assistance, assist with mobility and transfers. During an interview on 9/18/18 at 9:35 AM, Licensed Nurse,(LN) A stated on 9/4/18 Certified Nursing Assistant,(CNA) B found Resident 1 lying on the floor underneath the bathroom sink. She stated apparently Resident 1 had taken herself to the bathroom, and while trying to transfer herself to the toilet fell . LN A stated Resident 1 was grimacing and crying in pain, Family member C and the physician were notified which resulted in Resident 1 being sent to the Emergency Department for evaluation. Resident 1 was hospitalized for [REDACTED]. During an interview on 9/18/18 at 10:30 am, CNA C stated Resident 1 was one of his residents on 9/4/18. He stated he was giving a shower to another resident and his hall partner CNA B was helping on another hall. He stated Resident 1 had put on her call light and got up by herself to go to the bathroom. He stated that CNA B had found Resident 1 on the bathroom floor. CNA C stated it was unclear how long the call light was on.

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.