STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555775	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BROOKDALE RANCHO MIRAGE	72-201 COUNTRY CLUB DRIVE RANCHO MIRAGE, CA 92270

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, interview, and record review, the facility failed to ensure the appropriate wheelchair was provided to Resident 1. This failure resulted to a wheelchair-related fall incident that eventually led to Resident 1 being transferred to the acute hospital and admitted with [DIAGNOSES REDACTED]. Findings: On February 5, 2020, an unannounced visit was conducted at the facility to initiate a facility reported incident. On February 5, 2020, Resident 1's record was reviewed. Resident 1 was [AGE] year old female, admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The Minimum Data Set (MDS- an assessment tool) dated January 24, 2020, indicated Resident 1 needed one to two person assist with her ADLs (Activities of Daily Living). The nursing progres notes dated January 24, 2020, at 7:36 p.m., indicated Licensed Vocational Nurse (LVN) 1 documented Resident 1 was sitting on a wheelchair and a staff was trying to elevate her legs by putting legs on a chair and the wheelchair suddenly tipped backwards hitting the back of her head on the floor. LVN 1 further documented Resident 1sustained a skin tear on her left forearm and complained of pain at the back of her head. On January 24, 2020, at 8:28 p.m., Resident 1 was transferred to the acute hospital due to complaints of headache and elevated blood pressure. The Facility Investigation Report dated January 25, 2020, indicated, .1/24/2020 19:36 per Licensed Nursing Progress note, resident was sitting on her wheelchair and staff together with a family visitor were trying to elevate the resident's legs on a chair, when suddenly the wheelchair tipped backwards hitting the back of the resident's head on the floor. Resident's daughter was at bedside when the incident occured . 1/24/2020 20:28 - Resident was sent to (Name of acute hospital) ER (emergency room) with consent from the family via paramedics due to headache and elevated BP (blood pressure) . 1/25/2020 Resident was admitted to (name of the facility) Skilled Unit for clinical and rehab services. Resident is able to make most decisions and she consult with her daughter for other things . Further investigation revealed that resident was using a light weighted transport wheelchair at the time of the incident with an oxygen tank hanging in the back of the chair. Nutrition risk review showed (name of Resident 1) with current weight of 221.8 with a BMI (body mass index) of 36.9 and due to the disease process manifesting generalized [MEDICAL CONDITION] to include in her lower extremities . Root cause analysis disclosed that with a light weighted transport chair with a portable oxygen tank hanging in the back of the chair and with positioning occuring on both [MEDICAL CONDITION] lower extremities aiming to elevate it, the process created an imbalance with the weight distribution resulting for the chair to tip backward together with the resident . On February 6, 2020, at 11:20 a.m., Certified Nursing Asisstant (CNA) 1 was interviewed. CNA 1 stated she was the CNA assigned to Resident 1 on January 24, 2020 and she was with Resident 1 and the family visitor when the incident occured. CNA 1 stated on January 24, 2020, at around 7:36 p.m., she was in the Resident 1's room with the family visitor. CNA 1 stated Resident 1 was sitting on the blue transport wheelchair at that time. CNA 1 stated Resident 1 had requested her legs to be elevated on a chair so Resident 1's visitor instructed her to put a regular sitting chair underneath Resident 1's legs while the visitor picked and held Resident 1's both lower extremities She further stated Resident 1's visitor struggled to lift Resident 1's lower extremities so she went to Resident 1's side to help push the chair underrneath her legs and in the process of doing so, Resident 1's wheelchair tipped backwards together with the resident and hit the floor with the back of her head. CNA 1 stated the blue transport wheelchair Resident 1 was sitting on was lightweight and had a portable oxygen tank hanging in the back. She further stated the transport chair did not have anti-tippers at the rear wheels of the wheelchair to prevent it from tipping backwards. She further stated, Resident 1 had used the same wheelchair since she was admitted to the facility and she had not realized the wheelchair was inappropriate for the resident until the resident had fallen. On February 6, 2020, at 4:09 p.m., LVN 1 was interviewed. LVN 1 stated when he got to the room January 24, 2020, at around 7:36 p.m., Resident 1 was already on the floor lying on her back and was still sitting in the transport wheelchair. LVN 1 stated Resident 1 sustained a skin tear on her left forearm and they started monitoring the resident because her head hit the floor. LVN 1 further stated he had observed Resident 1 using the same blue transport wheelchair since she was admitted to the facility and it was not an appropriate wheelchair for Resident 1 to use. LVN 1 stated on January 24, 2020, at around 8:28 p.m., Resident 1 was transferred to the acute hospital due to complains of headache and elevated blood pressure reading of 170/80 after the incident. On February 5, 2020, at 9:56 a.m., the Skilled Nursing Facility- Rehabilitation Manager (SNF-RM) was interviewed. The SNF-RM verified the wheelchair that Resident 1 used at the time of the incident on January 24, 2020, was a lightweight transport wheelchair that was not safe and appropriate for daily use. The SNF-RM stated she did not know where the transport wheelchair came from and who provided it to Resident 1 for use. The SNF-RM stated Resident 1 should not have used that transport wheelchair for her daily use. On February 13, 2020, at 10:03 a.m., the SNF-RM was interviewed. The SNF-RM stated it was the facility's procedure for the Rehabilitation Department (RD) to screen and evaluate new admit residents within 24 hours upon admission. The SNF-RM explained the evaluation for the appropriate wheelchair use upon admission was a facility practice. The SNF-RM stated there was no documented evidence the RD screened and evaluated Resident 1 for the appropriate wheelchair use when she was admitted on [DATE]. On February 21, 2020, at 1:35 a.m., an interview was conducted with Resident 1's Family Member (FM). The FM verified Resident 1 fell backwards in her wheelchair while her lower extremities were being lifted with the intent of elevating the legs on the wheelchair. The FM started to get upset and stated the inappropriate wheelchair that Resident 1 used at the time had caused the incident on January 24, 2020. She further stated she had been requesting the facility since Resident 1 was admitted for an appropriate wheelchair to use and it was not provided. Per FM the staff had informed her they will have to check with the RD about her request for a different wheelchair for the resident but it was never provided. On February 13, 2020, at 11:55 a.m., the Director of Clinical Services (DCS) was interviewed. The DCS stated, the facility had established the transport wheelchair that Resident 1 used was the cause of the wheelchair-related fall incident on January 24, 2020. The DCS further stated the staff should have identified that Resident 1 used an inappropriate wheelchair. DCS stated the fall incident could have been avoided if Resident 1 had the right wheelchair. On February 18, 2020, Resident 1's acute hospital record was reviewed. Resident 1 was admitted to the acute hospital on January 24, 2020. The hospital records, dated January 28, 2020, indicated Resident 1 was brought to the emergency room by paramedics on January 24, 2020. The document further indicated Resident 1 was eventually admitted when she was found to have a small brain bleed on which could have been as a result of a fall or severely elevated blood pressure.

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.