STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055656	A. BUILDING _____ B. WING _____	**03/06/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RIVERSIDE CONVALESCENT HOSPITAL	**375 COHASSET RD CHICO, CA 95926**

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 0573 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Let each resident or the resident's legal representative access or purchase copies of all the resident's records.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to readily produce a copy of one of one residents (Resident 1) medical records, within 24-hours (excluding weekends and holidays) upon request to the facility. This action violated Resident 1 and her Responsible Party (RP, an appointed decision maker for health care decisions) rights to access the medical records in a timely manner. Findings: The facility's policy titled, Resident Access to Protected Health Information (PHI), dated 11/1/15, was reviewed and indicated that if the resident and/or their personal representative requests a copy of their medical record, the facility will provide this within two working days after receiving a written request. Resident 1's record was reviewed on 2/4/20. Resident 1 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of a nurse's note, dated 12/17/19 at 3:40 pm, indicated that Resident 1's RP had requested a copy of her medical record, and that the RP was informed at this time that he had to talk to Medical Records, and sign a release form. During an interview, with the Administrator (Admin) on 2/4/20 at 2:30 pm, she stated that residents, or their RP's are referred to Medical Records Department, where they fill out a form when they want copies of their medical records. On 2/4/20 at 2:50 pm, the Medical Records Clerk (MRC) was interviewed. The MRC stated that she believed the facility had three business days to provide medical records after receiving the signed release form. The MRC stated she could not find the medical release form that Resident 1's RP had signed, but presented a hand written letter dated and signed by Resident 1 on 12/17/19, requesting a full and complete copy of her medical record. The MRC stated that the facility does not keep a log of when the medical record is requested, when the release is signed, and when the medical record is provided. The MRS acknowledged that without a log, they would not be able to ensure the deadline was followed as they would not know when the request was made, and when the medical records were provided. On 2/5/20 at 2:45 pm, the Medical Records Supervisor (MRS) was interviewed. The MRS stated that she was off the day Resident 1's RP had requested copies, and could not remember the date the records were requested. The MRS could not find Resident 1's signed release form. The MRS confirmed that the facility does not keep a log of when the request is made, when the release of records form is signed, and when the records are picked up. The MRS stated she believed the facility had three business days to provide the requested records. On 2/12/20 at 10:40 am, the MRC stated that Resident 1's RP had picked up her medical records the day after Christmas (12/26/19), and provided a copy of a receipt for $41.00, for copy charges. The receipt was dated 12/26/19, and was signed by Resident 1's RP (six business days after the medical records request had been made on 12/17/19, and not within 2-days per the regulation, and the facility policy). On 2/12/20 at 11:10 am, during an interview with the Admin, she stated that the Medical Records Department should maintain a log in order to track medical records requests, and when they were provided. During a concurrent interview, and record review, with the Director of Nurses (DON) on 2/21/20 at 4 pm, she acknowledged that Resident 1, and her RP did not receive a copy of the medical records within two business days, but had received them six days after the request.
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 ensure that adequate supervision was provided for one of one residents (Resident 1) during a shower, when Certified Nursing Assistant (CNA) turned away from Resident 1 and she fell on to the floor. This failure resulted in Resident 1 experiencing a fall with injury, and the potential for further accidents and negative outcomes to occur to other residents. Findings: On 1/27/20 at 10:53 am, the California Department of Public Health (CDPH) received notification that on 12/16/19, Resident 1 fell while showering and landed on her face requiring fourteen sutures to close her head wound. The facility's policy titled, Fall Management Program, dated 11/7/16, was reviewed and indicated that the facility would provide an environment free from hazards. Resident 1's record was reviewed on 2/4/20. Resident 1 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of a Minimum Data Set (MDS, an assessment) dated 12/7/19, indicated that Resident 1 was cognitively impaired (confused), dependent on staff for transfers and personal hygiene. The MDS additionally indicated that Resident 1 had impaired vision and a difficult time hearing. A review of Resident 1's Fall Risk Evaluation, dated on 12/1/19, indicated Resident 1 was a high risk for falls due to confusion, an unsteady gait, and had a history of [REDACTED]. A review of nurses notes, dated 12/16/19 at 11:15 am, indicated that Resident 1 had sustained a witnessed fall while sitting in a shower chair, and was sent to a local hospital's emergency room (ER) for treatment. A review of a Post Fall IDT Note, dated 12/16/19, indicated that Resident 1 had returned from the ER with sutures to her forehead, and that staff were educated on making sure the resident was secured and in the proper position in the shower chair, prior to turning away to grab items in the room. A review of Occupational Therapist (OT) Notes, dated from 12/2 to 12/16/19, indicated that Resident 1 had weakness and decreased functional activity tolerance with a risk for falls. A long term goal was that Resident 1 would complete hygiene and grooming tasks while sitting in front of a mirror with independence and no verbal cues. The OT Progress Notes, indicated that Resident 1 was only able to complete 20 to 25% of the hygiene and grooming tasks. The OT care plan dated 12/21/19, included with the nursing care plans did not include the bathing and hygiene interventions of sitting in front of a mirror. On 2/7/20 at 2:05 am, CNA A was interviewed. CNA A stated that Resident 1 fell on [DATE] around 11 am, during the day shift. CNA A stated that on the day of the fall, it was the first time she had cared for Resident 1. CNA A stated that Resident 1 leaned forward while sitting in the shower chair, and she had asked her to lean back. CNA A stated she thought she did not hear her, so she asked her again to scoot back, and she could not do it. CNA A stated she then turned on the shower, and showered her. CNA A stated that she turned away and reached over for a towel, and Resident 1 fell forward gashing her head. CNA A stated that she screamed for help, and Licensed Nurse (LN) B came in and took over. During an interview, with LN B on 2/7/19 at 2:20 am, she stated that Resident 1 was slow to communicate and only alert to self. LN B stated that she went into the shower room after she heard CNA A scream for help. Upon entering the room, LN B reported observing Resident 1 lying on her left side on the shower floor with a puddle of blood pooling by her head. LN B stated that Resident 1 had a large laceration on her forehead, and was then taken to the ER. Resident 1 was interviewed at another skilled nursing facility where she resides now, on 2/7/20 at 11:20 am. Resident 1 stated she got the scar on her forehead, which was approximately six inches across when she fell . Resident 1 could not recall any circumstances of the fall. On 2/12/20 at 1:30 pm, the Rehabilitation Director (Rehab Dir) was interviewed. The Rehab Director stated that the OT that was working with Resident 1, no longer worked at the facility. While reviewing Resident 1's OT Notes, he stated

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) that Resident 1 was receiving training in how to do a sponge bath while sitting in a chair in her bathroom in front of a mirror. The Rehab Director stated the therapists leave showering up to the CNAs discretion. The Rehab Director stated that a shower should end if the resident is not in a safe position. On 2/12/20 at 1:50 pm, CNA C was interviewed. CNA C stated that she was the only other CNA that had showered Resident 1 prior to her fall. CNA C stated that Resident 1 leaned forward all the time while out of bed. CNA C stated the Therapists do instruct on how to do showers, but was not done for Resident 1. On 2/12/20 at 2:15 pm, CNA D was interviewed. CNA D stated that she was Resident 1's assigned CNA the day she fell , but CNA A was assigned to do the showers. She stated that CNA A never asked her how Resident 1 transferred. CNA D stated Resident 1 did not get out of bed much, and her posture was always bent in a forward position even when she was in bed. On 2/21/20 at 4 pm, the Director of Nursing (DON) acknowledged that CNA A's written statement included that Resident 1 was improperly positioned during the shower that resulted in a fall with injury.