| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **055409** | A. BUILDING _____ B. WING _____ | **03/19/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **COMMUNITY CARE AND REHABILITATION CENTER** | **4070 JURUPA AVENUE RIVERSIDE, CA 92506** |

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<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | **Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, and record review, the facility failed to routinely adequately monitor and closely supervise the activities of Resident 1 which resulted in repeated falls, with injury, within the facility. Findings: On February 13, 2020, an unannounced visit was made to the facility to investigate Resident 1's continued and repeated falls. Resident 1's falls were previously investigated in July 2019 and deficiencies were written for failure to adequately reassess and revise Resident 1's care plan titled At Risk for Falls /Injuries R/T . , dated (NAME)2019. Resident 1 was readmitted to the facility on [DATE], with [DIAGNOSES REDACTED]. to perform everyday activities). Since the surveyors last visit to the facility on [DATE], Resident 1 has had four additional falls (October 12, 17, 18, and December 6, 2019). The fall on October 12, 2019, took place in Resident 1's room at 10 p.m. (evening shift). The fall on October 17, 2019, took place in Resident 1's room at 12:40 p.m. (day shift). The fall on October 18, 2019, took place in Resident 1's room at 1:55 p.m. (day shift). The fall on December 6, 2019, took place in Resident 1's room at 7 p.m. (evening shift). The care plan titled At Risk for Falls/Injuries ., dated September 6, 2019, indicated Resident 1 would be observed frequently for safety. The same care plan had an undated entry indicating, . 1:1 (one to one staffing) on AM/PM shift until further notice . Both of these interventions were not adequately and routinely adhered to. The quarterly Resident Care Conference Review, dated October 22, 2019, was reviewed. The conference was attended by a representative of the nursing staff, Activities Department and Social Services Department. Additionally, Resident 1's responsible party, a family member was present at the meeting. The document indicated there was no documentation of the three falls in the month of October 2019., preventative measure taken or an assessment of the effectiveness of the measures taken to prevent further falls. The Interdisciplinary Resident Safety Investigation and Intervention, dated December 6, 2019, was reviewed and indicated Resident 1 had a fall in her room on the evening shift. Part of Resident 1's interventions, upon physician notification, was to wear a splint to her left forearm and to have an orthopedic (bone specialist) follow up visit. On February 13, 2020, at 1:30 p.m.,accompanied by the Director of Nurses (DON), Resident 1's room within the facility was observed. Resident 1 resided in a four bed room at the furthest end of the hallway away from the nurse's station. On February 13, 2020, at 1:45 p.m., Resident 1 was observed in her wheel chair in the hallway accompanied by a Sitter (person assigned to stay with and be responsible for a resident's safety and needs for a designated period of time). Concurrently, the Sitter was interviewed. The Sitter stated she was employed by the facility and was responsible for Resident 1 Monday through Friday from seven a.m. to three p.m. The Sitter stated she had been Resident 1's Sitter for approximately four months. The Sitter was unsure who was responsible for Resident 1 in her absence or if Resident 1 was always monitored 1:1. On February 13, 2020, at 2 p.m., The Assistant Director of Nurses (ADON) was interviewed. The ADON stated Resident 1 was monitored 1:1 on the day of the fall on December 6, 2019, but maybe not at the time of the fall. The ADON stated, There is no physician's order for 1:1 care. 1:1 is a nursing measure. We (staff) would do it according to her (Resident 1's) behavior, like when she is more confused or starts to have more falls. |

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.