STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056231	A. BUILDING _____ B. WING _____	09/28/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LASSEN NURSING & REHABILITATION CENTER	2005 RIVER STREET SUSANVILLE, CA 96130

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 0552 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that residents are fully informed and understand their health status, care and treatments.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1) was fully informed of the risks, benefits, and alternatives to care planned fall precautions, when there was no documented patient education prior to a fall on 10/25/19 which resulted in injury. This failure resulted in Resident 1 being uninformed of the risks of noncompliance with fall precautions, and had the potential to contribute to serious fall related injuries. Findings: A review of the clinical record indicated that Resident 1 was admitted on [DATE] and had [DIAGNOSES REDACTED]. A review of the Care Plan indicated that Resident 1 was placed on the Eyes on You program (a program for fall prevention) on 11/19/18, which included keeping the bed in low position. A review of the nursing notes from July 2019 through October 2019, indicated Resident 1 received no education regarding fall prevention, specifically keeping the bed in low position. A review of a nursing note dated 10/25/19 at 6:58 PM, indicated that Resident 1 had fallen from bed on 10/25/19 at 4:20 PM while the bed was elevated to a height of 3 - 4 feet. During an observation and interview on 11/7/19 at 11:20 AM, Resident 1 was observed in bed with the bed at normal height, not lowered as care planned. Resident 1 stated that on 10/25/19, she was in bed and the call light slipped out. When she reached to retrieve the call light, she fell out of bed. Licensed Nurse (LN) 3 left a voicemail on 1/15/20 at 4:55 PM confirming that there were no nursing notes indicating patient education was provided for Resident 1 to prevent falls, prior to 10/25/19. A review of a fax from the facility dated 3/18/20, indicated that the facility had no policy and procedure regarding resident education. During a telephone interview on 3/19/20 at 3:50 PM, the Director of Nursing (DON) confirmed that the Eyes on You program included a low bed. DON confirmed that the Care Plan for Resident 1 had included the Eyes on You program, and had not been fully implemented to provide resident education regarding a low bed prior to 10/25/19.
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement the Care Plan for one of three sampled residents (Resident 1) when Resident 1's Care Plan included a low bed to prevent injury falls, but the bed was kept at normal height. This failure had the potential to contribute to the spinal fracture Resident 1 sustained on 10/25/19 after falling from the elevated bed. Findings: A review of a facility policy and procedure titled Care Plans, Comprehensive Person-Centered revised December 2016, indicated that a Care Plan must be implemented for each resident. A review of a facility policy and procedure titled Falls - Clinical Protocol revised March 2018, indicated that staff were to prevent falls, and to reduce the consequences of falling. A review of the clinical record indicated that Resident 1 was admitted on [DATE] and had [DIAGNOSES REDACTED]. She was not able to make her own healthcare decisions. A review of the Care Plan indicated that Resident 1 was placed on the Eyes on You program (a program for fall prevention) on 11/19/18, which included keeping the bed in low position. A review of a nursing note dated 10/25/19 at 6:58 PM, indicated that Resident 1 had fallen from bed on 10/25/19 at 4:20 PM while the bed was elevated to a height of 3 - 4 feet. During an observation and interview on 11/7/19 at 11:20 AM, Resident 1 was observed in bed with the bed at normal height, not lowered as care planned. Resident 1 stated that on 10/25/19, she was in bed and the call light slipped out. When she reached to retrieve the call light, she fell out of bed. During a concurrent interview and record review on 11/8/19 at 10:50 AM, Licensed Nurse (LN) 3 confirmed that Resident 1 had been on the Eyes on You program, and should have had her bed lowered. During a telephone interview on 3/19/20 at 3:50 PM, the Director of Nursing (DON) confirmed that the Eyes on You program included a low bed. DON confirmed that the care plan for Resident 1 had included the Eyes on You program, and had not been fully implemented to provide a low bed prior to 10/25/19.
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 implement interventions to eliminate or reduce fall risk for one of three sampled residents (Resident 1) when they failed to provide resident education and implement care planned interventions for a low bed for Resident 1. This failure had the potential to contribute to Resident 1's injury fall on 6/25/19 at 4:20 PM, when she fractured her spine. Findings: A review of a facility policy and procedure titled Falls - Clinical Protocol revised March 2018, indicated that staff were to prevent falls, and to reduce the consequences of falling. A review of the clinical record indicated that Resident 1 was admitted on [DATE] and had [DIAGNOSES REDACTED]. She was not able to make her own healthcare decisions. A review of the Care Plan indicated that Resident 1 was placed on the Eyes on You program (a program for fall prevention) on 11/19/18, which included keeping the bed in low position. A review of a nursing note dated 10/25/19 at 6:58 PM, indicated that Resident 1 had fallen from bed on 10/25/19 at 4:20 PM while the bed was elevated to a height of 3 - 4 feet. Resident 1 was then sent to the hospital. A review of a hospital discharge note dated 10/29/19 at 8:26 AM, indicated that Resident 1 had been admitted to the hospital on [DATE] with a [DIAGNOSES REDACTED]. During an observation and interview on 11/7/19 at 11:20 AM, Resident 1 was observed in bed with the bed at normal height, not lowered as care planned. Resident 1 stated that on 10/25/19, she was in bed and the call light slipped out. When she reached to retrieve the call light, she fell out of bed. During a concurrent interview and record review on 11/8/19 at 10:50 AM, Licensed Nurse (LN) 3 confirmed that Resident 1 had been on the Eyes on You program, and should have had her bed lowered. During a telephone interview on 3/19/20 at 3:50 PM, the Director of Nursing (DON) confirmed that the Eyes on You program included a low bed. DON confirmed that the care plan for Resident 1 had included the Eyes on You program, and had not been fully implemented to provide a low bed prior to her injury fall on 10/25/19.

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.