STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056487	A. BUILDING _____ B. WING _____	**03/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RIO HONDO SUBACUTE & NURSING CENTER	**273 E BEVERLY BOULEVARD MONTEBELLO, CA 90640**

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 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 update and individualize the care plan for one of four sampled residents (Resident 1) after a fall incident that occurred on 1/14/2020. This deficient practice had the potential to cause injury to the resident. Findings: A review of Resident 1's Admission Record indicated the facility initially admitted the resident on 1/26/17 with [DIAGNOSES REDACTED]. A review of Resident 1's Minimum Data Set (MDS, a standardized resident screening and care-planning tool), dated 1/14/2020, indicated the resident had poor decisions and required cueing or supervision. The MDS indicated Resident 1 had short-term and long-term memory problems. The MDS indicated Resident 1 needed extensive assistance with bed mobility and transfers. The MDS indicated Resident 1's balance when moving from a seated to a standing position and transfer between bed to chair that Resident 1 was not steady and was only able to stabilize with staff assistance. A review of Resident 1's Admission History & Physical Examination, dated 1/10/2020, indicated the resident was confused. A review of Resident 1's care plan titled, Resident had an unwitnessed fall, initiated on 1/11/2020, indicated the following interventions: 1. Assisting the resident get in and out of bed with assistance. 2. Placing a call light within reach while in bed or close proximity to the bed. 3. Reminding the resident to use the call light when attempting to ambulate or transfer. A review of Resident 1's Situation, Background, Assessment, and Recommendation (SBAR, technique provides a framework for communication between members of the health care team and can be used as a tool to foster a culture of patient safety) Communication Form, dated 1/14/2020 at 7:15 a.m., indicated Resident 1 had a fall incident and was found kneeling on the right side of his bed parallel to his nightstand with no injuries noted. The form indicated the primary care physician recommended continued monitoring of Resident 1 for 72 hours. A review of Resident 1's Care Plan Evaluation, dated 1/14/2020 at 12:29 p.m., indicated Resident 1 continued to be at risk for fall but did not adhere to the safety precautions and was not consistent on using the call light for help. A review of Resident 1's Progress Notes, dated 1/14/2020 at 3:20 p.m., indicated a Licensed Vocational Nurse 1 (LVN 1) documented that Resident 1 was confused. LVN 1 documented that Resident 1 was attempting to stand up and was sliding himself down towards the side of the bed. A review of Resident 1's Progress Notes, dated 1/14/2020 at 4:35 p.m., LVN 1 indicated Resident 1 rolled out of the bed in a kneeling position that was witnessed by his family. During an interview on 1/30/2020 at 11:38 a.m., LVN 1 stated the licensed nurse must update the interventions in Resident 1's care plan for falls after a fall incident on 1/14/2020 to prevent injury or further injury to the resident. LVN 1 stated updated fall interventions included placing floor mats on both sides of the resident's bed, placing the resident's bed in lowest position, and doing more frequent visual monitoring or every 15-30 minutes. During a telephone interview and a concurrent review of Resident 1's medical records on 3/11/2020 at 10:29 a.m., the Assistant Director of Nursing (ADON) stated the licensed nurses did not update Resident 1's care plan for falls after the fall incident that occurred on 1/14/2020. A review of the facility's policy and procedures titled, Falls Management, dated 11/1/19, indicated an individualized plan of care for falls must be developed, reviewed, and revised regularly, and updated to reflect new interventions after a fall incident.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE