STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555435	A. BUILDING _____ B. WING _____	**05/07/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RECHE CANYON REGIONAL REHAB CENTER	**1350 RECHE CANYON RD COLTON, CA 92324**

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 interview and record review, the facility failed to ensure the following: 1. Safety of one of 3 sampled residents (Resident A) when Resident A was dropped off by himself and was left alone at his doctor's appointment. 2. Safety of Resident A when there was no evidence the facility attempted to locate Resident A on the same day Resident A did not return to the facility from his appointment. These failures had the potential to result in physical and psychological harm to Resident A. Findings: An unannounced visit was conducted on August 15, 2019 at 3:20 PM to investigate a complaint regarding Quality of Care. During a record review of the facility's Daily Census, dated August 14, 2019, the census indicated that Resident A was no longer residing in the facility. A record review of the facility's admission, discharge and transfer report from June 1, 2019 thru August 14, 2019, indicated Resident A was discharged to a private home on July 31, 2019. A record review of physician's orders [REDACTED]. Transportation p/u (pick-up) at 7:15 AM . A record review of Nursing Weekly Summary for Resident A, dated July 31, 2019, the report indicated Resident A was out on apt (appointment) left at 745am. There was no documented information regarding who accompanied the resident to the appointment and no documented evidence that the responsible party (RP) was informed of Resident A's leaving the facility that morning. A record review of Progress Notes for Resident A for July 31, 2019, indicated no information about the resident leaving the facility for the appointment, who the resident left with, and if the responsible party was contacted. A record review of Progress Notes for Resident A, dated August 1, 2019 at 11:06 AM, indicated, Patient (Resident A) was picked up on 6/31 (this date should be 7/31) for appointment with Neurologist and did not return to facility . During a telephone interview with Case Manager 1 (CM 1) on March 16, 2020 at 3:04 PM, CM 1 stated the case managers and / or social workers call and set up the appointments. CM 1 stated they notify the family and document if family agreed to accompany the resident to the appointment. She stated Resident A had neurologist appointment on July 31, 2019 and never came back. She stated there was no note that indicated someone accompanied Resident A to the appointment. During a telephone interview with Case Manager 2 (CM 2) on March 17, 2020 at 11:44 AM, CM 2 stated Resident A's wife (RP) informed her of the appointment on March 26, 2019. She stated, I didn't call the wife for the appointment because she knew about it already. CM 2 stated the case managers / social workers who set up the appointment would also arrange transport and arrange who would accompany the resident to the appointment. A record review of physician's orders [REDACTED]. A record review of Resident A's Admission Record, dated August 15, 2019, indicated Resident A's [DIAGNOSES REDACTED]. During a telephone interview with the medical office staff (MS1) of (name of neurologist) on February 24, 2020 at 3:18 PM, MS1 stated Resident A was dropped off and left alone at their office on July 31, 2019. She could not remember the time Resident A arrived in their office. She stated Resident A was there for a long time. She stated the doctor saw Resident A at 10:15 AM. MS1 stated she called the RP around 10:00 AM and remembered the RP being awaken by her call. She stated the RP was usually with Resident A on his appointments. She stated that the RP arrived around noon to pick-up Resident A. During a telephone interview with the RP on April 9, 2020 at 1:29 PM, the RP stated Resident A was not supposed to be left alone. Resident A was on a wheelchair. She stated the appointment was not until the following day, Thursday, August 1, 2019, at 8:15 AM. She stated she did not receive a call from the facility to confirm if she would accompany Resident A to the appointment. She stated the facility did not notify her when Resident A left the facility for his appointment. RP stated had she been informed, she would have told them the appointment was not until the day after and she could have gone to the medical office to be with her husband sooner. She stated the doctor had a cancellation and decided to see her husband since he was already there waiting. She received a call from the medical office late in the morning to see if she will accompany her husband since he has been there since around 8:00 AM. She stated she did not receive a call from the nursing facility until around 1:00 AM the next day asking if she knew where Resident A was. A record review of all the Progress Notes for Resident A, dated July 31, 2019 to August 1, 2019, indicated that Resident A, the RP, and the primary physician of Resident A was not contacted until August 1, 2019 when Resident A did not return to the facility on [DATE]. A record review of an electronic mail from the Director of Nursing (DON), dated March 16, 2020 at 4:45 PM, indicated, I do not have a policy related to what the facility does when resident has an appt. During a telephone interview with the Administrator (ADM), on March 16, 2020 at 5:00 PM, the administrator stated they did not have a policy relating to appointments and transport.

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.