

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER <b>555645</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED <b>03/17/2020</b>
NAME OF PROVIDER OF SUPPLIER <b>AUBURN RAVINE TERRACE</b>		STREET ADDRESS, CITY, STATE, ZIP <b>750 AUBURN RAVINE ROAD AUBURN, CA 95603</b>	
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  <b>Level of harm</b> - Minimal harm or potential for actual harm  <b>Residents Affected</b> - Few	<p><b>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</b></p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b></p> <p>Based on observation, interview, and record review, the facility failed to ensure that 1 of 2 sampled residents (Resident 1) was provided adequate supervision and assistance devices as required for a two person lift for transfers. This failure had the potential to result in an accident or injury to Resident 1. Findings: The facility reported an incident to the Department that occurred on 1/3/20 in which the Certified Nurse Assistant 4 (CNA 4) was observed to transfer Resident 1 by himself without the assistance of another staff person. This incident was perceived by other staff as rough handling by the CNA 4. Resident 1 received no injuries in the transfer incident. Resident 1 was admitted to the facility in 2015 with [DIAGNOSES REDACTED]. The Minimum Data Set (MDS-an assessment tool) dated 10/1/19 indicated Resident 1 was dependent on the assistance of staff for all care needs, nonverbal, and with severe cognitive impairment. Resident 1's family was the responsible party for decision-making. Review of a Care Plan for Resident 1 dated 7/3/19 indicated, had a decline in physical mobility.now needing extensive assist with transfers with (brand name) lift. An observation of Resident 1 was made on 1/14/20 at 7:38 a.m. Resident 1 was sitting in a high back, rocker wheelchair in front of the TV. Resident 1 was a tall, large resident. When addressed by name, Resident 1 was nonverbal with no reaction or response when addressed by name. Review of the clinical record for Resident 1 on 1/14/20 indicated, Height [HEIGHT] and [WEIGHT]. On 1/14/20 at 9:10 a.m. an interview was conducted with the CNA 1. The CNA 1 stated she requested CNA 4 assist in providing a 2-person lift for Resident 1 so the resident could be transferred from the wheelchair to the bed. The CNA 1 stated the CNA 4 placed his hands on Resident 1's shoulders and picked her up and put her in bed without assistance. The CNA 1 confirmed there were no injuries to Resident 1 and stated, the policy in the facility says always 2 people to lift. In an interview with the CNA 4 on 1/15/20 at 4:57 p.m., the CNA 4 confirmed he provided care to Resident 1 on 1/3/20. The CNA 4 confirmed he did not follow the facility policy or the resident's care plan for a 2-person lift during a transfer from the wheelchair to the bed. Review of a facility policy undated and titled, Moving a Resident, Bed to Chair/Chair to Bed, indicated, This procedure may require two (2) persons.Put the resident's feet firmly on the floor. The second person should now support the resident's back and head by raising them both at the same time.If the resident cannot stand alone, two persons (one on each side) should lock arms with the resident, gently stand and turn the resident and sit him or her in the chair.</p>		
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.