STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555915	A. BUILDING _____ B. WING _____	08/20/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE SPRINGS HEALTH AND REHABILITATION CENTER	25924 JACKSON AVE MURRIETA, CA 92563

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 0641 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure, Fall Risk Assessments, accurately documented and reflected the resident's status for three of ten sampled residents (Residents A, B and C) in a universe of 76 residents. This failure potentially lead to the residents' continuing to sustain falls. Findings: On July 8, 2020, at 12:42 a.m., an unannounced visit was made to the facility for the investigation of a complaint. On July 8, 2020, Resident A's facility record was reviewed. Resident A was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Review of Resident A's, History and Physical, (H&P) dated 3/7/2020, indicated, This resident does NOT have the capacity to understand and make decisions. Reason: Alzheimer's Dementia. Resident A's, Order Summary Report, indicated an order dated 3/8/2020, for [MEDICATION NAME] ([MEDICATION NAME]) Tablet 10 MG Give 1 tablet by mouth one time a day for Depression . (antidepressant that is in the category of [MEDICAL CONDITION] medications). [MEDICATION NAME] is known to have a side effect of confusion. A review of Resident A's care plans found a care plan dated 3/9/2020, that indicated, Focus: The resident is at risk for falls r/t (related to) sic Confusion, deconditioning, psychoactive drug use, history of falls at home. The care plan further indicated, Interventions/Tasks: Anticipate and meet the resident's needs, .The resident needs prompt response to all requests for assistance . A review of Resident A's initial Fall Risk Assessment, dated 3/10/2020, was conducted. The fall risk assessment was completed four days after the resident was admitted to the facility. The assessment indicated that the resident had a score of 17. The score indicated that the resident was considered, Low Risk. The assessment documented that the resident's [DIAGNOSES REDACTED].[MEDICAL CONDITION](stroke), 8. Hypertension/[MEDICAL CONDITION] (high blood pressure/low blood pressure), and 17. Additional Dx #1 Upper GI (gastrointestinal). The assessment indicated that it was undetermined if the resident had sustained a fall in the last month, or if she had had a fall in the last, 2-6 months. This assessment failed to document any medications that placed the resident at risk for falls. The document failed to list the [MEDICAL CONDITION] medication Resident A's physician had ordered. Review of a facility progress note for Resident A titled, SBAR- Communication for Changes in Condition, dated 3/16/2020, at 1:15 a.m., indicated, Situation: unwitnessed fall .Resd (resident) got up by herself and hit her head sustained ST (skin tear) to frontal head. Appears to be confused .Upon rounds, on-duty CNA (Certified Nursing Assistant) observed resident to be laying supine (lying horizontally with the face and torso facing up) by room desk with head towards desk and feet pointed toward resident's bed. Sustained BUE (bilateral upper extremities) skin tears and hematoma (blood or bleeding under the skin due to trauma) to L (left) frontal scalp S/P (status [REDACTED].RN Supervisor called 911 . A second facility progress note for Resident A, dated 3/16/2020, at 06:27 a.m., indicated, Received a call from ER (emergency room) (hospital initials) resident sustained [REDACTED]. A third progress note for Resident A, dated 3/16/2020, at 10:10 a.m., indicated, Patient on alert charting for s/p fall with fx to R (right) humerus, hematoma to L (left) forehead . Review of Resident A's, Fall Risk Assessment, dated 3/16/2020, after the fall indicated that the resident had a score of 41. The score indicated that the resident was considered, High Risk. The assessment documented that the resident's [DIAGNOSES REDACTED]. Dementia/Alzheimer. The assessment indicated that the resident had not sustained a fall in the last month, but had sustained a fall in the last, 2-6 months. This assessment failed to document any medications that placed the resident at risk for falls. The document failed to list the [MEDICAL CONDITION] medication the resident had been ordered. Further review of the Resident A's, Fall Risk Assessments indicated that the assessments failed to consistently and accurately document the resident's [DIAGNOSES REDACTED]. The assessments failed to accurately document her history of falls. The assessments failed to consistently and accurately document medications that attributed to her risk of falls. Additional review of the list of facility residents with falls for April, May and June of 2020, was conducted. The list indicated Resident B had sustained one fall on May 21, 2020, and Resident C had sustained three falls in April of 2020. A review of Resident B's facility medical record was conducted on July 8, 2020. Resident B was admitted to the facility on [DATE], and readmitted [DATE], with [DIAGNOSES REDACTED]. Review of Resident B's, Order Summary Report, indicated the following orders dated 5/8/2020: -[MEDICATION NAME] Tablet 500 MG (LevETIRAcetam) Give 1 tablet by mouth two times a day for [MEDICAL CONDITION] **Wean Down dose after 3 weeks** -[MEDICATION NAME] HCl ([MEDICATION NAME]) Tablet 20 MG Give 1 tablet by mouth one time a day for Depression m/b (manifested by) verbalization of sadness (antidepressant that is in the category of [MEDICAL CONDITION] medications). [MEDICATION NAME] has known side effects of drowsiness and dizziness. -Losartan Potassium Tablet 25 MG Give 1 table by mouth one time a day [MEDICAL CONDITION](high blood pressure). -saXagliptin HCl Tablet 5 MG Give tablet by mouth one time a day for DM (diabetes mellitus) . Further review of Resident B's, Order Summary Report, indicated the following order dated 5/10/2020, Pregabalin Capsule (anticonvulsant medication) 75 MG Give 1 capsule by mouth every 8 hours for [MEDICAL CONDITION] (disease or dysfunction of one or more peripheral nerves causing numbness or weakness). Resident B's admission Fall Risk Assessment, dated 5/8/2020, indicated that the resident had a score of 16. The score indicated that the resident was considered, Low Risk. The assessment documented that the resident's [DIAGNOSES REDACTED]. Diabetes, 8. Hypertension/[MEDICAL CONDITION], 17. Additional Dx #1 stroke, and 18. Additional Dx #2 [MEDICAL CONDITION]. The assessment indicated that it was undetermined if the resident had sustained a fall in the last month, or if he had had a fall in the last, 2-6 months. This assessment documented that the only medication that placed the resident at risk for falls was his antihypertensives (high blood pressure medication). The document failed to list the hypoglycemic agent (diabetic medication), the [MEDICAL CONDITION] medication (antidepressant), and the [MEDICAL CONDITION] medication that the resident had been ordered. Review of a facility progress note for Resident B titled, SBAR- Communication for Changes in Condition, dated 5/21/2020, at 12:10 p.m., indicated, Situation: .Appox (approximately) 1210 patient noted on patient's restroom floor on his knees crawling to door (sic). Patient noted with hematoma (blood or bleeding under the skin due to trauma) to r (right) side frontal portion of head open area, open area to R wrist. Patient had an unwitnessed fall . Review of Resident B's, Fall Risk Assessment, dated 5/21/2020, indicated that the resident had a score of 16. The score indicated that the resident was still considered, Low Risk. The assessment documented that the resident's [DIAGNOSES REDACTED]. Cardiac Arrhythmias (irregular heartbeat) and 14. [MEDICAL CONDITION]. The assessment indicated that it was undetermined if the resident had sustained a fall in the last month, or if he had had a fall in the last, 2-6 months. This assessment documented that the medications that placed the resident at risk for falls included, [MEDICAL CONDITION]/Antiepileptics and antihypertensives. Review of Resident B's, Fall Risk Assessment, dated 5/22/2020, after the unwitnessed indicated that the resident had a score of 51. The score indicated that the resident was considered, High Risk. The assessment documented that the resident's [DIAGNOSES REDACTED]. Diabetes, 8. Hypertension/[MEDICAL CONDITION], 17. Additional Dx #1 s/p (status [REDACTED]. This assessment documented that the medication that placed the resident at risk for falls included, [MEDICAL CONDITION]/Antiepileptics and antihypertensives. Review of a progress note for Resident B titled, SBAR- Communication for Changes in Condition, dated 5/25/2020, at 3:00 p.m., indicated, Situation: Patient had a fall in his room. He sustained a hematoma to his left fore-head .He is a repeated fall risk . Review of Resident B's, Fall Risk Assessment, dated 5/25/2020, indicated that the resident had a score of 83. The score indicated that the resident was considered, High Risk. The assessment documented that the resident's [DIAGNOSES

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.

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F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) REDACTED]. Hypertension/[MEDICAL CONDITION], and 16. Dementia/Alzheimer. The assessment indicated that the resident had sustained a fall in the last month, and had sustained a fall in the last, 2-6 months. This assessment documented that the medication that placed the resident at risk for falls was, Antihypertensives. Further review of the Resident B's, Fall Risk Assessments indicated that the assessments failed to consistently and accurately document the resident's [DIAGNOSES REDACTED]. The assessments failed to accurately document his history of falls. The assessments failed to consistently and accurately document medications that attributed to his risk of falls. The facility's fall list indicated that Resident C had sustained three falls in April, April 1st, 4th and 10th. Resident C had suffered an acute trapezium fracture to the left hand (trapezium bone is in the hand closest to the base of the thumb) in the fall on April 1, 2020, and a skin tear to the right elbow from the fall on April 10th. On July 8, 2020, Resident C's facility record was reviewed. Resident C was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Review of Resident C's Physician order [REDACTED]. Give 1 tablet by mouth as needed [MEDICAL CONDITION](high blood pressure) Give is SBP (systolic blood pressure-top number) > (greater than) 160 . -levETIRAcetam Tablet 500 MG Give 1 by mouth two times a day for [MEDICAL CONDITION] Disorder. Review of Resident C's facility record titled, SBAR-Change of Condition Progress Note, dated 4/1/2020, indicated, Situation: patient found scooting self on the floor. Review of Resident C's facility record titled, SBAR-Change of Condition Progress Note, also dated 4/1/2020, indicated, Situation: Left hand fracture confirmed via x-ray. Review of a progress note for Resident C dated 4/1/2020, indicated, Xray results for left hand received with acute trapezium fracture. MD (doctor) notified with order to send to ER (emergency room). Review of Resident C's, Fall Risk Assessment, dated 4/1/2020, indicated that the resident had a score of 87. The score indicated that the resident was considered, High Risk. The risk assessment documented that the resident's [DIAGNOSES REDACTED]. Arthritis, 8. Hypertension/[MEDICAL CONDITION], 14. [MEDICAL CONDITION] and 16. Dementia/Alzheimer. The assessment indicated that the resident had sustained a fall in the last month and that he had had a fall in the last, 2-6 months. This assessment documented that the medications that placed the resident at risk for falls included, [MEDICAL CONDITION]/Antiepileptics and antihypertensives (high blood pressure medication). Resident C's facility record found no documentation that indicated the resident had a [DIAGNOSES REDACTED]. The document further indicated, Assessment Details: Resident think (sic) he can able (sic) to get up on his own without assistance, apparently resident has unstable gait and a (sic) wheelchair bound, and needed assistance at all times. Resident is non-compliant on using call light. A second Fall Risk Assessment for Resident C, dated 4/4/2020, indicated that the resident had a score of 83. The score indicated that the resident was considered, High Risk. The risk assessment documented that the resident's [DIAGNOSES REDACTED]. Hypertension/[MEDICAL CONDITION], and 17. Additional Dx (diagnosis) #1. No additional [DIAGNOSES REDACTED].#1. The assessment indicated that the resident had sustained a fall in the last month and that he had had a fall in the last, 2-6 months. This assessment failed to document any medications that placed the resident at risk for falls. Review of Resident C's facility record titled, SBAR-Change of Condition Progress Note, dated 4/10/2020, documented a third fall that indicated, Situation: S/P (status [REDACTED]. The document further indicated, Assessment Details: Staff notified this writer about the res. (resident) condition. Res fell in his room. Res denies hitting his head. Res noted with skin tear to right elbow with c/o (complaint of pain). Res is now up sitting on wheelchair . Section titled, Appearance Details, indicated, Writer returning back from Station 3 to see RN/LVN assisting pt. (patient) on wheelchair with ST (skin tear) to right elbow . Review of Resident C's, Fall Risk Assessment, dated 4/10/2020, indicated that the resident had a score of 45. The score indicated that the resident was considered, High Risk. The risk assessment documented that the resident's [DIAGNOSES REDACTED]. [MEDICAL CONDITION], 7. Fracture, 14. [MEDICAL CONDITION] and 16. Dementia/Alzheimer. The assessment indicated that the resident had not sustained a fall in the last month and that he had had a fall in the last, 2-6, months. This assessment documented that the medications that placed the resident at risk for falls included, [MEDICAL CONDITION]/Antiepileptics and antihypertensives. Further review of the Resident C's, Fall Risk Assessments indicated that the assessments failed to consistently and accurately document the resident's [DIAGNOSES REDACTED]. The assessments failed to accurately document his history of falls. The assessments failed to consistently and accurately document medications that attributed to his risk of falls. On July 24, 2020, at 10:57 a.m., a concurrent interview and record review were conducted with the facility's Director of Nursing (DON). In reviewing the resident's medical records with the DON, the DON was asked the facility's expectation for assessments regarding fall risk for residents. The DON stated that the expectation for assessments was that they were to be documented accurately and timely. The DON confirmed that for both resident's B and C, given their [DIAGNOSES REDACTED]. Review of a facility policy titled, Fall Risk Assessment, revised February 25, 2018, indicated, The facility assesses all residents upon admission, quarterly, and as needed, for their risk of falling .The Licensed Nurse will use the Fall Risk Assessment Form to help identify individuals with a history of falls and risk factors for subsequent falling. The assessment will be conducted upon admission, quarterly, and with a change of condition. The Licensed Nurse will complete the Fall Risk Assessment Form in the electronic record and document: i: History of falls; ii. Medication use; iii: Memory and recall ability .Based on the initial information gathered, the Interdisciplinary Team (IDT) will identify and implement appropriate interventions to reduce the risk of falls .
F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure professional standards of quality of care were met for one of ten sampled residents (Resident A) in a universe of 76 residents when the resident was returned to bed without necessary care provided. This failure resulted in the resident attempting to get up and out of bed alone which resulted in a fall where the resident sustained [REDACTED]. On July 8, 2020, Resident A's facility record was reviewed. Resident A was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Review of Resident A's, History and Physical, (H&P) dated 3/7/2020, indicated, This resident does NOT have the capacity to understand and make decisions. Reason: Alzheimer's Dementia. Resident A's Physician order [REDACTED]. Review of a progress note for Resident A titled, SBAR- Communication for Changes in Condition, dated 3/15/2020, indicated, .Reported no urine output today and bladder scan done .Resident has [DIAGNOSES REDACTED]. A review of a progress note for Resident A dated 3/16/2020, at 00:32 a.m., indicated, Resident received sitting up in wheelchair by nurses' station. Resident ready for bed and observed with heavily urine-soaked brief. Taken back to bed and changed by on-duty CNA (Certified Nursing Assistant). No [MEDICAL CONDITION] observed at this time. Will continue to monitor. Review of a progress note for Resident A titled, SBAR- Communication for Changes in Condition, dated 3/16/2020, at 1:15 a.m., indicated, Situation: unwitnessed fall .Resd (resident) got up by herself and hit her head sustained ST (skin tear) to frontal head. Appears to be confused .Upon rounds, on-duty CNA observed resident to be laying supine (lying horizontally with the face and torso facing up) by room desk with head towards desk and feet pointed toward resident's bed. Sustained BUE (bilateral upper extremities) skin tears and hematoma (blood or bleeding under the skin due to trauma) to L (left) frontal scalp S/P (status [REDACTED].RN Supervisor called 911 . Further review of the progress note dated 3/16/2020, at 12:32 a.m., indicated the resident was observed with, heavily urine-soaked brief, the progress note which documented the resident's fall with injury was 43 minutes later at 1:15 a.m., on 3/16/2020. Review of a progress note for Resident A dated 3/16/2020, at 06:27 a.m., indicated, Received a call from ER (emergency room) (hospital initials) resident sustained [REDACTED]. A progress note for Resident A dated 3/16/2020, at 10:10 a.m., indicated, Patient on alert charting for s/p (status [REDACTED]. Review of a progress note for Resident A titled, IDT (interdisciplinary team) Progress Notes-Incident/Accident, dated 3/17/2020, at 12:18 p.m., indicated, IDT team met to review fall 03/16/2020 at 0115; per staff statement the resident was observed on the floor in her room in front of the desk in room. This is an unwitnessed fall .at the time of the fall she was soiled . A review of Resident A's care plans found a care plan that indicated, Focus: The resident is at risk for falls r/t (related to) Confusion, deconditioning, psychoactive drug use, history of falls at home. The care plan further indicated, Interventions/Tasks: Anticipate and meet the resident's needs, .The resident needs prompt response to all requests for assistance . On July 24, 2020, at 10:57 a.m., a concurrent interview and record review were conducted with the facility's Director of Nursing (DON). In reviewing the resident's medical record with the DON, the DON was asked that if the resident was observed at 12:32 a.m., with, heavily urine-soaked brief, and was changed as was alleged in the documentation, would she be soiled 43 minutes later when found on the floor at 01:15 a.m., especially given she was on monitoring for urine retention. The DON stated that she did not believe so. The DON was asked the expectation of the CNA staff to keep residents clean and dry. The DON stated that the CNA staff were expected to check residents every two hours and that this resident should have been changed prior to putting her in bed for the night. A review of the California Department of Human Services, California State Personnel Board Specification job duties for a Certified Nursing Assistant indicated a CNA, Provides physical support to assist patients/residents/clients or inmates in performing daily living

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F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) activities, including rising out of bed, bathing, dressing, feeding, toileting .
F 0675 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor each resident's preferences, choices, values and beliefs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure that it provided the necessary care and services to maintain the highest level of physical well-being for one of ten sampled residents (Resident A) in a universe of 76 residents. This failure occurred when the resident sustained [REDACTED]. Findings: On July 8, 2020, at 12:42 a.m., an unannounced visit was made to the facility for the investigation of a complaint. On July 8, 2020, Resident A's facility record was reviewed. Resident A was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Review of Resident A's facility History and Physical, (H&P) dated 3/7/2020, indicated, This resident does NOT have the capacity to understand and make decisions. Reason: Alzheimer's Dementia. A review of Resident A's care plans found a care plan dated 3/9/2020, that indicated, Focus: The resident is at risk for falls r/t (related to) Confusion, deconditioning, psychoactive drug use, history of falls at home. The care plan further indicated, Interventions/Tasks: Anticipate and meet the resident's needs, .The resident needs prompt response to all requests for assistance . A review of a progress note for Resident A dated 3/16/2020, at 00:32 a.m., indicated, Resident received sitting up in wheelchair by nurses' station. Resident ready for bed and observed with heavily urine-soaked brief. Taken back to bed and changed by on-duty CNA (Certified Nursing Assistant). No [MEDICAL CONDITION] (difficulty urinating and emptying the bladder) observed at this time. Will continue to monitor. Review of a progress note for Resident A titled, SBAR- Communication for Changes in Condition, dated 3/16/2020, at 1:15 a.m., indicated, Situation: unwitnessed fall .Resd (resident) got up by herself and hit her head sustained ST (skin tear) to frontal head. Appears to be confused .Upon rounds, on-duty CNA observed resident to be laying supine (lying horizontally with the face and torso facing up) by room desk with head towards desk and feet pointed toward resident's bed. Sustained BUE (bilateral upper extremities) skin tears and hematoma (blood or bleeding under the skin due to trauma) to L (left) frontal scalp S/P (status [REDACTED].RN Supervisor called 911 . Further review of the progress note dated 3/16/2020, at 12:32 a.m., indicated the resident was observed with, heavily urine-soaked brief, the progress note which documented the resident's fall with injury was 43 minutes later at 1:15 a.m., on 3/16/2020. Review of a progress note for Resident A dated 3/16/2020, at 06:27 a.m., indicated, Received a call from ER (emergency room) (hospital initials) resident sustained [REDACTED]. Review of a progress note for Resident A titled, IDT (interdisciplinary team) Progress Notes-Incident/Accident, dated 3/17/2020, at 12:18 p.m., indicated, IDT team met to review fall 03/16/2020 at 0115; per staff statement the resident was observed on the floor in her room in front of the desk in room. This is an unwitnessed fall .at the time of the fall she was soiled . On July 24, 2020, at 10:57 a.m., a concurrent interview and record review were conducted with the facility's Director of Nursing (DON). In reviewing the resident's medical record with the DON, the DON was asked that if the resident was observed at 12:32 a.m., with, heavily urine-soaked brief, and was changed as was alleged in the documentation, would she be soiled 43 minutes later when found on the floor at 01:15 a.m., especially given she was on monitoring for urine retention. The DON stated that she did not believe so. The DON was asked the expectation of the CNA staff to keep residents clean and dry. The DON stated that the CNA staff were expected to check residents every two hours and that this resident should have been changed prior to putting her in bed for the night. Review of a facility policy titled, Fall Management Program, revised February 25, 2018, indicated, It is the policy of this facility to provide the highest quality of care in the safest environment for the residents residing in the facility. The Facility has developed a Fall Management Program that strives to prevent resident falls through meaningful assessments, interventions, education and reevaluation .
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 that one of ten sampled residents (Resident A) in a universe of 76 residents received adequate supervision. This failure occurred when the resident sustained [REDACTED]. On July 8, 2020, at 12:42 a.m., an unannounced visit was made to the facility for the investigation of a complaint. On July 8, 2020, Resident A's facility record was reviewed. Resident A was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Review of Resident A's facility History and Physical, (H&P) dated 3/7/2020, indicated, This resident does NOT have the capacity to understand and make decisions. Reason: Alzheimer's Dementia. A review of Resident A's care plans found a care plan dated 3/9/2020, that indicated, Focus: The resident is at risk for falls r/t (related to) Confusion, deconditioning, psychoactive drug use, history of falls at home. The care plan further indicated, Interventions/Tasks: Anticipate and meet the resident's needs, .The resident needs prompt response to all requests for assistance . A review of a progress note for Resident A dated 3/16/2020, at 00:32 a.m., indicated, Resident received sitting up in wheelchair by nurses' station. Resident ready for bed and observed with heavily urine-soaked brief. Taken back to bed and changed by on-duty CNA (Certified Nursing Assistant). No [MEDICAL CONDITION] (difficulty urinating and emptying the bladder) observed at this time. Will continue to monitor. Review of a progress note for Resident A titled, SBAR- Communication for Changes in Condition, dated 3/16/2020, at 1:15 a.m., indicated, Situation: unwitnessed fall .Resd (resident) got up by herself and hit her head sustained ST (skin tear) to frontal head. Appears to be confused .Upon rounds, on-duty CNA observed resident to be laying supine (lying horizontally with the face and torso facing up) by room desk with head towards desk and feet pointed toward resident's bed. Sustained BUE (bilateral upper extremities) skin tears and hematoma (blood or bleeding under the skin due to trauma) to L (left) frontal scalp S/P (status [REDACTED].RN Supervisor called 911 . Review of a progress note for Resident A dated 3/16/2020, at 06:27 a.m., indicated, Received a call from ER (emergency room) (hospital initials) resident sustained [REDACTED]. A progress note for Resident A dated 3/16/2020, at 10:10 a.m., indicated, Patient on alert charting for s/p fall with fx to R (right) humerus, hematoma to L (left) forehead . Review of a progress note for Resident A titled, IDT (interdisciplinary team) Progress Notes-Incident/Accident, dated 3/17/2020, at 12:18 p.m., indicated, IDT team met to review fall 03/16/2020 at 0115; per staff statement the resident was observed on the floor in her room in front of the desk in room. This is an unwitnessed fall .at the time of the fall she was soiled . On July 24, 2020, at 10:57 a.m., a concurrent interview and record review were conducted with the facility's Director of Nursing (DON). In reviewing the resident's medical record with the DON, the DON was asked the expectation of the CNA staff to keep residents clean and dry. The DON stated that the CNA staff were expected to check residents every two hours. Review of a facility policy titled, Fall Management Program, revised February 25, 2018, indicated, It is the policy of this facility to provide the highest quality of care in the safest environment for the residents residing in the facility. The Facility has developed a Fall Management Program that strives to prevent resident falls through meaningful assessments, interventions, education and reevaluation .
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to maintain clinical records in accordance with accepted professional standards and practices that were accurately documented and contained a record of accurate detailed resident's assessments for three of ten sampled residents (Residents A, B, and C) in a universe of 76 residents. Findings: On July 8, 2020, at 12:42 a.m., an unannounced visit was made to the facility for the investigation of a complaint. On July 8, 2020, Resident A's facility record was reviewed. Resident A was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Review of Resident A's facility History and Physical, (H&P) dated 3/7/2020, indicated, This resident does NOT have the capacity to understand and make decisions. Reason: Alzheimer's Dementia. Resident A's Physician order [REDACTED]. (antidepressant that is in the category of [MEDICAL CONDITION] medications). This medication has a known side effect of confusion. A review of Resident A's care plans found a care plan dated 3/9/2020, that indicated, Focus: The resident is at risk for falls r/t (related to) Confusion, deconditioning, psychoactive drug use, history of falls at home. The care plan further indicated, Interventions/Tasks: Anticipate and meet the resident's needs, .The resident needs prompt response to all requests for assistance . A review of Resident A's initial Fall Risk Assessment, dated 3/10/2020, was conducted. The fall risk assessment was completed four days after the resident was admitted to the facility. The assessment indicated

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THE SPRINGS HEALTH AND REHABILITATION CENTER	**25924 JACKSON AVE MURRIETA, CA 92563**

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 0842

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Few

(continued... from page 3)

that the resident had a score of 17. The score indicated that the resident was considered, Low Risk. The assessment documented that the resident's [DIAGNOSES REDACTED].[MEDICAL CONDITION](stroke), 8. Hypertension/[MEDICAL CONDITION] (high blood pressure/low blood pressure), and 17. Additional Dx #1 Upper GI (gastrointestinal). The assessment indicated that it was undetermined if the resident had sustained a fall in the last month, or if she had had a fall in the last, 2-6 months. This assessment failed to document any medications that placed the resident at risk for falls. The document failed to list the [MEDICAL CONDITION] medication Resident A's physician had ordered. Review of Resident A's Fall Risk Assessment, dated 3/16/2020, indicated that the resident had a score of 41. The score indicated that the resident was considered, High Risk. The assessment documented that the resident's [DIAGNOSES REDACTED]. Dementia/Alzheimer. The assessment indicated that the resident had not sustained a fall in the last month, but had sustained a fall in the last, 2-6 months. This assessment failed to document any medications that placed the resident at risk for falls. The document failed to list the [MEDICAL CONDITION] medication the resident had been ordered. Further review of the Resident A's, Fall Risk Assessments indicated that the assessments failed to consistently and accurately document the resident's [DIAGNOSES REDACTED]. The assessments failed to accurately document her history of falls. The assessments failed to consistently and accurately document medications that attributed to her risk of falls. A review of Resident B's facility medical record was conducted on July 8, 2020. Resident B was admitted to the facility on [DATE], and readmitted [DATE], with [DIAGNOSES REDACTED]. Review of Resident B's Physician order [REDACTED].**Wean Down dose after 3 weeks** -[MEDICATION NAME] HCl ([MEDICATION NAME]) Tablet 20 MG Give 1 tablet by mouth one time a day for Depression m/b (manifested by) verbalization of sadness (antidepressant that is in the category of [MEDICAL CONDITION] medications). This medication has a known side effect of drowsiness and dizziness. -Losartan Potassium Tablet 25 MG Give 1 table by mouth one time a day [MEDICAL CONDITION](high blood pressure) -sAXagliptin HCl Tablet 5 MG Give tablet by mouth one time a day for DM (diabetes mellitus) . Further review of Resident B's, Order Summary Report, indicated the following order dated 5/10/2020, Pregabalin Capsule (anticonvulsant medication) 75 MG Give 1 capsule by mouth every 8 hours for [MEDICAL CONDITION] (disease or dysfunction of one or more peripheral nerves causing numbness or weakness). Review of a Fall Risk Assessment for Resident B dated 5/8/2020, indicated that the resident had a score of 16. The score indicated that the resident was considered, Low Risk. The assessment documented that the resident's [DIAGNOSES REDACTED]. Diabetes, 8. Hypertension/[MEDICAL CONDITION], 17. Additional Dx #1 stroke, and 18. Additional Dx #2 [MEDICAL CONDITION]. The assessment indicated that it was undetermined if the resident had sustained a fall in the last month, or if he had had a fall in the last, 2-6 months. This assessment documented that the only medication that placed the resident at risk for falls was his antihypertensives (high blood pressure medication). The document failed to list the hypoglycemic agent (diabetic medication), the [MEDICAL CONDITION] medication (antidepressant), and the [MEDICAL CONDITION] medication that the resident had been ordered. Review of a progress note for Resident B titled, SBAR- Communication for Changes in Condition, dated 5/21/2020, at 12:10 p.m., indicated, Situation: .Appox (approximately) 1210 patient noted on patient's restroom floor on his knees crawling to door (sic). Patient noted with hematoma (blood or bleeding under the skin due to trauma) to r (right) side frontal portion of head open area, open area to R wrist. Patient had an unwitnessed fall . Review of Resident B's, Fall Risk Assessment, dated 5/21/2020, indicated that the resident had a score of 16. The score indicated that the resident was still considered, Low Risk. The assessment documented that the resident's [DIAGNOSES REDACTED]. Cardiac Arrhythmias (irregular heartbeat) and 14. [MEDICAL CONDITION]. The assessment indicated that it was undetermined if the resident had sustained a fall in the last month, or if he had had a fall in the last, 2-6 months. This assessment documented that the medications that placed the resident at risk for falls included, [MEDICAL CONDITION]/Antiepileptics and antihypertensives. Review of Resident B's, Fall Risk Assessment, dated 5/22/2020, indicated that the resident had a score of 51. The score indicated that the resident was considered, High Risk. The assessment documented that the resident's [DIAGNOSES REDACTED]. Diabetes, 8. Hypertension/[MEDICAL CONDITION], 17. Additional Dx #1 s/p (status [REDACTED]. This assessment documented that the medication that placed the resident at risk for falls included, [MEDICAL CONDITION]/Antiepileptics and antihypertensives. Review of a progress note for Resident B titled, SBAR- Communication for Changes in Condition, dated 5/25/2020, at 3:00 p.m., indicated, Situation: Patient had a fall in his room. He sustained a hematoma to his left fore-head .He is a repeated fall risk . Review of Resident B's, Fall Risk Assessment, dated 5/25/2020, indicated that the resident had a score of 83. The score indicated that the resident was considered, High Risk. The assessment documented that the resident's [DIAGNOSES REDACTED]. Hypertension/[MEDICAL CONDITION], and 16. Dementia/Alzheimer. The assessment indicated that the resident had sustained a fall in the last month, and had sustained a fall in the last, 2-6 months. This assessment documented that the medication that placed the resident at risk for falls was, Antihypertensives. Further review of the Resident B's, Fall Risk Assessments indicated that the assessments failed to consistently and accurately document the resident's [DIAGNOSES REDACTED]. The assessments failed to accurately document his history of falls. The assessments failed to consistently and accurately document medications that attributed to his risk of falls. Review of Resident C's facility record indicated the resident sustained [REDACTED]. Resident C had suffered an acute trapezium fracture to the left hand (trapezium bone is in the hand closest to the base of the thumb) in the fall on April 1, 2020, and a skin tear to the right elbow from the fall on April 10th. On July 8, 2020, Resident C's facility record was reviewed. Resident C was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Review of Resident C's, Order Summary Report, indicated the following orders dated 12/10/2019: -[MEDICATION NAME] HCl Tablet 25 MG (milligram). Give 1 tablet by mouth as needed [MEDICAL CONDITION](high blood pressure) Give is SBP (systolic blood pressure-top number) > (greater than) 160 . -levETIRAcetam Tablet 500 MG Give 1 by mouth two times a day for [MEDICAL CONDITION] Disorder. Review of Resident C's, Fall Risk Assessment, dated 4/1/2020, indicated that the resident had a score of 87. The score indicated that the resident was considered, High Risk. The risk assessment documented that the resident's [DIAGNOSES REDACTED]. Arthritis, 8. Hypertension/[MEDICAL CONDITION], 14. [MEDICAL CONDITION] and 16. Dementia/Alzheimer. The assessment indicated that the resident had sustained a fall in the last month and that he had had a fall in the last 2-6 months. This assessment documented that the medications that placed the resident at risk for falls included, [MEDICAL CONDITION]/Antiepileptics and antihypertensives (high blood pressure medication). Review of the resident's facility record found no documentation that indicated the resident had a [DIAGNOSES REDACTED]. MD (doctor) notified with order to send to ER (emergency room). Review of Resident C's, Fall Risk Assessment, dated 4/4/2020, indicated that the resident had a score of 83. The score indicated that the resident was considered, High Risk. The risk assessment documented that the resident's [DIAGNOSES REDACTED]. Hypertension/[MEDICAL CONDITION], and 17. Additional Dx (diagnosis) #1. No additional [DIAGNOSES REDACTED].#1. The assessment indicated that the resident had sustained a fall in the last month and that he had had a fall in the last, 2-6 months. This assessment failed to document any medications that placed the resident at risk for falls. Review of Resident C's facility record titled, SBAR-Change of Condition Progress Note, dated 4/4/2020, indicated, Situation: Resident was found sitting on the floor nearby (sic) the window with arms on the side around 00:45 am. The document further indicated, Assessment Details: Resident think (sic) he can able (sic) to get up on his own without assistance, apparently resident has unstable gait and a (sic) wheelchair bound, and needed assistance at all times. Resident is non-compliant on using call light. Review of Resident C's, Fall Risk Assessment, dated 4/10/2020, related to the resident's second fall indicated that the resident had a score of 45. The score indicated that the resident was considered, High Risk. The risk assessment documented that the resident's [DIAGNOSES REDACTED]. [MEDICAL CONDITION], 7. Fracture, 14. [MEDICAL CONDITION] and 16. Dementia/Alzheimer. The assessment indicated that the resident had not sustained a fall in the last month and that he had had a fall in the last, 2-6, months. This assessment documented that the medications that placed the resident at risk for falls included, [MEDICAL CONDITION]/Antiepileptics and antihypertensives. Review of Resident C's facility record titled, SBAR-Change of Condition Progress Note, dated 4/10/2020, documented a third fall that indicated, Situation: S/P (status [REDACTED]. The document further indicated, Assessment Details: Staff notified this writer about the res. (resident) condition. Res fell in his room. Res denies hitting his head. Res noted with skin tear to right elbow with c/o (complaint of pain). Res is now up sitting on wheelchair . Section titled, Appearance Details, indicated, Writer returning back from Station 3 to see RN/LVN assisting pt. (patient) on wheelchair with ST (skin tear) to right elbow . Further review of the Resident C's Fall Risk Assessments indicated that the assessments failed to consistently and accurately document the resident's [DIAGNOSES REDACTED]. The assessments failed to accurately document his history of falls. The assessments failed to consistently and accurately document medications that attributed to his risk of falls. On July 24, 2020, at 10:57 a.m., a concurrent interview and record review were conducted with the facility's Director of Nursing (DON). In reviewing the resident's medical records with the DON, the DON was asked the facility's expectation for assessments regarding fall risk for residents. The DON stated that the expectation for assessments was that they were to be documented accurately and timely. The DON confirmed that for both resident's B and C, given their

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555915	A. BUILDING _____ B. WING _____	**08/20/2020**

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F 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 4) [DIAGNOSES REDACTED]. Review of a facility policy titled, Documentation-Nursing, revised January 8, 2016, indicated, Nursing documentation will be concise, clear, pertinent, and accurate .Admission nursing assessments completed by individual assessment on the day of admission .