STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055042	A. BUILDING _____ B. WING _____	**05/14/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ALTA VISTA HEALTHCARE & WELLNESS CENTRE	**9020 GARFIELD STREET RIVERSIDE, CA 92503**

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 0604 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one resident (Resident 1) was free from unnecessary restraints when she had an abdominal binder, a mitten, and bilateral wrist restraints applied. This failed practice resulted in the resident being restrained for multiple days without a plan to re-evaluate and remove the restraints when they were no longer necessary. Findings: During a confidential employee interview on April 22, 2020, at 8:39 a.m., the employee stated Resident 1 was, literally restrained to her bed 24 hours a day since April 8, 2020. The employee stated she did not restrain the resident during the shifts she was caring for her, and there were no problems. During an interview with the Director of Nursing (DON) on April 22, 2020, at 10:40 a.m., the DON stated there was one resident (Resident 1) in restraints due to pulling out her gastrostomy tube (a tube inserted into the stomach to allow nutrition to be delivered directly). The DON stated the resident had pulled the tube out five times, so she had an abdominal binder (to cover the tube), a mitten on her left hand (to limit her ability to use her hand), and bilateral (both sides) wrist restraints. The DON stated she received a verbal order to apply restraints from the resident's attending physician (MD 1). On April 22, 2020, at 11:35 a.m., Resident 1 was observed lying in her bed. The resident had an abdominal binder and a bulky mitten on her left hand. There were no wrist restraints on the resident. Wrist restraints were observed on the bedside table. The resident was continuously moving her left arm and leg, but did not attempt to pull out the gastrostomy tube. There was no movement observed in the right arm or hand, and Resident 1 went to sleep. At 11:45 a.m., while still observing Resident 1 (sleeping), two licensed vocational nurses (LVN 1 and LVN 2) walked into the resident's room and applied bilateral wrist restraints. The restraints were wrapped around and tied to the bedrails with knots, not to the bed frame. The restraints were not tied in a quick release fashion. In a concurrent interview, the LVNs stated they were applying the restraints because they had a scheduled time to put them on, and they released them every two hours. The LVNs stated the order was to apply them for two hours and release them for 15 minutes, then reapply them. During an interview with the certified nursing assistant (CNA 1) monitoring the hallway on April 22, 2020, at 1:05 p.m., the CNA stated she knew Resident 1, and the resident did not have fine motor movement in her right hand so she could not pull the tube out with that hand. During an interview with the DON on April 22, 2020, at 1:15 p.m., the DON stated the restraints should have been tied to a non-moveable part of the bed, and not the bed rails. The DON was observed removing the restraints from the siderails and tying them to the bed frame. The record for Resident 1 was reviewed on April 22, 2020. The record indicated on April 8, 2020, at 4:30 p.m., an order was written (verbal order) for bilateral wrist restraints. There was no evidence the behavior of the resident was re-evaluated to determine if the restraints could be removed. During an interview with the DON on April 22, 2020, at 1:15 p.m., the DON stated the facility policy was to remove the restraints every two hours, for 15 minutes, and remove them when the resident was no longer displaying behavior. During an interview with MD 1 on April 23, 2020, at 1:50 p.m., MD 1 stated he had not seen the resident, and he ordered the restraints based on text messages he received from the DON. MD 1 stated he or his nurse practitioner would be there to see the resident that evening (16 days after the resident had been restrained). The facility policy titled, Restraints, was reviewed. The policy indicated the following: a. If necessary, the attending physician order [REDACTED]. Restraints must be easily removable in case of fire or other emergency. No knots would be used in applying restraints. A review of nursing practice guidelines regarding restraint application indicated the following: a. Always use quick release knots; and, b. DON'T tie to side rails.
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.** Based on interview and record review, the facility failed to ensure a comprehensive care plan was developed and implemented when one resident (Resident 1) was placed in an abdominal binder, a bulky mitten on her left hand, and bilateral wrist restraints. This failed practice resulted in no plan to attempt to remove any of the restraints, and the potential for harm to the resident. Findings: During an interview with the Director of Nursing (DON) on April 22, 2020, at 10:40 a.m., the DON stated there was one resident (Resident 1) in restraints due to pulling out her gastrostomy tube (a tube inserted into the stomach to allow nutrition to be delivered directly). The DON stated the resident had pulled the tube out five times, so she had an abdominal binder (to cover the tube), a mitten on her left hand (to limit her ability to use her hand), and bilateral (both sides) wrist restraints. The DON stated she received a verbal order to apply restraints from the resident's attending physician (MD 1). On April 22, 2020, at 11:35 a.m., Resident 1 was observed lying in her bed. The resident had an abdominal binder and a bulky mitten on her left hand. There were no wrist restraints on the resident. Wrist restraints were observed on the bedside table. The resident was continuously moving her left arm and leg, but did not attempt to pull out the gastrostomy tube. There was no movement observed in the right arm or hand, and Resident 1 went to sleep. At 11:45 a.m., while still observing Resident 1 (sleeping), two licensed vocational nurses (LVN 1 and LVN 2) walked into the resident's room and applied bilateral wrist restraints. The restraints were wrapped around and tied to the bedrails with knots, not to the bed frame. The restraints were not tied in a quick release fashion. In a concurrent interview, LVN 1 stated there was no care plan specific to the use of restraints. The record for Resident 1 was reviewed. There was no evidence of a care plan for safe use of restraints or attempting to discontinue the use of restraints.

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.