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 _____	08/19/2020

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. A review of a list of facility residents with falls for April, May and June of 2020, was conducted. The list indicated that Resident A had sustained three falls in April, April 1st, 4th and 10th. Resident A 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 A's facility record was reviewed. Resident A was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Review of Resident A's, physician's orders [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 the resident's facility record found no documentation that indicated the resident had a [DIAGNOSES REDACTED]. Review of Resident A'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 A 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 A'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 Resident A'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. A second Fall Risk Assessment for Resident A, 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. Additional review of Resident A's facility record titled located a third SBAR-Change of Condition Progress Note, dated 4/10/2020, 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 . A third Fall Risk Assessment for Resident A, 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 A's, Fall Risk Assessments indicated that the resident's score decreased over time, when falls continued to occur. 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 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. 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 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] HCI ([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). Side effects of this medication include restlessness, drowsiness, and dizziness. -Losartan Potassium Tablet 25 MG Give 1 table by mouth one time a day [MEDICAL CONDITION](high blood pressure) -sAXagliptin HCI Tablet 5 MG Give tablet by mouth one time a day for DM (diabetes mellitus) . Further review of Resident B's physican 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 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 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 (high blood pressure medications). AFall Risk Assessment for Resident B, dated 5/22/2020, indicated that the resident had a score of 51. The

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) 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 . Resident B's second 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. On July 8, 2020, Resident C's facility record was reviewed. Resident C was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Resident C's Physician order [REDACTED]. (antidepressant that is in the category of [MEDICAL CONDITION] medications). A known side effects of this medication is confusion. A review of Resident C's admission 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], 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 ordered for the resident. Review of a progress note for Resident C titled, SBAR- Communication for Changes in Condition, dated 3/16/2020, indicated, Situation: unwitnessed fall. The progress note further indicated, Resd (resident) got up by herself and hit her head sustained ST (skin tear) to frontal head . Review of Resident C'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 ordered for Resident C. 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 her history of falls. The assessments failed to consistently and accurately document medications that attributed to her 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 assessmentss 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 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure comprehensive care plans were reviewed and revised for one of ten sampled residents (Resident A) in a universe of 76 residents. This failure occurred when the resident sustained [REDACTED]. This failure had the potential to result in serious harm for the resident. Findings: On July 8, 2020, at 12:42 a.m., an unannounced visit was made to the facility for the investigation of a complaint. A review of a list of facility residents with falls for April, May and June of 2020, was conducted. The list indicated that Resident A had sustained three falls in April, April 1st, 4th and 10th. Resident A 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 A's facility record was reviewed. Resident A was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Review of Resident A's facility care plans located a care plan that indicated, Focus: The resident is at risk for recurrent falls with injuries r/t (related to) Confusion, Deconditioning, Gait/balance problems, Unaware of safety needs. Diagnosis: [REDACTED]. The care plan was initiated on 12/11/2019. The care plan failed to document any new or revised interventions to address the three falls the resident sustained [REDACTED]. Further review of Resident A's facility care plans found a care plan that indicated, Focus: The resident has had an actual fall on 4/04/2020 and 4/10/2020, Poor balance, Unsteady gait, resident verbalized he tried to get closer to the window inside room. Causative factors: poor safety awareness, poor trunk support, impaired memory. The care plan had an initiated date of 4/4/2020, with a revision date of 4/10/2020. Review of the interventions for the care plan found no new interventions after the 4/4/2020, fall. There was an intervention dated 4/4/2020, that indicated, Continue interventions on the at-risk plan. 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 facility's expectation for the revision of care plans to address new interventions for each of the resident's falls. The DON stated that the expectation would have been to have the care plans updated with new interventions to address future falls. Review of a facility policy titled, Fall Management Program, revised February 25, 2018, indicated, .II. Care Planning: A. The Nursing Staff will develop a plan of care specific to the resident's needs with interventions to reduce the risk of falls. B. The Interdisciplinary Team will review the plan of care at minimum of quarterly, with a change of condition, and post fall. Interventions will be implemented or changed based on the resident's condition and response .IV. Post Fall: B. The Licensed Nurse will review the circumstances of the fall, review the plan of care, implement new interventions as appropriate and revise the plan as indicated .
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. A review of a list of facility residents with falls for April, May and June of 2020, was conducted. The list indicated that Resident A had sustained three falls in April, April 1st, 4th and 10th. Resident A 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 A's facility record was reviewed. Resident A was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Review of Resident A'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 A's facility care plans found a care plan that indicated, Focus: The resident is at risk for recurrent falls with injuries r/t (related to) Confusion, Deconditioning, Gait/balance problems, Unaware of safety needs. Diagnosis: [REDACTED]. The care plan was initiated on 12/11/2019. The care plan failed to document any new or revised interventions to address the three falls the resident sustained [REDACTED]. Review of Resident A'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 A's facility

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F 0675 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) 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 A 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 A'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 Resident A'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 A'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. Further review of Resident A's facility care plans found a care plan that indicated, Focus: The resident has had an actual fall on 4/04/2020 and 4/10/2020, Poor balance, Unsteady gait, resident verbalized he tried to get closer to the window inside room. Causative factors: poor safety awareness, poor trunk support, impaired memory. The care plan had an initiated date of 4/4/2020, with a revision date of 4/10/2020. No new interventions were added to the care plan after the 4/4/2020, fall. There was an intervention dated 4/4/2020, that indicated, Continue interventions on the at-risk plan. Review of Resident A's facility record titled, SBAR-Change of Condition Progress Note, dated 4/10/2020, 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 A'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 A's, Fall Risk Assessments indicated that the resident's score decreased over time, when falls continued to occur. The assessments failed to consistently and accurately document the resident's [DIAGNOSES REDACTED]. The assessment failed to accurately document the resident's 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 record with the DON, the DON was asked the facility's expectation for the revision of care plans to address new interventions for each of the resident's falls. The DON stated that the expectation would have been to have the care plans updated with new interventions to address future falls. The DON was asked the facility's expectation for assessment's regarding fall risk for residents. The DON stated that the expectation for assessments was that they were to be documented accurately. 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]. Findings: On July 8, 2020, at 12:42 a.m., an unannounced visit was made to the facility for the investigation of a complaint. A review of a list of facility residents with falls for April, May and June of 2020, was conducted. The list indicated that Resident A had sustained three falls in April, April 1st, 4th and 10th. Resident A 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 A's facility record was reviewed. Resident A was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Review of Resident A's facility care plans found a care plan that indicated, Focus: The resident is at risk for recurrent falls with injuries r/t (related to) Confusion, Deconditioning, Gait/balance problems, Unaware of safety needs. Diagnosis: [REDACTED]. The care plan was initiated on 12/11/2019. The care plan further indicated, Interventions/Tasks: .Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance . Review of Resident A'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 A'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 A 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). Resident A's facility care plans located a care plan that indicated, Focus: The resident has Left hand Fracture r/t (related to): Fall. The care plan was initiated on 4/1/2020. The care plan further indicated, Interventions/Tasks: Anticipate and meet needs. Be sure call light is within reach and respond promptly to all requests for assistance . Review of Resident A'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 Resident A'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. A second Fall Risk Assessment completed for Resident A, 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 A's facility record titled, SBAR-Change of Condition Progress Note, dated 4/10/2020, 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 A'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.

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F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) 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 Resident A's facility care plans found a care plan that indicated, Focus: The resident has had an actual fall on 4/04/2020 and 4/10/2020, Poor balance, Unsteady gait, resident verbalized he tried to get closer to the window inside room. Causative factors: poor safety awareness, poor trunk support, impaired memory. The care plan had an initiated date of 4/4/2020, with a revision date of 4/10/2020. Review of the care plan found no new interventions after the 4/4/2020, fall. There was an intervention dated 4/4/2020, that indicated, Continue interventions on the at-risk plan. Review of Resident A's facility care plans found a care plan that indicated, Focus: ST (skin tear) 3X10 cm (centimeters) to right elbow. The care plan was initiated on 4/10/2020. Further review of the Resident A's, Fall Risk Assessments indicated that the resident's score decreased over time, when falls continued to occur. The assessments failed to consistently and accurately document the resident's [DIAGNOSES REDACTED]. The assessment failed to accurately document the resident's 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 record with the DON, the DON was asked the facility's expectation for the revision of care plans to address new interventions for each of the resident's falls. The DON stated that the expectation would have been to have the care plans updated with new interventions to address future falls. The DON was asked the facility's expectation for assessment's regarding fall risk for residents. The DON stated that the expectation for assessments was that they were to be documented accurately. 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. The policy further indicated, .II. Care Planning: A. The Nursing Staff will develop a plan of care specific to the resident's needs with interventions to reduce the risk of falls. B. The Interdisciplinary Team will review the plan of care at minimum of quarterly, with a change of condition, and post fall. Interventions will be implemented or changed based on the resident's condition and response .IV. Post Fall: B. The Licensed Nurse will review the circumstances of the fall, review the plan of care, implement new interventions as appropriate and revise the plan as indicated .
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. A review of a list of facility residents with falls for April, May and June of 2020, was conducted. The list indicated that Resident A had sustained three falls in April, April 1st, 4th and 10th. Resident A 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 A's facility record was reviewed. Resident A was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Review of Resident A'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. Resident had Fall Risk Assessments after each of the resident's three falls. The first 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]. 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 A'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. Resident A's third 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 A's, Fall Risk Assessments indicated that the resident's score decreased over time, when falls continued to occur. 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. 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] HCI ([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 a known side effect of restlessness, drowsiness, and dizziness. -Losartan Potassium ([MEDICATION NAME]) Tablet 25 MG Give 1 table by mouth one time a day [MEDICAL CONDITION](high blood pressure). A side effect of this medication included dizziness. -sAXagliptin HCI 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 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 that had been ordered for Resident B. Review of Resident B's, Fall Risk Assessment, dated 5/21/2020, after an unwitnessed fall 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. Resident B's second Fall Risk assessment dated [DATE], after the first fall 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

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 _____	**08/19/2020**

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

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F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 4) 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 . A third Fall Risk Assessment for Resident B after a second fall, dated 5/25/2020, was completed and 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. On July 8, 2020, Resident C's facility record was reviewed. Resident C was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Resident C's Physician order [REDACTED]. (antidepressant that is in the category of [MEDICAL CONDITION] medications). A known side effect of [MEDICATION NAME] is confusion. A review of Resident C's, 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], 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 ordered for Resident C. A second Fall Risk Assessment for Resident C after a fall, 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 ordered for Resident C. 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 her history of falls. The assessments failed to consistently and accurately document medications that attributed to her 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 assessmentss 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, 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 .