

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055001	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/10/2025
NAME OF PROVIDER OR SUPPLIER Redlands Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1620 West Fern Avenue Redlands, CA 92373	

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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47110</p> <p>Based on observations, interviews, and a review of records, the facility failed to execute one of the post-fall interventions established by the Interdisciplinary Team (IDT) on October 4, 2024, for one of the three sampled residents (Resident 1). When, Certified Nurse Assistant (CNA 1) did not provide verbal reminders to Resident 1, which were intended to help prevent falls.</p> <p>This failure has resulted in Resident 1 suffered another fall on March 24, 2025, leading to a head injury that required hospitalization .</p> <p>Findings:</p> <p>A review of Resident 1's Admission Record (a document that gives a summary of resident's information), indicated Resident 1 was admitted to the facility on [DATE], with diagnosis that included Legal blindness, history of falling, muscle wasting and atrophy (the shrinking or loss of muscle tissue).</p> <p>During a review of the facility document titled, Change of Condition/Fall, dated March 24, 2025, indicated Resident was on the floor in a supine position and bleeding from the head. 911 was called, resident was transported to the hospital.</p> <p>During a review of a facility provided document titled Change of Condition/Fall, dated October 3, 2024, indicated Resident 1 had a unwitnessed fall incident on October 3, 2024.</p> <p>During an observation and interview on April 10, 2025, at 1:40 PM, with Resident 1 in Resident 1's room, Resident 1 was lying in bed with her son present. When asked how the incident happened, resident 1 stated she was sitting in the toilet, when she got up, she lost her balance. Stated she though a staff was with her, but she was told that the staff walk away, and she cannot remember if the staff told her about leaving her.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During interview on April 10, 2025, at 2:53 PM, with CNA 1, CNA 1 identified herself as the CNA responsible for the resident on the day of the incident on March 24, 2025. She described her response to Resident 1's call light, during which Resident 1 indicated a need to use the bathroom. Consequently, she assisted Resident 1 to the restroom. While on the way to the bathroom, Resident 1 complained of feeling cold, which led her to notice that the sliding door in the room was open. After helping Resident 1 to the toilet, she informed Resident 1 that she would be closing the sliding door, assuming Resident 1 would remain seated during this process. She proceeded to close the sliding door and the curtain, at which point she heard a fall, realizing she was not quick enough to prevent it. She acknowledged that when she informed Resident 1 about closing the sliding door, she failed to instruct Resident 1 not to stand up in her absence, operating under the assumption that the resident would stay seated. She admitted that had she explicitly advised Resident 1 against getting up, it is possible the fall could have been avoided. Additionally, she noted that while Resident 1 generally requires assistance to walk, there are instances when the resident attempts to walk independently.</p> <p>During a concurrent interview and record review on April 10, 2025, at 3:20 PM with the Director of Nursing (DON 1), the review included IDT report dated October 4, 2024, concerning an unwitnessed fall involving the resident on October 3, 2024. The IDT report outlined that current interventions involve providing verbal reminders and cues for the resident to request assistance as needed. The DON concurred that the CNA 1 should consistently educate Resident 1 on the importance of asking for help rather than attempting to get up independently when staff are unavailable. Although Resident 1 can be challenging to persuade, prioritizing safety remains essential.</p> <p>During a review of the facility Policy and Procedure (P&P) titled, Fall - Clinical Protocol, dated 2001, indicated, .Monitoring and follow up .2. The staff and physician will monitor and document the individual's response to interventions in-tended to reduce falling or the consequences of falling. a. Frail elderly individuals are often at greater risk for serious adverse consequences of falls. b. Risks of serious adverse consequences can sometimes be minimized even if falls cannot be prevented .</p>