STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055182	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lemon Grove Care and Rehabilitation Center	8351 Broadway Lemon Grove, CA 91945

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 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** 49330 Based on interview and record review, the facility failed to update the care plan with resident-specific interventions for one of one resident reviewed for falls (Resident 1). This failure had the potential for Resident 1 to sustain further falls. Findings: According to the Admission Record, Resident 1 was admitted to the facility on [DATE] with diagnoses that included muscle weakness, cognitive communication deficit (difficulty with memory and communicating needs) , and early onset Alzheimer ' s disease (a disease which affects memory). A review of Resident 1's MDS (Minimum Data Set, an assessment tool) indicated for showering, Resident 1 was dependent on staff. The MDS indicated, Dependent- Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity. On 9/27/24 at 9:17 A.M., an interview was conducted with Resident 1. Resident 1 stated she had a fall in the shower, while sitting in a shower chair. Resident 1 stated Certified Nursing Assistant (CNA) 1 was standing next to her in the shower. Resident 1 stated, I think they should have two people showering me from now on so it doesn ' t happen again. On 9/27/24 at 10:07 A.M., an interview was conducted with Licensed Nurse (LN) 1. LN 1 stated Resident 1 was .alert, but can get forgetful and confused sometimes. LN 1 stated prior to the fall on 9/12/24, Resident 1 required the assistance of one staff member for activities of daily living (ADL ' s). LN 1 stated after the fall on 9/12/24, Resident 1 required two staff members for assistance. On 10/15/24 at 3:02 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated the root cause of Resident 1 ' s fall was determined as .a sudden movement . by Resident 1. The DON stated interventions to prevent further falls included giving Resident 1 a bed bath instead of showers, and . educate the resident and staff . (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055182	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lemon Grove Care and Rehabilitation Center	8351 Broadway Lemon Grove, CA 91945

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 1 ' s records indicated Resident 1 ' s care plan dated 9/16/24, was not updated with the interventions that addressed the root cause of the fall. A review of the facility ' s policy titled Falls Prevention dated 1/24 indicated, It is the policy of this facility to: . identify residents at risk for falls and determine appropriate interventions .Care plans will be revised and/or updated to reflect changes in intervention .