

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055581	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2024
NAME OF PROVIDER OR SUPPLIER Jurupa Hills Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 6401 33rd Street. Riverside, CA 92509	

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 - 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** 40000</p> <p>Based on interview and record review, for one of three residents reviewed (Resident A), the facility failed to ensure the effectiveness of the interventions to prevent falls were evaluated, and new interventions were implemented to address Resident A ' s repeated falls due to behavior of getting up unassisted and prevent further falls.</p> <p>These failures resulted in Resident A to have 16 falls from October 16, 2023, to February 13, 2024, while at the facility. Resident A ' s fifth (5th) fall resulted to the resident to sustain a laceration (cut) on the back of his head and was treated in the emergency room (ER) with two staples (used to close wounds) placed on the laceration. Resident A ' s ninth (9th) fall resulted to the resident to sustain a skin tear on the right elbow. Resident A ' s 15th fall resulted to the resident to be transferred to the acute hospital and sustained multiple left rib fractures (broken bone) and thoracic compression fractures (a break in a bone in the middle section of the spine).</p> <p>Findings:</p> <p>On August 5, 2024, at 8:54 a.m., an unannounced visit was conducted at the facility to investigate a complaint regarding quality of care and accidents.</p> <p>A review of Resident A's Admission Record, indicated Resident A was initially admitted to the facility on [DATE], with diagnoses which included spinal stenosis (spaces inside the bones of the spine get too small), chronic atrial fibrillation (irregular heart beat that causes poor blood flow), emphysema (lung disease), history of falling, difficulty walking, and alcohol dependence.</p> <p>A review of Resident A's Fall Risk Observation/Assessment, dated October 12, 2023, indicated a score of 26 (high risk for falls score of 16-42).</p> <p>A review of Resident A's care plan, developed on October 12, 2023, indicated, .Falls: Resident is at risk for falls with or without injury related to impaired safety awareness due to episodes of confusion and forgetfulness, history of falls, hx (history) of alcohol dependence, anxiety, multiple medications, and hx of vertigo (a sensation in which you feel as though you are moving, spinning, or off balance) .Goal .Will have no serious injury til (sic) next review .Interventions/Tasks .Anticipate and meet needs .Educate/remind resident to call for assistance with all transfers .keep call light within reach and reorient during routine care .keep bed to lower position .keep personal items within reach .PT/OT (physical therapy/occupational therapy) eval (evaluation) as indicated .</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 - Actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident A's Minimum Data Set (MDS- a standardized comprehensive assessment and care planning tool), dated February 29, 2024, indicated the following:</p> <ul style="list-style-type: none"> - Resident A had a Brief interview for Mental Status (BIMS -a tool used to screen and identify cognitive [process of thinking] condition of residents) score of 3 (severe cognitive impairment); and - Resident A required moderate to maximum assistance with ADL ' s (activities of daily living includes bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet and eating). <p>Further review of Resident A's documents indicated the resident had multiple falls during his stay at the facility as follows:</p> <p>1. A review of Resident A's Change of Condition Evaluation, dated October 16, 2023, at 1:26 p.m., indicated, .resident found on floor near bed on both knees @ (at) 0930 (9:30 a.m.). pt (patient) awake and alert c/o (complain of) left rib pain. no redness or any discoloration noted to site. denies pain to touch. fall mats beside bed and call light noted within reach. MD (doctor) notified .</p> <p>A review of Resident A's Post Fall Review, dated October 16, 2023, indicated, Unable to independently come to a standing position, exhibits loss of balance while standing, Strays off the straight path of walking, requires hands-on assistance to move from place to place, uses short discontinuous steps and/or shuffling steps, Changes gait pattern when walking through doorways, has lurching, swaying, or slapping gait .</p> <p>A review of Resident A's care plan, dated October 17, 2023, included additional interventions which indicated, .encourage and assist to activity to keep self-occupied .move to room closer to nursing station .</p> <p>A review of Resident A's Interdisciplinary Team (IDT-staff from different health care disciplines discuss to help people receive the care they need) Notes, dated October 17, 2023, indicated, .resident was not able to explain what happened not explained what he was trying to do due to resident with episodes of confusion and forgetfulness .</p> <p>2. A review of Resident A's Change of Condition Evaluation, dated November 10, 2023, at 6:54 p.m., indicated, .Resident was in hallway trying to sit in his wheelchair when the wheelchair rolled away and resident fell and landed on buttock. He did not hit his head and does not c/o any pain or discomfort at this time. MD notified and his order was to monitor patient for now .</p> <p>A review of Resident A's Post Fall Review, dated November 10, 2023, indicated, .Exhibits loss of balance while standing, requires hands-on assistance to move from place to place, uses as assistive device, e.g. (example) cane, walker, etc.</p> <p>A review of Resident A's care plan, dated November 10, 2023, included additional interventions which indicated, .PT/OT (physical therapy/occupational therapy) focusing on wheelchair mobility, application of brakes, redirection, assist with verbal cues</p> <p>Further review of Resident A's medical record did not indicate IDT notes after the Resident A's fall on November 10, 2023.</p> <p>(continued on next page)</p>		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	<p>13. A review of Resident A's Change of Condition Evaluation, dated January 8, 2024, at 6:59 a.m., indicated, .the resident is trying to stand up from the wheelchair. CNA and LVN (Licensed Vocational Nurse) keep telling the resident to stay but he never listen (sic) and he lose (sic) his balance standing up and fell on the floor .</p> <p>A review of Resident A's care plan, dated January 8, 2024, indicated additional intervention to ambulate with handheld assist when trying to get up and not being redirected, and assist up in chair and keep by nursing station for immediate visual monitoring when restless in bed.</p> <p>Further review of Resident A's medical record did not indicate a Post Fall Review and IDT notes were completed after Resident A fell on [DATE].</p> <p>14. A review of Resident A's Change of Condition Evaluation, dated January 11, 2024, at 4:29 a.m., indicated, .Was called into resident's room re: fall. On assessment resident seen lying on floor out on hallway in supine (lying face upward) position with knees drawn up. CNA verbalized that he was trying to grab a bottle off nurses desk when he stumbled, fell backwards, hitting head against door frame. Neuro checks performed, is able to state name and move all limbs, c/o having headache and back pain .</p> <p>A review of Post Fall Review, dated January 11, 2024, indicated, .Unable to independently come to a standing position, exhibits loss of balance while standing, strays off the straight path of walking, requires hands-on assistance to move from place to place, uses short discontinuous steps and/or shuffling steps, exhibits jerking or instability when making turns .</p> <p>A review of Resident A's care plan, dated January 14, 2024, indicated for resident to be placed in a merry walker (a mobility aid that combines the features of a walker and a wheelchair, allowing users to walk independently and safely) when up and out of bed.</p> <p>Further review of Resident A's medical record did not indicate IDT notes after resident had a fall on January 11, 2024.</p> <p>15. A review of Resident A's Change of Condition Evaluation, dated February 2, 2024, at 12:44 p.m., indicated, .Loud noise heard down the hallway. Resident was found on floor in room next to bed A. RN notified. Resident assessed by charge nurse and RN resident assisted to side of bed. resident observed to be holding back of head and forehead. Resident unable to state how he fell .</p> <p>A review of Resident A's Post Fall Review, dated February 2, 2024, indicated, .Exhibits loss of balance while standing, strays off the straight path of walking, requires hands-on assistance to move from place to place, uses short discontinuous steps and/or shuffling steps, changes gait pattern when walking through doorways, has lurching, swaying, or slapping gait, exhibits jerking or instability when making turns, wears poorly fitting shoes .</p> <p>A review of the facility document titled, Transfer Form, dated February 2, 2024, at 2:57 p.m., indicated Resident A was transferred to the general acute hospital (GACH).</p> <p>A review of Resident A ' s GACH document titled, History of Present Illness, dated February 2, 2024, indicated, .on Eliquis (medication to thin the blood) presenting from his nursing care facility for ground level fall when he fell off his bed hitting his head .</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident A's radiology report for CT (Computerized Tomography - a medical imaging procedure that uses x-rays to create detailed images of the body) of the Lumbar Spine (lower back region of spine) Region, dated February 2, 2024, indicated, .Subacute (happened about 5 to 14 days) to chronic (old) 6-9 (rib fractures) left lateral fractures .There is 10% superior endplate vertebral (round, thick, weight-bearing bones in the spine) body height loss at T1 and T2 (first two bones in the middle part of the spine) .These may represent acute (new) to subacute compression fractures[EC12] (a break in a bone in the spine that collapses) .</p> <p>A review of Resident A's GACH document, dated February 5, 2024, indicated, .plan .remains at risk to fall again. Would not leave a wheelchair by his bedside with this being his primary mobility prior to his fall and injury .</p> <p>A review of Resident A's IDT Notes, dated February 5, 2024, indicated IDT discussed resident condition and director of nursing assess resident upon returned from hospital and no change in mental status noted, no external trauma including any open skin not discoloration noted, no tenderness no swelling noted. IDT discuss plan of care and to continue currently in place .</p> <p>A review of Resident A's care plan related to the fall incidents from October 16, 2023, to February 5, 2024, included the following interventions:</p> <ul style="list-style-type: none"> - keep resident clean and dry; - maintain hazard free environment; - proper footwear; - keep frequently use personal items within reach; - assist with needs as anticipated and as needed; - lowest bed position; floor mats when in bed; - assist to activity to keep self-occupied; - room closer to the nursing station for immediate and frequent visual check; and - taken for a walk within the facility and outside patio when restless, provide simple activity book, and other noncomplicated activity when up in the chair to keep self-busy, assist with needs as anticipated and as needed. <p>16. A review of Resident A's Change of Condition Evaluation, dated February 13, 2024, at 2:26 p.m., . Resident was sitting in wheelchair in front of station. Writer turned away from med (medication) cart. Writer heard loud bang, resident found sitting on floor against the wall in front of station, resident holding back of head. RN made aware and assessed resident .</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident A's Progress Notes, dated February 13, 2024, indicated, .@ (at)approx. (approximately) 1300 (1:00 p.m.) Resident was sitting in wheelchair in front of station. Writer turned away from med cart. Writer heard loud bang, resident found sitting on floor against the wall in front of station, resident holding back of head. RN made aware and assessed resident .Resident assisted back into bed by charge nurse and assigned CNA .MD made aware .orders for CT scan of head and spine. MD made aware that CT are not done in facility. MD agreed .send to (name of GACH) .</p> <p>A review of Resident A's IDT Notes, dated February 14, 2024, at 3:43 p.m., indicated, On 2/13/2024 (February 13, 2024) at approx. (approximately) 1300 (1:00 p.m.) patient was found sitting on buttock with back facing the wall. Patient was holding back of head, complains of slight pain. Nurse notified MD and patient was sent to acute care hospital for further observation. IDT interviewed nurse that was in care of patient at the time of fall. Nurse stated that patient had been monitored at nursing station majority of the early afternoon, she stated she turned around to print something (still standing at station) and when she turned around patient was sitting on the floor .</p> <p>On August 5, 2024, at 2:16 p.m., during an interview LVN 2, he stated Resident A was alert and oriented to his name and place. LVN 2 stated the staff would assist him in the seat but would get up right away. LVN 2 stated Resident A's mobility was limited and had to keep an eye on him constantly, even if staff turned for a second, Resident A could get up. LVN 2 stated Resident A would take off the alarm from the wheelchair and tried to break the cord because the resident did not like the sound. LVN 2 stated Resident A had multiple falls and a 1:1 (staff assigned only to one resident to prevent falls) sitter was not used all the time. LVN 2 also stated Resident A's falls could have been prevented if he had a 1:1 sitter.</p> <p>On August 5, 2024, at 2:52 p.m., during a concurrent interview and record review of Resident A's therapy notes with the Director of Rehabilitation (DOR) and the Physical Therapist (PT), the PT stated Resident A was not steady on his feet and was high risk for falls, and had no dynamic balance (ability to remain standing and be stable). The DOR stated a reassessment was completed after every fall and if there were no changes, and continued with the therapy goals.</p> <p>On August 5, 2024, at 3:55 p.m., during concurrent interview with the Director of Nursing (DON), the DON stated the residents were being assessed for falls upon admission, quarterly, annually and when the resident had a change of condition. The DON stated Resident A had a history of dementia (cognitive impairment with memory loss) had interventions in place to address risk for falls but Resident A would get up constantly. The DON stated most of Resident A ' s falls were from the edge of the bed and a complete fall risk assessment was done and discussed with the IDT team and interventions to monitor the resident.</p> <p>On August 13, 2024, at 9:26 a.m., during a concurrent interview and record review of Resident A's post fall review with the DON, she stated a Post Fall Review should be completed by nursing after every fall. The DON stated Post Fall Reviews were not completed for the following dates:</p> <ul style="list-style-type: none"> - November 14, 2023, after the third fall; - November 20, 2023, after the fourth fall; - November 28, 2023, after the fifth fall; <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Jurupa Hills Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 6401 33rd Street. Riverside, CA 92509	

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 - Actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> - December 9, 2023, after the seventh fall; - December 20, 2023, after the ninth fall; - January 8, 2024, after the 13th fall; and - February 13, 2024, after the 16th fall. <p>The DON stated IDT meetings were to be held to discuss a resident ' s plan of care after a fall incident. The DON stated an IDT meeting was held after each of Resident A's falls and the plan was discussed with the team, but there was no documentation in Resident A ' s medical record. The DON stated the IDT notes were not completed to address each of Resident A's fall incidents on the following dates:</p> <ul style="list-style-type: none"> - November 10, 2023, after the 2nd fall; - November 14, 2023, after the third fall; - November 20, 2023, after the fourth fall; - November 28, 2023, after the fifth fall; - December 5, 2023, after the sixth fall; - December 9, 2023, after the seventh fall; - December 14, 2023, after the eighth fall; - December 20, 2023, after the ninth fall; - December 23, 2023, after the 10th fall; - December 25, 2023, after the 11th fall; - December 30, 2023, after the 12th fall; - January 8, 2024, after the 13th fall; - January 11, 2024, after the 14th fall; and - February 13, 2024, after the 16th fall. <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The DON stated they did a trial for Resident A to use the merry walker but was not implemented thereafter as was not working for the resident after the 14th fall. The DON stated the staff on the unit took turns to watch Resident A, but a 1:1 sitter was not assigned to him despite the multiple falls. The DON stated if a 1:1 staff was assigned to Resident A, it could have minimized the repetitive falls because most of the falls were a result of Resident A trying to get up unassisted. The DON stated Resident A's multiple falls were not properly evaluated to address the cause of the fall and implement appropriate interventions to prevent injuries and repeat falls.</p> <p>A review of facility's policy and procedure titled, Falls-Clinical Protocol with a revision date of [DATE], indicated, .physician will help identify individuals with a history of falls and risk factors for subsequent falling . risk factors for subsequent falling include .musculoskeletal (related to muscles and bones) abnormalities .gait and balance disorders, cognitive impairment, weakness .confusion .the physician will identify medical conditions affecting fall risk .and the risk for significant complications of falls .Cause Identification .after a first fall, the staff .should watch the individual rise from a chair without using his or her arms, walk several paces and return not sitting .if the individual has difficulty or is unsteady in performing this test, additional evaluation should occur .Treatment/Management .the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling .Monitoring and Follow-Up the staff, with the physician ' s guidance, will follow up on any fall with associated injury until the resident is stable .the staff and physician will monitor and document the individual ' s response to interventions intended to reduce falling or the consequences of falling .</p>		