STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055650	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Care Center of Redlands	700 East Highland Avenue Redlands, CA 92374

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 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** 47206 Based on observation, interviews, and record reviews the facility failed to ensure a resident Care Plan was fully implemented for one of four sampled residents (Resident 1) when Resident 1was not placed closer to the nursing station as indicated in the plan of care as a specified intervention following a fall. This failure had the potential to put a clinically compromised resident (Resident 1) at risk for serious injury due to falling. Resulting in Resident 1falling and being transferred to a general acute hospital for evaluation and treatment of injuries. Findings: During a review of Resident 1's clinical record, the face sheet (contains demographic and medical information), indicated Resident 1 was admitted on [DATE], with a diagnosis that included repeated falls, degenerative disease of the nervous system (progressive conditions that occur when nerve cells in the brain or peripheral nervous system [part of your nervous system that lies outside the brain and spinal cord. It plays a key role in both sending information from different areas of your body back to your brain as well as carrying out commands from your brain to various parts of your body] gradually lose function or die, they can affect many aspects of person ' s life including mobility and balance), other abnormalities of gait and mobility (an unusual walking pattern), osteoporosis (a condition in which bones becomes weak and brittle) Additionally, the resident was admitted from an acute general hospital following an incident of falling. During a telephone interview with Resident 1 ' s daughter on August 15, 2024, at 4:06 PM, she stated that her mother fell at home on July 3, 2024, and was sent to an acute general hospital on July 5, 2024, before being transferred to the facility on the same day. Resident 1 ' s daughter further communicated that her mother had another fall incident at the facility on July 10, 2024, which necessitated her transfer to a general acute hospital for further evaluation. Additionally, on July 18, 2024, Resident 1 experienced another fall incident at the facility, which required transport to an acute general hospital for further evaluation and treatment. The daughter emphasized that the facility was aware of her mother's high risk for falls during the initial admission. (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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During review of records, specifically the nurses ' progress notes, it was noted that the resident had experienced a fall incident on July 10, 2024, leading to a transfer to the emergency room for further evaluation. X-ray (use to generate images of tissues and structures inside the body) results from the hospital conducted on July 10, 2024, revealed that Resident 1 has a clavicular (a long, slightly curved bone that connects arm to the body) fracture. Further review of records revealed a second fall incident on July 18, 2024, which also required transfer to an acute general hospital. During an observation on August 19,2024, at 3:40 PM, It was noted that room where the resident was staying during the last fall incident, This private room is designed to a single resident room and is notably one of the farthest rooms from the nursing station. A post fall care plan reviewed dated July 10, 2024, indicated that the interventions include frequent visual monitoring and moving resident closer to the nursing station. During a telephone interview with the facility administrator (ADM 1) on August 20, 2024, at 2:16 PM, ADM 1 has acknowledged that Resident 1 was staying in a room at that time of the fall incident, and this room was one of the farthest from the nursing station. This situation contradicts one of the interventions outlined in the post-fall care plan dated July 10, 2024, which was to move Resident 1 closer to the nursing station after a fall incident on July 10, 2024. Upon review of the interdisciplinary team meeting summary conducted by the facility on July 10, 2024, at 11:50 AM following a fall incident on the same day at 11:35 AM, it was indicated that there was a high risk for falls and risk for fractures. One of the interventions mentioned was to move Resident 1 ' s room closer to the nursing station. During an interview with the ADM 1 on August 21, 2024, at 3:48 PM, I informed ADM 1 that the interdisciplinary meeting conducted on July 10, 2024, following a fall incident, indicated that one of the mentioned interventions was to move Resident 1 closer to the nursing station. Additionally, the care plan following a fall incident on July 10, 2024, included two interventions: frequent visual monitoring and moving the resident closer to the nursing station. ADM 1 acknowledged that during the fall incident on July 18, 2024, Resident 1 was in room [ROOM NUMBER], which happened to be one of the farthest rooms from the nursing station. During an interview with the director of rehabilitation (Director 1) on August 21, 2024, at 3:38 PM, Director 1 stated that Resident 1 required standby assistance during ambulation during the initial assessment upon admission. Furthermore, it was noted that on July 18, 2024, prior to the second fall incident at the facility, Resident 1 continued to require assistance during ambulation based on rehabilitation department ' s recommendation. During an interview with the Certified Nursing Assistant (CNA 1) on August 21, 2024, at 3:38 PM, CNA 1 admitted to helping Resident 1 to go to the bathroom. However, CNA 1 mentioned that he went to see another resident who needed help while Resident 1 was in the bathroom. Additionally, he revealed that a resident in an adjacent room called the front desk for help because Resident 1 had fallen in the bathroom. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a interview with resident 2 on August 22, 2024, at 9:59 AM, Resident 2 stated that her room is near Resident 1 ' s room during the fall incident on July18, 2024. Resident 2 reported that a staff member initially helped Resident 1 to the bathroom and then assisted her in using the bedpan around 3:50 PM. However, after 10 to 15 minutes, the staff did not return despite her repeated calls for help using the call light and shouting for staff to come, during which time Resident 1 was still in the bathroom. Resident 2 mentioned that she had been sitting on the bedpan for over half an hour when she heard a loud noise, described as a big bang. When she asked Resident 1 if she was okay, she stated she was not, and was unable to use the emergency call light when she instructed her. Despite Resident 2 ' s attempt to call for help, by using her call light and shouting for assistance no staff responded to help, during that time Resident 2 was continuously in communication with Resident 1 while she was in the bathroom, Resident 1 eventually became quiet. At 4:41 PM, Resident 2 contacted the nursing station using her cell phone, explaining that Resident 1 had fallen in the bathroom and needed assistance. The staff promptly responded and immediately contacted 911, and the paramedics arrived at 5:05 PM. During an interview with the nurse supervisor in charge (Supervisor 1) on August 19, 2024, at 3:50 PM regarding the alleged fall incident on July 18, 2024, Supervisor 1 stated that the charge nurse reported to her that Resident 1 had fallen in the bathroom, and when she went and checked, Resident 1 was found lying on the floor in the bathroom on her left side. She was told that one of the CNAs had placed Resident 1 on the toilet and the resident had tried to get up. During a review of Resident 2 ' s records, the progress notes dated July 18, 2024, at 5:45 PM, of supervisor 1, it was noted that the charge nurse reported to Supervisor 1 that Resident 1 had fallen, upon entry to the room, Resident 1 was in the bathroom laying left lateral with feet positioned towards toilet/sink and head at doorway entry to the bathroom on roommates ' side, resident had pants and brief at knees with noted bleeding in the forehead. Also noted was a left laceration in the left forehead and left eye with significant swelling. Paramedics arrived at 5:00 PM and Resident 1 was transferred to the emergency room (ER) for further evaluation. During a review of the undated facility ' s policy and procedure (P&P) titled, Fall Risk Assessment, the P&P indicated The staff and attending physician will collaborate to identify and address modifiable fall risk factors and interventions to try to minimize the consequences of risk factors that are not modifiable. During a telephone interview with Director of Nursing (DON 1) on August 27, 2024, at 2:53 PM, DON 1 acknowledged that the facility ' s fall risk assessment policy was not followed when Resident 1 had a fall incident on July 18, 2024.