

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  056365	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/13/2025
NAME OF PROVIDER OR SUPPLIER  Yucaipa Hills Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 13542 Second St. Yucaipa, CA 92399	

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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 40171</p> <p>Based on observation, interview, and record review, the facility failed to ensure the prevention of avoidable accidents for one of three sampled residents (Resident 1) when Resident 1, a resident who was at high risk for falls and fully dependent upon staff for mobility while in bed, fell from his bed while being changed by Certified Nursing Assistant 1 (CNA 1).</p> <p>This failure resulted in Resident 1 to sustain a head injury which included a bleeding laceration to his right eyebrow and a subarachnoid hemorrhage (bleeding in the area between your brain and the thin tissues that cover and protect it).</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record (contains medical and demographic information), the record indicated Resident 1 was admitted on [DATE], with diagnoses which included cerebral palsy (neurological disorder that causes permanent problems with movement, balance, and posture), parkinson's disease (a disorder of the central nervous system that affects movement), disorders of bone density and structure (medical conditions that affect the strength and composition of bones which can significantly impact bone structure and increase fracture risk), and epilepsy (a brain disorder that causes recurring, unprovoked seizures).</p> <p>During an interview on November 4, 2024, at 3:25 PM, with the Director of Nursing (DON), the DON stated on October 18, 2024, Resident 1 fell off his bed when CNA 1, who was a contracted registry staff member (an employee provided by a contracted staffing agency), turned the resident away from her (rolled the resident towards the opposite side of the bed from which the CNA was standing) when cleaning up the resident's bowel movement.</p> <p>During a continued interview on November 4, 2024, at 3:35 PM, with the DON, the DON stated CNA 1 should have had another staff member assist with turning the resident in bed since the resident had contractures (permanent tightening of the muscles, tendons, skin, and nearby tissues that causes the joints to shorten and become very stiff). The DON further stated as a result of the fall, Resident 1 sustained an abrasion to his right eyebrow and was subsequently sent to the hospital where it was identified that the resident also had a subarachnoid hematoma.</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 a review of Resident 1's Minimum Data Set assessment (MDS - a computerized resident assessment tool), dated October 18, 2024, the MDS assessment indicated Resident 1 had a Brief Interview for Mental Status (BIMS - a tool used to screen and identify the cognitive condition of residents upon admission into a long-term care facility) score of 1 (score of 0-7 is severe cognitive impairment).</p> <p>During a further review of Resident 1's MDS assessment, dated October 18, 2024, section GG (section regarding functional abilities), indicated for rolling left and right in bed, Resident 1 was dependent - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 [two] or more helpers is required for the resident to complete the activity.</p> <p>During a review of Resident 1's fall assessment titled, Fall Risk Assessment, (a scored assessment of Resident 1's fall risk) dated October 20, 2024, the fall risk assessment indicated Resident 1 was identified to be at high-risk for falls, with a score of 14. The document further indicated, .If the total score is 10 or greater, the resident should be considered at HIGH RISK for potential falls .</p> <p>During a review of Resident 1's care plan (an individualized plan for the medical care of a resident) (untitled), dated April 14, 2023, the care plan indicated, [Name of Resident 1] is high risk for falls r/t [related to] confusion .balance problems, incontinence [involuntary loss of bowel or bladder control], poor communication/comprehension, psychoactive drug use [A drug or other substance that affects how the brain works and causes changes in mood, awareness, thoughts, feelings, or behavior], unaware of safety needs . goal the resident will be free of falls through the review date . interventions included, Anticipate and meet the resident's needs .follow facility fall protocol.</p> <p>During a review of the written statement from CNA 1, dated October 18, 2024, the statement indicated, at approx. [approximately] 5:30-5:40 [AM] I was providing patient care to [Name of Resident 1] who had BM and urine spillage since his previous brief was shifted while wiping and cleaning mattress I had patient turned facing the door when patient fell off the bed that was about mid-thigh height. I immediately [sic] notified nurse and put patient back on mattress. Patient hit his face on floor resulting in cut to the side of his eye.</p> <p>CNA 1 was not available for interview.</p> <p>During a review of Resident 1's hospital paperwork from [name of Hospital] the document titled, History of Present Illness, dated October 18, 2024 indicated, BIBA [brought in by ambulance] from care facility for evaluation s/p [status post] fall that occurred this morning .CT head shows small subarachnoid hemorrhage along the bilateral bifrontal sulci [portion of the frontal lobe of the brain] .Condition: serious .</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Fall Prevention, dated December 2023, the P&amp;P indicated, It is the policy of this facility to investigate the circumstances surrounding each resident fall and implement actions to reduce the incidence of additional falls and minimize potential for injury .</p>