

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555135	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/21/2024
NAME OF PROVIDER OR SUPPLIER Highland Springs Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1441 Michigan Avenue Beaumont, CA 92223	

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** 48240</p> <p>Based on interview and record review, the facility failed to ensure one of three sampled residents' (Resident 2) whereabouts was being frequently monitored. This failure potentially could have contributed for Resident 2 to be able to wander to Resident 1's room and was found on top of the resident on April 27, 2024.</p> <p>Findings:</p> <p>A review of Resident 2 ' s medical record indicated Resident 2 was admitted to the facility on [DATE]. Resident 2 ' s History and Physical (H&P), dated November 17, 2023, indicated Resident 2 had diagnoses which included dementia (impaired ability to remember, think, or make decisions that interfered with doing everyday activities).</p> <p>A review of Resident 2 ' s Minimum Data Set (MDS- an assessment tool) dated March 29, 2024, indicated Resident 2 had severely impaired cognition.</p> <p>A review of Resident 2 ' s care plan dated May 16, 2022, indicated Resident 2 was . at risk for leaving safe area without authorization, leaves premises without authorization secondary to dementia as evidenced by resident wanders around the facility hallway and to other resident rooms .Interventions * Monitor at frequent intervals .Redirect resident to alternatives .provide 1:1 if indicated to redirect behaviors on interim basis .</p> <p>A review of Resident 1's medical record was conducted. Resident 1's 'Admission Record, indicated Resident 1 was admitted to the facility on [DATE], with diagnoses which included peripheral vascular disease (reduced circulation to a body part other than brain or heart), hypertension (high blood pressure), and anxiety (mental health condition). Resident 1's History and Physical dated June 29, 2024, indicated Resident 1 cannot make decisions.</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>On May 7, 2024, at 10:53 a.m., an interview with Certified Nursing Assitant (CNA) 1 was conducted. CNA 1 stated Resident 1 was non-verbal. CNA 1 stated on April 27, 2024, at the beginning of the morning shift, she was passing breakfast trays when she found Resident 2 on top of Resident 1. CNA 1 stated Resident 1's gown was lifted; her upper body was exposed, and her briefs were undone. CNA 1 stated Resident 2 was touching Resident 1's chest. CNA 1 stated Resident 1 saw her, got off the bed, and tried to fight her (CNA 1). CNA 1 stated Resident 1 looked scared, and she reported the incident immediately to Licensed Vocational Nurse (LVN) 1. CNA 1 further stated Resident 2 had behavior of going into other residents ' rooms.</p> <p>On May 7, 2024, at 1:08 p.m., an interview with LVN 1 was conducted. LVN 1 stated on April 27, 2024, CNA 1 informed her that Resident 2 was on top of Resident 1. LVN 1 stated when she got to the room, Resident 1 ' s gown was up, and her breasts were exposed, and briefs were undone. LVN 1 stated they immediately removed Resident 2 from the room and provided one on one monitoring.</p> <p>On May 7, 2024, at 3:32 p.m. during an interview, the Director of Nursing (DON) stated Resident 2 did not have any behaviors prior to the incident on April 27, 2024, when he was found on top of Resident 1 in Resident 1 ' s room.</p> <p>There was no other documented evidence that Resident 2 exhibited a behavior of entering other residents ' rooms.</p> <p>On May 30, 2024, at 12:52 p.m. during an interview, the DON stated that residents exhibiting behaviors such as entering other residents ' rooms were redirected and placed on every-30-minute or hourly monitoring to track their location within the facility. The DON she was unaware that Resident 2 exhibited behavior of entering other residents ' room since there was no documented evidence that Resident 2 had exhibited any behavior. The DON stated when Resident 2 was found on top of Resident 1 in Resident 1 ' s room, it was the first time this incident occurred involving Resident 2. The DON stated she did not know that a staff member knew about Resident 2 having behavior of entering residents ' rooms. The DON stated that the staff member who knew about Resident 2 ' s behavior should have reported it to her, to any licensed nurses or any member of the interdisciplinary team. The DON stated if they would have been told about Resident 2 ' s behavior of entering residents ' room, they would have called Resident 2 ' s family member to find out if he had been wandering to resident's rooms; conduct root cause analysis; and provide interventions based on the analysis.</p>		