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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555350 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 03/19/2025 |
| NAME OF PROVIDER OR SUPPLIER Madison Grove Post Acute | | STREET ADDRESS, CITY, STATE, ZIP CODE 1618 Laurel Avenue Redlands, CA 92373 | |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| (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** 42615</p> <p>Based on observation, interview, and record review, the facility failed to ensure adequate supervision was provided to prevent avoidable accidents when one of four residents (Resident 2)'s left knee noted with pain and fracture of the proximal left tibia (break in the long bone of the left lower leg).</p> <p>This failure resulted in Resident 2 a clinically compromised resident being sent to the hospital for evaluation and treatment.</p> <p>Findings:</p> <p>During an observation on March 19, 2025, at 12:35 PM, Resident 2 was lying in bed awake and did not respond verbally.</p> <p>During an interview on March 19, 2025, at 12:50 PM, with Certified Nursing Assistant (CNA 2), the CNA 2 stated, He (Resident 2) does not talk. He is total dependent with ADLs (activity of daily living). I usually give him bath, clean and change him, and reposition him every two hours.</p> <p>During an interview on March 19, 2025, at 1:00 PM, with Licensed Vocational Nurse (LVN 2), LVN 2 stated, [Resident 2's name] does not talk. I don't know what happened, but I know he was transferred to the hospital due to pain of his legs and he came back with a diagnosis of fracture.</p> <p>During a review of Resident 2' Admission Record (general demographics) on March 19, 2025, the document indicated Resident 2 was originally admitted to the facility on [DATE], with diagnoses that included quadriplegia (paralysis that affects all four limbs) and contracture other specified joint (a permanent tightening of muscle and tissues leading to a loss of movement).</p> <p>During an interview on March 19, 2025, at 1:50 PM, with the Director of Nursing, she stated, nursing staff used facial grimacing to assess [Resident's name]'s pain since the resident could not speak.</p> <p>A review of Resident 2's care plan dated June 24, 2024, indicated, Focus . has an ADL self-care performance deficit r/t (related to) activity intolerance, confusion, limited mobility. Goal: The resident will maintain current function . Intervention: The resident is totally dependent on (2) staff for repositioning and turning in bed (every 2 hours) and as necessary .</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.

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| 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>A review of Resident 2's Restorative Nursing Assistant Treatment dated January 1, 2025 - January 31, 2025, indicated, RNA (restorative nursing assistant) program passive range of motion to bilateral lower extremities every day shift 3 time a week as tolerated.</p> <p>A review of Resident 2's SNF/NF to Hospital Transfer Form dated January 20, 2025, indicated reason for transfer, S/S of pain in bilateral lower extremity (signs of pain of both lower legs).</p> <p>A review of Resident 2's Clinical Record indicated, EXAMINATION: Left tibia and fibula, 2 views. Indication: Left lower leg pain. Impression: Moderate diffuse osteopenia. Finding suspicious for a fracture of the proximal tibia just below the tibial . Suggestion of a mildly impacted fibular neck fracture is present .</p> <p>A review of facility's undated Policy and Procedure (P&P), titled, Safety and Supervision of Residents, the P&P indicated, Policy Statement Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities .</p> |