

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  08/27/2025
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.

(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 - Actual harm  Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.  (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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(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 - Actual harm  Residents Affected - Few	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to ensure adequate supervision for one of three sampled residents (Resident1) when Resident 1, who requires a two-person assist, fell out of bed while one Certified Nursing Assistant (CNA) was repositioning the resident and providing a brief change. This failure resulted in Resident 1 sustaining intertrochanteric (thigh bone) fracture of left hip. Findings: During review of Resident 1's admission Record (general demographics information), the document indicated Resident 1 was admitted to the facility on [DATE], with diagnoses which included type 2 diabetes (body has trouble controlling blood sugar), hypertension (high blood pressure), dependence on respirator (difficult to breathe on own, machine dependent). During a review of Resident 1's History and Physical (H&amp;P), dated January 27, 2025, the H&amp;P indicated, Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS - clinical assessment tool used in nursing homes that serves as a comprehensive summary of a resident's functional capabilities, health conditions, and care needs.) Section GG Functional Abilities, dated June 7, 2025, the MDS Section GG Functional Abilities indicated, . Toileting hygiene, Shower/bath self, Roll Left and Right=Dependent= Helper does All of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity. During a review of Resident 1's Situation Background Assessment Recommendation (SBAR) notes dated July 29, 2025, at 5:22 AM, the SBAR indicated During rounds resident noted to slide from bed and struck head on oxygen concentrator and was lowered on to the ground by staff. Noted with open area to top of Left eye with scant bleeding. Noted with bruising to cheekbone and cheek. Transfer to acute to rule out fracture. During a review of Resident 1's X-ray (generate images of tissue and structure of body) report, dated July 29, 2025, the X-ray of the left hip shows displaced intertrochanteric fracture. The X-ray report also indicated PLAN: At this time, family is choosing to pursue nonsurgical management for left hip fracture, and they are listing his high propensity (natural tendency) to infections as a deterrent to surgery at this time. During a review of Resident 1's care plan dated June 25, 2024, the care plan indicated Resident 1 has an ADL (Activities of Daily Living) self-care performance deficit r/t (related to) Activity Intolerance, Confusion, Limited Mobility, Limited ROM. INTERVENTIONS: BATHING/SHOWERING: The resident is totally dependent on (2) staff to provide (bath/shower). and as necessary. BED MOBILITY: The resident is substantial assistance on (2) staff for repositioning and turning in bed (Q2hrs) and as necessary. During an interview on August 27, 2025, at 1:20 PM, with CNA 1, CNA 1 stated, It's always a two (2) person assist to change the residents here in subacute. The CNAs help each other. If it is busy I have to wait, I cannot take the risk of doing the care alone. The nurse also helps if needed. During an interview on August 27, 2025, at 1:38 PM, with CNA 2, CNA 2 stated, In subacute, we always have 2 persons assist with ADLs, we have a buddy with another CNA, but we can always ask the nurses or Respiratory Therapist. During an interview on September 2, 2025, at 10:08 AM, with CNA 3, CNA 3 stated, It was about 1:30 AM. I wanted to see if Resident 1 was wet. He was, so I placed him on his side, he rolled and I tried to catch him, I ran to the other side, he slid down to the floor. I called for the nurses and we got him back to bed. He was not able to help in the repositioning, he is contracted (a shortening or tightening of muscles, tendons, or other tissues). He is a two-person assist after the fall. Now everyone in subacute is two-person assist. I would always provide care for him on my own. I was made aware he had a fracture. During an interview on August 27, 2025, at 2:10 PM, with the Director of Nursing (DON), the DON stated Resident 1 had a fall on July 29, 2025, with femur (thigh bone) fracture. The DON stated that upon their investigation, CNA 3 did not wait for help. The LVN, stated she was in the middle of medication pass, and said to give a couple minutes. CNA 3 was doing patient care, there was no siderails and the residents fell. The DON further stated, Resident 1 requires a two-person assist, CNA 3 should have waited for help as they have a 'buddy system. During a review of the facility's policy and procedure (P&amp;P) titled, Fall and Fall Risk, Managing, undated, the P&amp;P indicated, Based on previous evaluation and current data, the staff will identify interventions related to the residents specific risk and causes to try to prevent the resident from falling and to try to minimize complications from falling.</p>		