

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555376	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/20/2024
NAME OF PROVIDER OR SUPPLIER Danville Post-Acute Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 336 Diablo Road Danville, CA 94526	

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>38534</p> <p>Based on interview and record review, the facility failed to ensure one of three sample selected residents (Resident 1) was free of accidents in the facility when Resident 1 had a fall and fracture while she was residing at the facility.</p> <p>This failure in practice resulted in Resident 1 ' s hip fracture, suffering from pain, and hospitalization .</p> <p>Findings:</p> <p>A review of Resident 1 ' s Face Sheet indicated, Resident 1 was admitted to the facility with multiple diagnoses including history of cognitive deficit, multiple falls and fractures, muscle weakness, neuropathy (when nerve damage leads to pain, weakness, numbness or tingling in one or more parts of your body).</p> <p>During an interview on 5/20/24 at 10:40 a.m. with Rehabilitation Director (RD), RD stated Resident 1 finished her group physical therapy and asked the Physical Therapy Aid (PTA) to take her to the facility ' s patio. PTA took Resident 1 to the patio and left, then Certified Nurse Assistant (CNA) who was assigned to another resident at the patio went to the nursing station to let them know that Resident 1 fell on the patio. RD heard that and went to the patio with nurse and saw Resident 1 on the ground on her back. Nurse and RD evaluated Resident 1 and transferred her to her room in a wheelchair.</p> <p>During an interview on 5/20/24 at 11:35 a.m. with PTA, PTA stated Resident 1 asked PTA to take her to the patio. PTA took Resident 1 to the patio and did not inform nurses or physical therapist about Resident 1 ' s decision to go to the patio instead of her room. She left Resident 1 in the patio after a few minutes and later heard from other staff that Resident 1 had a fall in the patio. PTA stated she should have informed the nurses that Resident 1 wanted to go to the patio instead of her room.</p> <p>A review of Resident 1 ' s Minimum Data Set (MDS, a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan) section GG, indicated Resident 1 needed assistance for all activities and mobility.</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>A review of Resident 1 ' s Fall Risk Assessment, dated 3/25/24, indicted Resident 1 ' s score was 13 (high risk for falling).</p> <p>A review of Resident 1 ' s Xray, dated May 12, 2024 (after accident), indicated Resident 1 had a hip fracture.</p> <p>A review of Nurses Progress Notes, dated 5/10/24, indicated Resident 1 was suffering from pain (10/10).</p> <p>A review of the facility ' s policy and procedure Fall Management System, undated, indicated . This facility is committed to promoting autonomy by providing an environment that remains as free of accident hazard as possible .</p> <p>Based on interview and record review, the facility failed to ensure one of three sample selected residents (Resident 1) was free of accidents in the facility when Resident 1 had a fall and fracture while she was residing at the facility.</p> <p>This failure in practice resulted in Resident 1's hip fracture, suffering from pain, and hospitalization .</p> <p>Findings:</p> <p>A review of Resident 1's Face Sheet indicated, Resident 1 was admitted to the facility with multiple diagnoses including history of cognitive deficit, multiple falls and fractures, muscle weakness, neuropathy (when nerve damage leads to pain, weakness, numbness or tingling in one or more parts of your body).</p> <p>During an interview on 5/20/24 at 10:40 a.m. with Rehabilitation Director (RD), RD stated Resident 1 finished her group physical therapy and asked the Physical Therapy Aid (PTA) to take her to the facility's patio. PTA took Resident 1 to the patio and left, then Certified Nurse Assistant (CNA) who was assigned to another resident at the patio went to the nursing station to let them know that Resident 1 fell on the patio. RD heard that and went to the patio with nurse and saw Resident 1 on the ground on her back. Nurse and RD evaluated Resident 1 and transferred her to her room in a wheelchair.</p> <p>During an interview on 5/20/24 at 11:35 a.m. with PTA, PTA stated Resident 1 asked PTA to take her to the patio. PTA took Resident 1 to the patio and did not inform nurses or physical therapist about Resident 1's decision to go to the patio instead of her room. She left Resident 1 in the patio after a few minutes and later heard from other staff that Resident 1 had a fall in the patio. PTA stated she should have informed the nurses that Resident 1 wanted to go to the patio instead of her room.</p> <p>A review of Resident 1's Minimum Data Set (MDS, a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan) section GG, indicated Resident 1 needed assistance for all activities and mobility.</p> <p>A review of Resident 1's Fall Risk Assessment, dated 3/25/24, indicted Resident 1's score was 13 (high risk for falling).</p> <p>(continued on next page)</p>		

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