STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555383	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Blythe Post Acute LLC	285 West Chanslor Way Blythe, CA 92225

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 46145 Based on observation, interview, and record review, the facility failed to conduct and complete neurological assessment (neuro checks - assessment of neurological function and [LOC]-level of consciousness) for the first hour after an unwitnessed fall for one out of three sampled residents (Resident 1). This failure had the potential to result in serious consequences, including loss of consciousness, seizures (uncontrolled movements), and coma (unable to wake up) which could go undetected. Findings: On January 16, 2025, at 9:25 a.m., an unannounced visit was made to the facility for a quality-of-care issue. On January 16, 2025, at 9:35 a.m., a concurrent observation & interview with Resident 1 was conducted. Resident 1 was observed in her room, lying face down on the floor next to her bed. Resident 1 was turned over onto her back, then helped to sit on her bed, by Licensed Vocational Nurse (LVN 1) and a Certified Nursing Assistant (CNA). Observation of Resident 1, indicated, a small pinkish, discolored area of resident's right forehead. Resident 1 stated she had fallen, hit her head, and had complaints of right shoulder discomfort, and nausea. On January 16, 2025, at 9:42 a.m., LVN 1 was interviewed. LVN 1 stated, Resident 1 hit her head and stated she would initiate neurochecks every 15 minutes for the first hour, every 30 minutes for the second hour and then every 4 hours for 24 hours. LVN 1 further stated neurochecks are important to assess residents for any changes in their level of consciousness. A review of Resident 1's Resident Information, dated January 17, 2025, at, 8:31 a.m., indicated, resident was admitted to the facility on , August 30, 2024, with a diagnosis of muscle weakness and history of falling. A review of Resident 1's Brief Interview for Mental Status (a cognitive assessment), dated December 9, 2024, indicated a score of 12 (moderate cognitive impairment). A review of Resident 1's SBAR (Situation, Background, Assessment, Recommendation)/COC (Change of Condition) ASSESSMENT FORM, dated January 16, 2025, indicated, .unwitnessed fall . (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 1's progress notes dated January 16, 2025, indicated, .Resident was found on the floor by CNA(Certified Nursing Assistant) .Neuro checks implemented .Patient (Resident 1) complained of headache. Will continue to monitor per doctors ordered . A review of Resident 1's document titled NEUROLOGICAL ASSESSMENT, dated January 16, 2025, indicated, the licensed nurses did not complete Resident 1's neurological assessment during the start of neuro-checks by not assessing the resident's pupil response. In addition, the licensed nurses did not conduct a neurological assessment (pupil response, eye response, level of consciousness, speech, and motor response) after 9:55 a.m., despite the requirement for assessments every 15 minutes for the first hour following the fall. On January 16, 2025, at 10:25 a.m., a concurrent interview and observation of CNA 1 were conducted. CNA1 was observed entering Resident 1's room. CNA 1 stated, she was returning to assess Resident 1's vital signs (pulse, respirations, blood pressure, and temperature) every 15 minutes, per neuro-check policy. CNA 1 stated, other components of the neuro checks would be completed by the licensed nurse. CNA 1 stated, the licensed nurse should have returned after 15 minutes to reassess Resident 1. On January 16, 2025, at 10:36 a.m., an observation of LVN 1 was conducted. LVN 1 was seen by down the hall from Resident 1's room, working at the medication cart and passing medications to residents. LVN 1 was not observed returning to Resident 1's room to conduct a neuro check assessment between 9:55 a.m. and 10:36 a.m. On January 16, 2025, at 10:47 a.m., an interview with LVN 1 was conducted. LVN 1 stated, she notified Resident 1's physician of the resident's fall and received an order to monitor Resident 1 and conduct neuro checks. LVN 1 stated her last assessment of Resident 1 was at 9:55 a.m. and has not returned to re-assess Resident 1. LVN 1 further stated she reported Resident 1's unwitnessed fall to RN 1 at approximately 10:30 a.m. and RN 1 was to take over the monitoring and neurological assessment of Resident 1. On January 16, 2025, at 10:59 a.m., an interview with RN 1 was conducted. RN 1 stated, at approximately 10:40 a.m., she received a report from LVN 1 indicating Resident 1 had an unwitnessed fall. RN 1 stated she informed LVN 1 that she would monitor Resident 1 and conduct neuro checks per facility protocol. RN 1 stated Resident 1 should be assessed, initiate neuro-checks every 15 mins the first hour, every 30 minutes for the second hour, hourly for four hours, and then every four hours for 24 hours.RN 1 stated, she had not yet assessed Resident 1 for neuro checks. On January 16, 2025, at 11:10 a.m., an interview was conducted with the Director of Nursing (DON), who stated, the licensed nurse should monitor a resident who experienced an unwitnessed fall by conducting neuro checks assessment, at the time of the fall, every 15 minutes the first hour, every 30 minutes the second hour, hourly for 4 hours, then every 4 hours for 24 hours. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON stated neuro-check assessments are important to complete, to ensure residents who hit their head during a fall do not experience an altered level of consciousness. The DON stated physical assessments are part of the neuro-check process and are important to complete to ensure a resident did not sustain additional physical injuries during a fall. The DON verified, RN 1 and LVN 1 had not monitored & assessed Resident 1's neuro-checks for the first hour, per facility policy. The DON stated, it is her expectations licensed nurses follow facility protocol of neuro-check monitoring & assessments. The DON further stated, the facility does not have a written policy and procedure specifically for Neuro-checks. The DON stated, the procedures and time frames written on the neuro-check document, are followed. The DON further stated, Resident 1 is on a blood thinning medication (Blood thinners place a resident at increased risk for internal bleeding after a fall), and she had received orders to transfer Resident 1 to acute hospital for further evaluation.