STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555435	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Reche Canyon Regional Rehab Center	1350 Reche Canyon Rd Colton, CA 92324

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 - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47206 Based on observation, interview, and record review, the facility failed to adhere to its safety and supervision of resident ' s policy when one of the four sampled residents (Resident 1) was left unattended during patient care. This failure had the potential to put a clinically compromised resident (Resident 1) at risk for serious injury, resulting in Resident 1 falling and requiring transfer to an acute general hospital for evaluation and treatment. Findings: During a review of Resident 1's clinical record, the face sheet (contains demographic and medical information), indicated Resident 1 was admitted on [DATE] with a diagnosis that included persistent vegetative state (someone with brain damage appears to be awake but does not respond to their surroundings or perform purposeful actions). During an interview on 9/24/2024 at 2:07 p.m. with Licensed Vocational Nurse (LVN)1, LVN 1 stated the certified nursing assistant (CNA) was in the process of changing Resident 1. The CNA went to gather supplies, and upon returning, she found the resident on the floor, undressed. During a telephone interview on 9/25/2024 at 5:34 p.m. with Certified Nursing Assistant (CNA)1, CNA 1 stated she was finishing changing Resident 1 when he started urinating. She covered him and went to get supplies like a brief and washcloth. As she was putting these down, she heard Resident 1 fall. CNA 1 reported she was uncertain of how Resident 1 fell . During a review of Resident 1 ' s progress note, dated September 2024, the progress note indicated, Resident 1 fell on [DATE] at 6:18 a.m. while the CNA was at the room door putting on an isolation gown. It was noted that Resident 1 sustained a cut to the left side of his forehead with moderate amount of blood, G-tube (Gastrostomy tube - a surgically placed tube that delivers food, medicine, and hydration, directly to a patient ' s stomach) was also dislodged as a result of the fall incident. Resident 1 was transferred to an acute general hospital for further evaluation. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/26/2024 at 1:00 p.m. with the assistant director of nursing (ADON) 1, ADON 1 stated when Resident 1 coughs, he tends to lean forward, which is why the nurses are monitoring him. I informed ADON 1 that if Resident 1 had the tendency to lean forward when he coughs, fall precaution and appropriate preventive measures should have been implemented such as bed alarm, and relocating the resident closer to the nurses ' station for better monitoring to prevent falls. ADON 1 did not give a direct response to my statement. Instead, ADON 1 stated the facility is trying to place Resident 1 closer to the nursing station for easier and more frequent monitoring. During a review of the undated facility provided policy and procedure (P&P) titled, Safety and Supervision of Residents, the P&P indicated, Resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the individual resident ' s assessed needs and identified hazards in the environment.