STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555710	A. Building B. Wing	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tice Valley Post Acute	1975 Tice Valley Blvd. Walnut Creek, CA 94595

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. 36087 Based on observation, interview, and record review, the facility failed to provide appropriate safety measures and adequate supervision to prevent one of three residents (Resident 1) from slipping out of bed and falling on the floor during incontinence care. The failure to provide adequate measures to prevent a dependent resident from slipping off the bed and falling onto the floor during incontinence care, resulted in Resident 1 being transported to the emergency department for further evaluation, requiring 15 stitches to maintain closure of the laceration (cut) on the right lower leg, and fracturing (partial or complete break in the bone) their right shoulder. Findings: A review of Resident 1's Admission Record, printed 12/12/24, indicated Resident 1 was admitted to the facility in 2016 with diagnoses of dementia (memory loss), diabetes (high blood sugar), essential tremor (a nervous system disorder that cause rhythmic shaking), and morbid obesity (having too much body fat). A review of Resident 1's Minimum Data Set (MDS, resident assessment tool used to provide care), dated 10/21/24, indicated Resident 1 had clear speech, was understood, and was able to understand others. The MDS indicated Resident 1 was dependent (helper does all the effort. Resident does none of the effort to complete the activity. Or the assistance of two or more helpers is required for the resident to complete the activity) on most Activities of Daily Living (ADLs, the basic self-care tasks an individual does on a day-to-day basis) including toileting hygiene, shower/bathe self, and lower body dressing. The MDS also indicated resident required substantial/maximal assistance (the helper does more than half the effort of lifting or holding trunk or limbs) when rolling from lying on back to left and right side and return to lying on back on the bed. The MDS further indicated Resident 1 had a urinary ostomy (a surgical opening in the belly to re-direct urine away from the damaged bladder) and was always incontinent (no voluntary control of feces) of bowel (defecation). A review of Resident 1's Care Plan titled, Falls: Resident is at risk for falls with or without injury related to . dementia, bipolar disorder, essential tremor ., date initiated 7/8/24, indicated a goal of, Will minimize complications related to falls to extent possible The care plan interventions/tasks indicated, Anticipate and meet needs . (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 1's clinical record titled, Situation, Background, Appearance, Review and Notify (SBAR) Communication Form, dated 11/4/24, at 5:36 a.m., indicated resident had a fall, with a pain intensity of 10 (rate on scale of 1-10, with 10 being the worst). The SBAR indicated, Resident laying on her back on the floor, screaming, stating, I am in so much pain all over. A review of Resident 1's Nursing Progress Notes, dated 11/4/24, at 8:21 a.m., by Licensed Vocational Nurse 1 (LVN 1), LVN 1 indicated Resident 1 had a witnessed fall on 11/4/24, at around 5:15 am; LVN 1 found resident in prone position (lying on her stomach) in between the bed and wooden furniture, so LVN 1 and CNA 1 assisted the resident down to the floor on her back. The Progress Notes also indicated resident complained of right arm pain, requested to be sent out to the Emergency Department (ED), and was sent out to the hospital via 911 (an emergency call/code) for evaluation. During a telephone interview on 1/13/25, at 3 p.m., with Certified Nursing Assistant 1 (CNA 1), CNA 1 stated she was with the resident when Resident 1 slowly slipped out of the bed during incontinent care. CNA 1 stated she was positioned on the left side of the bed, while resident was turned to the opposite side facing the window. As the resident grabbed on to the headboard frame, CNA 1 stated her one hand was on the resident's waist while CNA's other hand applied the brief under the resident. CNA 1 stated she tried to pull the resident back toward her, but resident rolled out of the bed in a prone position, in between the bed and wooden furniture. CNA 1 stated she yelled for help and together with LVN 1, they assisted the resident down to the floor on her back. During a telephone interview on 1/14/25, at 12 p.m., with LVN 1, LVN 1 stated during night shift while he was in the hallway doing rounds, LVN 1 heard someone from a resident room yelling for help. LVN 1 stated he went to Resident 1's room and saw CNA 1 held on to Resident 1 in prone position in between the bed and wooden furniture, so LVN 1 and CNA 1, with the help of the other staff members who came and rushed to the room assisted the resident down to the floor on her back. LVN 1 stated Resident 1 complained of pain, was bleeding, and wanted to be sent out to the hospital for further evaluation, and 911 was called. During an interview on 1/15/25, at 12:15 p.m., with Resident 1, in her room, Resident 1 stated during that early morning, as she was being changed by CNA 1, CNA 1 pushed her too hard that resident slipped from the bed. Resident stated her right arm fell first and resident used this to support herself up, but her arm gave up and resident fell on to the floor in a prone position. Resident 1 stated she was taken to the hospital where they took an X-ray (X-radiation, a quick, painless test to create images of the inside of the body) of her right arm and fixed the laceration to her right lower leg. At this time during the interview, Resident 1 started crying as she continued with her recollection of the incident. Resident stated she felt bad that this had happened to her and continued to feel upset whenever the incident was discussed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 1's hospital record titled, After Visit Summary, dated 11/4/24, indicated special instructions upon resident's return to facility, 1. The unna boot (a semi-rigid compression bandage that treats leg ulcers, sprains, strains, and other conditions) was applied to the leg laceration. Stiches were placed for the leg wound. WOUND CARE CLINIC NEED TO EVALUATE THE WOUND FOR FURTHER CARE. 2. PLEASE START TAKING ANTIBIOTICS TO PREVENT INFECTION OF THE AREA. 3. If you develop fevers, new or worsening symptoms then please return to the emergency room (ER). 4. The right greater tuberosity (a bony bump at the top of the humerus bone in the shoulder) is fractured and the orthopedic clinic will follow up, a referral is ordered. Keep the sling in place until told otherwise and evaluated by orthopedic surgery. Further review of the resident 1's hospital record indicated an antibiotic (a drug that treats bacterial growth) order of Cephalexin (Keflex) 500 milligram (mg) capsule, take one capsule by mouth two times a day for seven days. A review of the facility's policy and procedure (P&P) titled, Falls and Fall Risk, Managing, revision date 2001, indicated, .The staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling .A fall is defined as: Unintentionally coming to rest on the ground, floor, or other lower level, but not as a result of an overwhelming external force .An episode where a resident lost his or her balance and would have fallen, if not for another person or if he or she had not caught him/herself, is considered, a fall. A fall without injury is still a fall. Unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred .