STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555772	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Joshua Tree Post Acute	8515 Cholla Ave Yucca Valley, CA 92284

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** 47098 Based on interview and record review, the facility failed to ensure their fall prevention policies and procedures were implemented for one of three sampled residents (Resident 1). This failure resulted in Resident 1 to fall on March 27, 2024, sustained an injury (subdural hematoma-occurs after a head injury such as a fall) necessitating admission to the acute hospital to intensive Care Unit (ICU) trauma for a higher level of care. Findings: During a review of Resident 1 ' s Admission Record (a document that contains resident ' s information that includes admitted , demographic information, and medical history) dated April 3, 2024, the admission record indicated Resident 1 was admitted to the facility on [DATE], with the diagnoses which included dementia (a condition was a person experiences a decline in their memory, thinking and reasoning skills), lack of coordination (difficulty on maintaining balance), and muscle weakness (lack of muscle strength). During a review of Resident 1 ' s Minimum Data Set (MDS) Under Section C- Cognitive Patterns (section used to determine a resident cognitive functioning status), dated February 20, 2024, indicated Resident 1 had a Brief Interview for Mental Status (BIMS a score 0-15 used to determine cognitive functioning) score of 99 (99 indicate the resident was unable to complete the interview. During a review of Resident 1 ' s Minimum Data Set (MDS) under Section GG - Functional Abilities and Goals (Section used to indicate the level of assistance), dated February 20, 2024, it indicated Resident 1 needed substantial or maximal assistance (Helper does more than half the effort) during sit to stand. During a review of Resident History and Physical (H&P) dated March 18, 2024, it indicated Resident 1 does not have the capacity to understand and made decisions. During a review of Resident 1 ' s Fall Risk assessment dated [DATE], at 5:50 PM, indicated Resident had a score of 18 (If the total score 10 or greater, the resident is on a high risk for potential falls). (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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NAME OF PROVIDER OR SUPPLIER Joshua Tree Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 8515 Cholla Ave Yucca Valley, CA 92284	

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1 ' s SBAR - Change of Condition Report (Situation, Background, Assessment and Recommendation is a communication tool used in healthcare settings) dated, March 27, 2024, at 6:03 PM, it indicated 7. Behavior resident is not compliant with it comes to calling for help and tries to get out of bed and wheelchair on his own. During a review of Resident 1 ' s IDT Post Fall Review (IDT-team composed of staff from various disciplines) dated March 28, 2024, at 7:19 AM, in indicated . Per LVN (License Vocational Nurse) report, resident was found on the floor by nursing staff in common area (outside of room [ROOM NUMBER]), left side lying in front of wheelchair with both wheelchair locks in the unlocked position. Resident was observed with eyes open and full movement of upper extremities attempting to get themselves up from off the floor . Interventions: resident was sent to ER (emergency room) for further evaluation . During a review of Resident 1 ' s undated care plan for falls (an individualize plan of care) indicated, resident is capable of unlocking w/c (wheelchair) and propels self through hallway. Goal, resident will remain free from falls r/t (related to) independently propelling self through facility, interventions .maintain visual checks for resident safety . During a review of Resident 1 ' s care Plan for falls (an individualize plan of care) undated, indicated Resident 1 is at risk for falls/injury related to: difficulty walking, gen (general) weakness, history of falls, impaired cognition, poor balance, poor safety awareness .interventions visibly observe resident frequently . During a review of Resident 1 ' s care plan for high risk for falls r/t (related to) confusion dated March 12, 2024, indicated Unaware of safety needs .Goal, Resident 1 will be free for falls .Interventions .follow facility fall protocol, [NAME] and [NAME] for Fall Prevention . During a review of Resident 1 ' s Admission H & P EMR (admission history and physical of emergency medical record) dated March 27, 2024, at 9:58 PM, it indicated, M (male) BIBA ([NAME] by ambulance) as transfer from (acute hospital name) for ground level fall .Workup at outside of facility subdural hematoma with midline shift (a condition where blood accumulate and put pressure on the brain) . During a review of Resident 1 ' s Nursing Note dated March 30, 2024, at 2:01 PM, it indicated Resident [Resident 1] is admitted to ICU (intensive care unit) trauma. Resident is s/p (status post) neurosurgery / craniotomy (surgery in the skull) for removal of subdural hematoma after recent fall . During a telephone interview on April 3, 2024, at 4:15 PM with the Administrator (Admin), the Admin stated leaving Resident 1, who has cognitive impairment and high risk for falls, without supervision was not a safe practice. During a telephone interview on April 3, 2024, at 6:41 PM with Certified Nurse Assistant, (CNA 1), CNA 1 stated that prior to the start of the shift on the day of Resident 1 ' s fall incident, they did not have a huddle. CNA 1 further stated there was a lack of communication between license nurses and CNA ' s. During an interview on April 8, 2024, at 10:06 AM, with CNA 2, CNA2, indicated that no huddle had occurred on that day or on any other day. CNA 2 expressed concerns regarding lack of communication between licensed nurses and CNAs regarding resident care. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on April 8, 2024, at 11:05 AM with CNA 3, CNA 3, stated on March 27, 2024, they did not have a huddle the day when Resident 1 fell . During a review of the facility ' s policy and procedure titled [NAME] and [NAME] - Fall Prevention Program dated 2015, indicated, 2. Any resident who fell withing the 3-month period would be given yellow bands until they graduate off the [NAME] and [NAME] Program. 5. Management will identify a [NAME] and [NAME] Champion per shift for continuous re-education to staff on the floor. High fall risk residents should be mentioned every huddle for reinforcement . During a review of the facility ' s policy and procedure (P&P) titled Safety and Supervision of Residents undated, indicated Facility - Oriented Approach to Safety 1. Our resident-oriented approach to safety address risk identified based on assessments .Individualized, Resident -Centered Approach to Safety .10. Implementing interventions to reduce accidents risk and hazards shall include the following: a. Communication specific interventions to all relevant staff .c. Ensuring that interventions are implemented; and d. Documenting interventions . During a review of the facility ' s policy and procedure (P&P) titled Falls - Clinical Protocol undated indicated Treatment / Management 1. Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address risk of clinically significant consequences of falling .2. If the underlying causes cannot be readily identified or corrected, staff will try various relevant interventions, based on assessments of the nature or category of falling, until falling reduces or stops or until a reason is identified for its continuation (for example, if the individual continues to try to get up and walk without waiting for assistance) .Monitor and Follow -Up .2. The staff and physician will monitor and document the individual ' s response to interventions intended to reduce falling or the consequences of falling.