STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555928	A. Building B. Wing	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgeview Skilled Nursing Facility	9825 Glen Center Drive San Diego, CA 92131

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. (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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to implement interventions consistent with resident's needs to eliminate or reduce the risk of falling for one of four residents (Resident 1) reviewed for accidents when: Adequate assistance was not provided to Resident 1, who required total assistance with activities of daily living (ADL-bathing or showering, getting in and out of bed or a chair, turning, walking, toileting and eating). This failure resulted in Resident 1 falling off the bed.Findings:Resident 1 was readmitted to the facility on [DATE] with diagnoses including hemiplegia (total or partial paralysis of one side of the body) and hemiparesis (muscle weakness on one side of the body) following other cerebrovascular disease (a condition affecting blood flow and blood vessels in the brain) affecting the left side and left femur (thigh bone) fracture according to the facility's admission Record. During a review of Resident 1's Minimum Data Set (MDS- a federally mandated resident assessment tool) dated 8/6/25, section C0500 indicated Resident 1's Brief Interview for Mental Status (BIMS- evaluates cognition, the ability to remember and think clearly) score was 15, intact cognition. During an observation and interview on 8/14/25 at 1:33 pm with Resident 1, Resident 1 stated he had fallen from bed when his brief was being changed. Resident 1 was in bed that was narrow (similar to a twin sized bed) with an air mattress. Resident 1's feet were at the edge of the lower part of the mattress. Resident 1 stated staff turned him to his left side and had nothing to hold on to, so he rolled off the bed, and landed on the floor. Resident 1 stated he sustained a fracture on his left leg and asked for pain medication as needed. A review of Resident 1's fall risk evaluation dated 6/30/25 was conducted. The fall risk evaluation indicated a score of 10, high risk for falls. A review of Resident 1's care plans in the electronic medical record was conducted. The care plan dated 7/1/25 indicated Resident 1 was at risk for falls related to multiple medical diagnoses including a history of cardioembolic (blood clot that originated from the heart) stroke resulting in left sided hemiparesis and vertigo (dizziness). An interview was conducted on 8/14/25, at 1:40 P.M. with certified nurse assistant (CNA) 1 who was assigned to Resident 1. CNA 1 stated during repositioning and brief change, Resident 1 assisted by holding on to a bedside table. CNA 1 stated since the bed did not have bedrails and the bed was narrow, he used a bedside table for Resident 1 to hold on to. During an interview on 8/14/25 at 1:58 P.M. with licensed nurse (LN) 1, LN 1 stated Resident 1 had weakness on the left side due to a stroke. LN 1 stated since Resident 1's bed was narrow; Resident 1 may need something to hold on to during repositioning. An interview on 8/29/25 at 11:45 A.M. was conducted with CNA 3. CNA 3 stated on 7/30/25 at approximately 5 A.M., she answered Resident 1's call light. CNA 3 stated Resident 1 needed his brief to be changed. CNA 3 stated Resident 1 was laying on a pad which she pulled close to her while Resident 1 was on lying on his back. CNA 3 stated she then turned Resident 1 to Resident 1's left side while holding on Resident 1's shoulder and hip. After turning, CNA 3 stated she held on to Resident 1's right hip. CNA 3 stated she needed more wipes, so she let go of Resident 1's hip to pull out wipes from a package on Resident 1's bed. CNA 3 stated Resident 1's legs went over the side of the bed and Resident 1 rolled off the bed and landed on the floor. CNA 3 stated Resident 1 was petite but long and she did not think of putting something like a bedside table on the other side of the bed for Resident 1 to hold on to. During a review of the MDS for Resident 1 dated 8/6/25, the MDS section GG0170A functional abilities indicated Resident 1's ability to roll.left and right side, and return to lying on back on the bed was coded 01 Dependent.Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity. An interview with the Director of Nursing (DON) was conducted on 8/22/25 at 2:13 P.M. The DON stated she expected CNAs to be familiar with providing care for residents and if there was a concern to communicate to the nursing staff to evaluate the resident's risk for fall. The DON stated she was not aware of concerns regarding providing care for Resident 1. A review of the facility's policy and procedures (P&P) titled, Falls Intervention Policy and Procedure, dated 4/9/25 was conducted. The P&P indicated, All resident will be evaluated for risk of falling.Residents who are identified as high risk will be care planned and individualized precautions will be noted.