STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555060	A. BUILDING _____ B. WING _____	C 03/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR THE RIDGE REHABILITATION CENTER	350 IRIS DRIVE SALINAS, CA 93906

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH
MAR 2 2 2016
LICENSING & CERTIFICATION DIVISION
SAN JOSE

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during an abbreviated survey regarding a complaint investigation conducted from 2/3/16 through 3/11/16. For Complaint CA00473782 regarding Quality of Care/Treatment, a federal deficiency was identified (see F323). A Class "B" Citation was also identified. Inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility. Representing the California Department of Public Health: 30366; Health Facilities Evaluator Nurse.	F 000	**"Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusions set forth on the Statement of Deficiencies. This plan of Correction is prepared and/or executed solely because it is required by the provisions of Health and Safety Code Section 1280 and 42 CFR 483 et seq."** [redacted] **F-323** **CORRECTIVE ACTION:** CNA "A" was re-in serviced by DSD on Lifting Residents by use of Mechanical Devise and safe patient preparation on 01/06/16. Competency checklist was also conducted by DSD on 01/06/16 to ensure compliance of understanding of CNA "A". Resident "2" has had no further falls. Total ADL care being given ongoing along with continued Hoyer Lift transfers with the assistance of 2 staff members.	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure Resident 2 was free from an avoidable accident. The resident had a fall from his bed on 12/28/15 resulting in a fractured right lower tibia/fibula, and subsequent above the knee amputation of the same leg. The	F 323		01/06/16 [redacted]

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [redacted] TITLE (X6) DATE 3/22/16

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.

3/16/16 POC accepted with administrator 4:30pm in facility. [redacted]

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F 323	Continued From page 1 facility failed to follow its established policy and procedure in lifting residents by use of a mechanical device and follow the safety recommendations of the mechanical device manufacturer. These failures resulted in Resident 2 falling from his bed resulting in a fractured leg with subsequent amputation. Findings: A review of Resident 2's clinical record indicated Resident 2 was admitted to the facility on 2/28/03 with numerous diagnoses including, hereditary hemorrhagic telangiectasia (HHT abnormal blood vessel formation in skin and organs) unspecified dementia, COPD (chronic lung disease), mental disorder secondary to physical condition, high blood pressure, and hypothyroidism (low performing gland causing fatigue and sluggishness). A review of Resident 2's fall risk assessment dated 12/13/15 indicated that Resident 2 had a "moderate risk" fall level. Resident 2 had a non-injury fall earlier in the year on 2/22/15. Review of the facility's 12/2012 policy, "Falls Management," indicated, "residents will be assessed for fall risk and interventions will be implemented to reduce the risk of falls." Resident 2's Minimum Data Sets (MDS, an assessment tool), dated 9/2/15 and 12/2/15, indicated he was severely impaired, required extensive assistance with 2+ persons in bed mobility, transfer, dressing, bathing, and toileting. He was totally dependent on staff. Resident 2's Fall Care Plan dated 3/11/2013	F 323	DSD in-serviced the CNA's and Licensed staff proper positioning of the Hoyer Lift residents along with the P&P of Hoyer Lift use. Conducted on 01/04/16, 01/06/16, 01/19/16, 01/25,16, 01/26/16, 02/10/16. **IDENTIFICATION:** All Hoyer Lift residents may have the potential for the same deficient practice. DSD conducted a visual check on all resident Hoyer Lift and Easy Stand transfers conducted by the CNA's. This was completed on 1/30/2016 and found safe transfers in place.	1/4/16 1/6/16 1/19/16 1/25/16 1/26/16 2/10/16 [redacted] 1/30/16 [redacted]

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F 323	Continued From page 2 indicated he was a fall risk relative to his history of falls, use of heart medications, poor safety awareness, and decline in functional status. The interventions used were putting the bed in the lowest position, fall mat on the floor, and sensor pads on the bed and wheelchair. Another care plan addressed Resident 2's self-care deficit in bathing, hygiene, dressing, toileting and transfer (how resident moves between surfaces including to or from, bed, chair, wheelchair or standing position). Additionally, there was a care plan addressing Resident 2's cognitive loss/dementia causing impaired decision making. During an interview with the facility regional quality manager (RQM) on 2/4/16 at 11 a.m., she stated certified nurse assistant A (CNA A) was attending to Resident 2's ADLs, had gotten him changed, dressed and was getting ready to put him in the wheelchair at bedside. The lifting sling was underneath Resident 2 while he was flat on his back. The beds do not have side rails, but bars at the head of the bed. CNA A went out to get the lifting device located outside Resident 2's room. When CNA A returned to the room, Resident 2 was on the floor. Resident 2's bed was at medium height while the ADLs were being performed. CNA A alerted the charge nurse, licensed nurse B (LN B) who assessed Resident 2 and he was placed back in bed. During an interview with charge nurse, LN B, on 2/4/16 at 2:15 p.m., she stated, CNA A came to her and told her Resident 2 fell out of bed. LN B went to the room, and saw Resident 2 was on his back on the floor. Resident 2 stated, "I slide off from the bed." The resident had a mild abrasion on his left forehead. LN B further stated the resident slid off the bed with the lift pad under him	F 323	**MEASURES TO PREVENT REOCCURANCE:** All Nursing dept. shall be in-serviced the proper safety use of Hoyer Lifts to prevent resident falls or injury upon hire and annually **All licensed staff , DSD and DON shall visually monitor while making daily rounds, the proper use of mechanical lifts. Any issues shall be immediately corrected and in-services revisited.**	

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F 323	Continued From page 3 and he usually used side rails to hold on to as he does not want to fall. During an interview with CNA A on 2/4/16 at 2 p.m., she stated she was a regular caregiver for Resident 2 and was familiar with his level of care needs. She stated he fell out of bed and landed on his right side. CNA A stated that it takes two CNAs to lift Resident 2 onto the lift device and two CNAs to use the lifting device. She further stated that she left Resident 2 on the lifting sling on his bed and went to get the lift device out in the hallway. When CNA A returned to Resident 2, he was on the floor. During an interview with LN C, the director of staff development, on 2/5/16 at 1:55 p.m., she stated she trains the facility CNAs in skills training upon hire, annually, and as needed. "How I train them is when you get ready to use the Hoyer lift, there is the prepping stage, then the assist/lift stage. The prepping stage is the resident's clothes are on, the Hoyer pad is placed underneath them. One CNA is able to do this. The CNA then goes to get the machine. Lifting stage, two people need to be there for the transfer part itself, always. Was working on day [Resident 2] had fall. Passed by his room just second before fall, then immediately after and saw him on the floor, on his left side facing the door." Review of the nurses note dated 12/28/15 at 1022 late entry, indicated "Resident found on floor by CNA, resident was ready to get up to the W/C (wheelchair), CNA left him on top of the bed with the Hoyer pad under him, she said she went to bring the Hoyer lift to transfer resident to the W/C, so when she come back resident was on	F 323	The DSD shall continue the Monthly S.M.A.R.T Program. This teaches safe movement and resident transfer to Nursing staff. A log will be maintained, by the DSD of the monthly participants. **MONITORING AND INCORPORATION INTO THE QA&A SYSTEM:** The DON shall report all incidents and accidents to the monthly QAPI meeting for further discussion and resolutions if warranted.	

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F 323	Continued From page 4 the floor. Nurse practitioner was notified and she assess the resident like 1330." Per review of Interdisciplinary (IDT) Progress Notes dated 12/31/15 at 1446, revealed present at the meeting were the Regional Quality Manager, director of nursing, and director of staff development. "The resident was in bed underneath his Hoyer lift pad. The CNA left to get the hoyer lift and another staff member for assistance. By the time they returned (about three minutes later) the resident was found on the floor with the hoyer pad still underneath him....Explained to responsible party (RP) when the resident fell on 12/28/15 that nurse practitioner and nurse assessed patient he had no apparent injury. On 12/30/15 some deformities were noted. NP assessed resident and ordered x rays to rule out fx (fracture) to R (right) lower leg. RP stated that the nurse practitioner called him yesterday and left a message. Explained to him if the resident does have a fracture it is mostly r/t (related to) his fall from 12/28/15. Resident does not ambulate, is transferred via hoyer lift and needs mostly total assistance with bed mobility." A review of the nurse practitioner progress note dated 12/31/15 at 1730 "xray: Acute comminuted shattered) fx of the distal fibula and tibia with medial angulation. Send to local hospital to stabilize fracture with a splint." Review of the facility policy and procedure dated 11/2012 disclosed, "Lifting Residents by Use of Mechanical Device" indicated in underlining "Facility staff are to follow the manufacturer's instructions for use of each specific type of lifting machine. In addition, a minimum of 2 staff members should be used to reduce risk of staff or	F 323	The Monthly S.M.A.R.T Program Log shall be brought to the monthly QAPI meeting for discussion and further resolutions if warranted by DSD. **COMPLETION:** 3/16/16	3/16/16 [redacted]

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F 323	Continued From page 5 resident injury." The transfer lift utilized to lift Resident 2, per the manufacturer's manual indicated "Invacare recommends that two assistants be used for all lifting preparation, transferring from or transferring to procedures...."	F 323		