STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555859	A. BUILDING _____ B. WING _____	**03/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
KINDRED HOSPITAL BREA D/P SNF	**875 N BREA BLVD BREA, CA 92821**

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** Based on observation, interview, and medical record review, the facility failed to thoroughly investigate the occurrence of falls for two of three sampled residents (Residents 1 and 3). * Residents 1 and 3 had the unwitnessed falls in the facility; however, the facility failed to conduct the interviews with staff members to identify the cause of the residents' falls. This failure had the potential for Residents 1 and 3 to suffer from recurrent falls and injury. Findings: Review of the facility's P&P titled Fall Response and Management revised 2/14/1, showed if the fall is unwitnessed, evaluate the resident for injury, investigate the cause of the fall, and revise the plan of care, as appropriate. 1. On [DATE] at 0913 hours, an observation of Resident 3 was conducted. Resident 3 was in bed, asleep. Resident 3's bedside was observed with bilateral floor mats. A private caregiver was observed sitting at Resident 3's bedside. Resident 3's call light was observed within his reach and his bed was in a low position. Medical record review for Resident 3 was initiated on [DATE]. Resident 3 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Review of the MDS dated [DATE], showed Resident 3 had severe cognitive impairment and required total assistance of two persons with transfers. Review of Resident 3's Clinical Notes Report, showed Resident 3 had suffered from falls on 1/9, 1/15, and 1/17/2020, since his admission to the facility. a. Review of Resident 3's Post Fall Investigation dated 1/9/2020, showed Resident 3 had an unwitnessed fall on 1/9/2020 at 1615 hours. Resident 3 was found kneeling on the floor mat at the right side of his bed. Resident 3 was found without any injuries. The document listed confusion and Resident 3's history of falls as the contributing conditions for the fall. The area to document the distance from a transfer surface or activity during or at the time of the fall were left blank. Review of Resident 3's Event Investigation dated 1/9/2020, showed an attached Interview Record dated 1/9/2020. The Interview Record failed to show any interviews conducted with the staff or possible witnesses to Resident 3's behavior or activities prior to the fall. On [DATE] at 1515 hours, an interview was conducted with the Executive Director. The Executive Director verified staff interviews were not conducted as part of the fall investigation. b. Review of Resident 3's Post Fall Investigation dated 1/15/2020, showed Resident 3 had an unwitnessed fall. Resident 3 was found kneeling down on the floor and was found without any injuries. The investigation identified Resident 3 was confused and was trying to get out of bed unassisted. Review of Resident 3's Event Investigation dated 1/15/2020, showed Resident 3 suffered a fall on 1/15/2020 at 1230 hours. The investigation showed Resident 3 received therapy prior to the fall. However, the investigation reports did not show any interviews with the staff regarding Resident 3's behavior or activities prior to the fall. On [DATE] at 1515 hours, an interview was conducted with the Executive Director. The Executive Director verified staff interviews were not conducted as part of the fall investigation. c. Review of Resident 3's Post Fall Investigation dated 1/17/2020, showed Resident 3 had another unwitnessed fall on 1/17/2020 at 1900 hours. Resident 3 was found on the floor of his room. The investigation listed Resident 3's unsteady gait, history of falls, non-compliance and incontinence as contributing factors for the fall. The area to document the position the resident was found such as the position of their limbs, the distance from a transfer surface to the ground, or the activity during or at the time of the fall were left blank. Review of Resident 3's Event Investigation dated 1/17/2020, showed Resident 3 was sitting on the floor mat next to his bed. The investigation showed an interview was conducted with one CNA. However, the investigation did not show any other interviews were conducted with other staff members regarding Resident 3's behavior or activities prior to the fall. On [DATE] at 1515 hours, an interview was conducted with the Executive Director. The Executive Director verified the above findings. The Executive Director stated it is important to interview direct care staff because they know the residents well and they provide information that would be pertinent to why the resident fell . 2. On [DATE] at 0625 hours, Resident 1 was observed sleeping in bed with bilateral upper side rails elevated. Medical record Review for Resident 1 was initiated on [DATE]. Resident 1 was readmitted to the facility on [DATE]. Review of Resident 1's Clinical Notes Report showed Resident 1 had an unwitnessed fall on 2/5/2020 at 0315 hours. Resident 1 was found sitting on the floor, leaning against the bed with her legs crossed. Record review of Resident 1's Post Fall Investigation dated 2/5/2020, showed Resident 1 had an unwitnessed fall on 2//5/2020 at 0315 hours, and was found sitting on the floor leaning against the left side of her bed. The area to document the resident's activity during or at the time of the fall were left blank. Review of Resident 1's Event Investigation dated 2/5/2020, showed Resident 1 was found sitting on the floor. The investigation did not show any staff interviews regarding Resident 1's behavior or activities prior to the fall. On [DATE] at 1530 hours, an interview was conducted with the Executive Director. The Executive Director stated the investigation was not thoroughly conducted. The Executive Director stated it was important to interview the direct care staff because they could have provided information that would help finding the cause of the fall and could help in preventing future falls.

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

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.