STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555565	A. BUILDING _____ B. WING _____	**06/02/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WINDSOR PALMS CARE CENTER OF ARTESIA	**11900 E. ARTESIA BLVD. ARTESIA, CA 90701**

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 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop a care plan that described the services and staff interventions to be provided to the resident to maintain the resident's safety for one of three sampled residents (Resident 1), who was at a high risk for fall. This deficient practice or the lack of care plan interventions resulted in the resident' s fall and sustained acute non-displaced [MEDICAL CONDITION] metacarpal bone (break of 4th finger bone within the palm). Findings: On 6/19/18 at 8:45 a.m., an unannounced visit was made to the facility to investigate a facility reported incident regarding the resident safety. A review of Resident 1's Face Sheet (admission record) indicated that the facility admitted the resident on 3/21/18 and readmitted the resident on 4/30/18. Resident 1's [DIAGNOSES REDACTED]. A review of Resident 1's Minimum Data Set (MDS), a resident assessment and care-screening tool, dated [DATE]3/18, indicated the resident's cognition was intact. The MDS indicated that Resident 1 required extensive assistance from one to two persons to perform activities of daily living such as bed mobility (movement in lying position and turning from side to side), transfers from one surface to another, dressing, toilet use, and personal hygiene. The MDS indicated that Resident 1 used a wheelchair for mobility. A review of Resident 1's medical record, titled Fall Risk assessment dated [DATE], documented by Registered Nurse (RN 1). indicated the resident was identified as at high risk for fall. The Fall Risk Assessment indicated that RN 1 assessed the resident as being unable to independently come to a standing position, exhibiting a loss of balance while standing, and requiring hands-on assistance to move from place to place, categorizing the resident as a high risk for fall. This record review was conducted with the Assistant Director of Nursing (ADON). A review of Resident 1's medical record titled, Physical Therapy Initial Evaluation dated 3/22/18, indicated Resident 1 was at risk for falls due to physical impairments and associated functional deficits. A review of Resident 1's care plan from 3/22/18 to 3/28/18, indicated no plan of care developed to address the problem of resident at high risk for falls. A review of Resident 1's Progress Notes dated 3/29/18 at 9:01 a.m., indicated at around 8:45 a.m., the resident's left hand was swelling and a bruised on the palm. The resident was asked what happened, the resident stated, The bed rocked like a boat and I fell in between the bed and the nightstand, I landed on the floor and must have hurt my hand. The physician was notified and ordered X-ray of the left hand. The Progress Noted dated 3/29/18 at 15:14 (3:14 p.m.) indicated receiving Resident 1's left hand X-ray result with positive findings of 4th metacarpal acute non displaced [MEDICAL CONDITION]. The notes indicated the physician was notified and ordered to apply splint to the 4th metacarpal temporarily to immobilized the affected finger and to consult with specialized physician. A review of Resident 1's Radiology Results Report dated, 3/29/18 at 1:42 p.m. indicated that Resident 1 had an acute non-displaced [MEDICAL CONDITION] of the fourth metacarpal bone. During an interview on 6/20/18 at 11 a.m., the ADON stated that the RN Supervisor or the MDS nurse is responsible for initiating the care plan after they identify the problem. During an interview on [DATE] at 7:09 a.m., RN 1 stated that she performs a resident admission assessment each time the facility admits a new resident, which includes a fall risk assessment. She creates a care plan when she identifies a concern during the evaluation. RN 1 stated that she could not recall admitting Resident 1 on 3/21/18 but recalls doing a fall risk assessment on the resident. RN 1 stated that it was almost the end of her shift when she did the fall risk assessment and had no time to make a care plan for the resident since she had other important responsibilities to fulfill. She stated that she endorsed the making of the care plan to the dayshift nurse but was not able to follow-up when she returned to work. RN 1 stated that providing a low bed, floor mats, bed alarm, fall risk indicators, and PT/OT services, would be the interventions in a care plan for a resident who is a high risk for fall. During an interview on [DATE] at 2:15 p.m., Licensed Vocational Nurse 1 (LVN 1) stated that he never had Resident 1 under his care prior to his shift on 3/28/18. During his shift, he asked Resident 1's certified nurse assistant (CNA) if the resident takes any sleeping pill since the resident was still awake at 10 p.m. The CNA replied that Resident 1 takes a sleeping pill. LVN 1 stated that he [MEDICATION NAME] but could not recall the name of the CNA who gave him that information. LVN 1 stated that Resident 1 was not a fall risk and did not have any fall risk interventions in place. During an interview on [DATE] at 2:45 p.m., CNA 1 stated that he was the CNA for Resident 1 on 3/28/18, 3-11 p.m. shift but could not recall LVN 1 asking him if the resident had a sleeping pill. A review of Resident 1's Medication Administration Record [REDACTED]. The MAR indicated [REDACTED]. A review of the facility's policy and procedure titled, Care Plan revised, November 2017, indicated it is the policy of this facility to develop, upon admission and following completion of the admission nursing assessment, an interim and comprehensive care plan for the resident. A baseline care plan will be implemented within 48 hours of admission. The comprehensive care plan must describe the services that are to be furnished to attain or maintain the resident's highest physical, mental and psychosocial well-being.

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