| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **555768** | A. BUILDING _____ B. WING _____ | **03/10/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **SERENTO ROSA** | **17803 IMPERIAL HIGHWAY YORBA LINDA, CA 92886** |

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<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, and medical record review, the facility failed to provide adequate supervision and assistive devices to prevent one of two sampled residents (Resident 1) from falling, which had the potential to negatively affect the resident's well being. Findings: Medical record review for Resident 1 was initiated on 2/7/2020. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's MDS dated [DATE], showed Resident 1 had severe cognitive impairment. Review of Resident 1's SNF Initial history and physical examination [REDACTED]. Review of the facility's document titled Falls Investigation Worksheet dated 12/22/19, showed on 12/22/19 at 2346 hours, Resident 1 had an unwitnessed fall in his room. Under the section for Recommendations/Interventions, it showed to place floor mats, conduct neuro checks, monitor increased risk for bleeding (related to fall with head injury/pain). The investigation showed Resident 1 attempted to get up unassisted to go the bathroom and fell . Review of the MDS for Resident 1 dated 12/28/19, Resident 1 needed extensive assistance with two persons to assist him for his bed transferring and walking in his room.<br>Review of the plan of care for Resident 1 showed a care plan problem with a creation date of 12/22/19, addressing Resident 1's risk for falls. The interventions included to provide cueing/supervision as indicated. Another intervention with a creation date of [DATE], showed to provide family/companion for the one on one supervision as needed. The interventions were generic and had no information specific to Resident 1's care needs to prevent future falls. Review of the facility's document titled Falls Investigation Worksheet dated 1/25/2020, showed on 1/25/2020 at 0315 hours, Resident 1 had an unwitnessed fall when his CNA was watching another CNA's resident who needed one on one care. On 2/7/2020 at 0630 hours, an interview was conducted with CNA 1. CNA 1 stated on 1/25/2020, she stayed with Resident 1 most of the time during her night shift (2300 to 0700 hours shift) because Resident 1 was always trying to get out of bed. CNA 1 stated around 0300 hours, she was helping another resident who needed close supervision since that resident's CNA went for her break. CNA 1 stated LVN 1 informed her Resident 1 fell . On 2/7/2020 at 0700 hours, an interview was conducted with RN 1. RN 1 worked the 2300 to 0700 hours shift. RN 1 stated Resident 1 needed to be supervised closely because he attempted to move around. RN 1 stated on 1/25/2020, she was on break when Resident 1's fall incident happened. RN 1 stated when she came back from her break, LVN 1 told her Resident 1 had a fall incident. RN 1 stated Resident 1 had pain to his left hip when she assessed him. RN 1 stated Resident 1 was sent out to the acute care hospital for further evaluation. On 2/7/2020 at 0715 hours, an interview was conducted with LVN 1. LVN 1 stated Resident 1 did not use the call light for his needs. LVN 1 stated CNA 1 was watching him closely because Resident 1 was at high risk for falls. When the CNA went on her break, the RN was at the nurses' station watching Resident 1. LVN 1 stated it was a very busy night and there were a couple of residents trying to get out of bed. While CNA 1 went to help another CNA's resident while that CNA was on break, Resident 1's roommate pressed the call light for him. LVN 1 stated she went in Resident 1's room and found the resident sitting on the floor. On 2/7/2020 at 0910 hours, an observation was made of the visual site line between Resident 1's room and the nurses' station. Resident 1's room could not be seen from the nurses' station. On 2/7/2020 at 1400 hour, an interview was conducted with Resident 1's roommate. Resident 1's roommate stated on 1/25/2020 at night time, he heard Resident 1 crying for help. After Resident 1 called out for help three times, Resident 1's roommate stated he saw Resident 1 was sitting on the floor against the wall by the door. Resident 1's roommate stated he pressed the call light to get help. On 2/7/2020 at 1500 hours, an interview was conducted with the DON. When asked how to evaluate if the interventions to prevent falls were effective for Resident 1, the DON stated the CNAs were instructed to check the resident frequently. The DON stated the CNAs did rounds every two hours. The DON stated Resident 1 had his own caregiver during the day, and during the night, the CNAs were asked to stay close to the resident. The DON could not provide any documentation showing the frequency of staff rounds or visual checks required for Resident 1. On 3/4/2020 at 0700 hours, an interview was conducted with LVN 1. LVN 1 stated during Resident 1's fall incident on 1/25/2020, she was charting in the nurses' station while CNA 1 left Resident 1 unattended to help another CNA's resident. Review of acute care hospital's x-ray report dated 1/25/2020, showed Resident 1 sustained a left [MEDICAL CONDITION], requiring hospitalization and undergoing a surgical repair. Review of hospital's Discharge Summary dated 1/29/2020, showed Resident 1 was discharged back to the facility. The physician documented due to the resident's advanced dementia, the recovery might be prolonged as well as may not even occur after this type of surgery.<br>On 3/4/2020 at 0720 hours, a telephone interview was conducted with RN 1. When asked the meaning of providing cueing or supervision as indicated, RN 1 stated Resident 1 had dementia and would need supervision no matter what. RN 1 stated if the resident became agitated and tried to get out of the bed, the family member would be called to have one on one supervision because the CNA was needed to attend other residents for their needs. When asked how the staff would know the resident was trying to get out of bed during the night, RN 1 stated the staff would hear the sound of bumping or moving. |
| F 0880<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Provide and implement an infection prevention and control program.**<br><br>Based on observation, interview, and medical record review, the facility failed to maintain the infection control practices to help prevent the development and transmission of diseases and infections. * The facility failed to ensure the staff practiced contact precautions when entering the room of one sampled resident (Resident 2) who was on transmission-based precautions. This failure posed the risk of infection and the transmission of disease causing microorganisms. Findings: According to the CDC, for contact precautions, everyone should wear a gown and gloves for all interactions that may involve contact with the resident or the resident's environment. On 2/7/2020 at 0835 hours, an observation of Room A and concurrent interview with CNA 3 was conducted. Room A was observed with a precaution sign warning people to stop and talk to a nurse before entering the room. CNA 3 was observed inside Room A removing bed linen without wearing a gown. CNA 3 verified she was not wearing a gown inside Room A. CNA 3 stated she was removing Room A's bed linens to be cleaned. On 2/7/2020 at 0855 hours, an interview was conducted with RN 2. RN 2 stated Resident 2 residing in Room A was currently on transmission-based contact precautions for VRE in the urine. RN 2 stated anyone who entered the room should have worn the PPE no matter what they were doing in the room. |

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.