STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055979	A. BUILDING _____ B. WING _____	**03/16/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FRANCISCAN CONVALESCENT HOSPITAL	**3169 M STREET MERCED, CA 95348**

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 -** 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 record review, the facility failed to ensure residents received adequate supervision to prevent falls for one of three sampled residents (Resident 1) when Resident 1 was assessed as high risk for falls and the Interdisciplinary team (IDT) (a facility group composed of a physician, a registered nurse, a social worker and additional appointed facility staff) did not conduct a timely update, revision and implementation of Resident 1's fall care plan interventions based on assessed and recommended needs following falls on 3/22/19 and 12/21/19. These failures resulted in Resident 1 having an avoidable fall on 12/21/19 which caused a laceration to the left eyebrow and a skin tear to the lip. The injuries to Resident 1 required transportation to the acute care hospital (ACH) emergency department (ED) and surgical repair. Resident 1 experienced pain and suffering as a result of the injuries. Findings: During an interview with the Director of Nursing (DON), on 1/8/2020, at 2:08 p.m., the DON stated Resident 1 leaned forward and fell on the floor in the facility lobby near the nurses' station while on her wheelchair on 12/21/19 and sustained a laceration above her left eyebrow. The DON stated Resident 1 was transferred to the acute care hospital on [DATE] at 1:51 p.m. for further evaluation and medical management. During a concurrent interview and record review with the DON, on 1/8/2020, at 2:08 p.m., the DON reviewed Resident 1's IDT notes dated 3/25/19 and stated Resident 1 had a history of [REDACTED]. The DON stated Resident 1 fell out from her wheelchair and sustained a hematoma (localized bleeding outside of blood vessels due to trauma) on her left brow area. The DON stated Resident 1 was assessed as high fall risk on 2/8/19 before the fall on 3/22/19 and on 9/22/19 (before the fall on 12/21/19). During a concurrent interview and record review with the DON, on 1/8/2020, at 2:08 p.m., the DON reviewed Resident 1's IDT note dated 3/25/19, which indicated, . Provide rest periods after meals . She stated the IDT recommendations on 3/22/19 did not specify where Resident 1 needed to take rest periods after every meal. The DON stated Resident 1's rest periods were not determined whether they needed to be taken in bed or in her wheelchair. The DON stated Resident 1 needed to take rest periods to prevent recurrent falls. During a review of Resident 1's face sheet (a document with demographic, personal and medical information) dated 1/8/2020, the record indicated Resident 1 was admitted to the facility on [DATE]. Resident 1's [DIAGNOSES REDACTED]. During a review of the clinical record for Resident 1, the Minimum Data Set (MDS) (assessment of healthcare and functional needs) dated 12/26/19, indicated Resident 1 had short and long term memory impairment. The MDS document indicated Resident 1 was severely impaired in decision making during activities of daily living, and on wheelchair with total dependence (full staff performance) and required two-person physical assistance with mobility and transfers. During a review of the clinical record for Resident 1, the initial, Fall Risk Observation/Assessment (a health assessment by licensed nurses to evaluate risk of fall) dated 9/22/19, indicated Resident 1's fall risk score was 12 (the document indicated a score of 10 or higher was considered high risk for falls) with a history of falls on 3/22/19. During an observation with Resident 1, on 1/8/2020, at 2:24 p.m., she laid on her bed with the reclining wheelchair on the foot of her bed and did not respond to questions. During a concurrent interview and record review with Licensed Vocational Nurse (LVN) 1, on 1/8/2020, at 2:36 p.m., she stated she was assigned to Resident 1 on the morning of 12/21/19 when she sat at the nurses' station and heard a loud noise. She stated she found Resident 1 on the floor and laid on her left side of the body with the left eyebrow bled profusely. LVN 1 reviewed Resident 1's IDT note dated 3/25/19 (previous fall on 3/22/19), which indicated, . IDT met to review a witnessed fall occurring on 3/22/19 at 1630 (4:30 p.m.). (Resident 1) was sitting in her WC (wheelchair) by the lobby when all of a sudden (Resident 1) slowly falling asleep on her chair hitting her face down on the floor . noted a golf ball size hematoma on top of her left brow bone . As per report from CNA (Certified Nursing Assistant) assigned to her (Resident 1) for the shift, (Resident 1) has been sitting on her WC since lunch time and she was noted sleepy prior to her fall . IDT recommendations . Provide rest periods after meals . LVN 1 stated Resident 1's care plan interventions were not updated by IDT based on assessed needs on 3/28/19 and was not specific to indicate whether the rest period for Resident 1 had to be in bed or in the wheelchair to implement and prevent Resident 1's recurrent falls. During an interview with LVN 1, on 1/8/2020, at 2:36 p.m., she stated Certified Nursing Assistants (CNAs) were used to placing Resident 1 by the nurses' station right after lunch meal and would put Resident 1 in bed after assisting all other residents after lunch meal. She stated she saw Resident 1 asleep in the wheelchair with eyes closed minutes before she fell on [DATE]. LVN 1 stated Resident 1 had a habit of rocking herself a lot and at times would fall asleep while in her wheelchair. She stated CNAs should have put Resident 1 in bed immediately after lunch meal to provide Resident 1 rest period. LVN 1 stated Resident 1 was dependent on staff for all activities of daily living and used the wheelchair for mobility with one staff assistance. During a review of the clinical record for Resident 1, the Progress Notes dated 12/21/19, at 1:55 p.m., indicated, . At 1315 (1:15 p.m.) writer (LVN 1) was sitting at nurses' station when a loud noise was heard . resident found on floor lying on L (left) side of body in lobby. She was last seen in WC (wheelchair) with arms crossed and eyes closed minutes before fall. Upon Observation laceration to L eyebrow significant bleeding present pressure applied and controlled. Resident also had small ST (skin tear) to lip Send to ER (emergency room) for further eval. (evaluation) . Resident transferred out of facility at 1330 (1:30 p.m.) . During a review of acute care hospital records for Resident 1, the Emergency Department progress notes dated 12/21/19, at 2:36 p.m., indicated, . The patient presents following fall .The fall was described a lost balance, from wheelchair laceration to left side of forehead and pelvic pain . Procedure: Laceration repair . 3.5 cm (centimeters) in length. Left brow. Linear. Superficial. Skin closure: # 6 (number of staples) staples (used in surgery in place of sutures to close skin wounds) . During an interview with CNA 1, on 1/8/2020, at 2:59 p.m., she stated Resident 1 had similar falls on 3/22/19 and 12/21/19 when Resident 1 fell forward on her wheelchair in the facility lobby and sustained an injury. She stated Resident 1 often moved from side to side while sitting in her wheelchair and sometimes would lean on her one side while in wheelchair. CNA 1 stated Resident 1 used a standard wheelchair at the time of the falls on 3/22/19 and 12/21/19 where Resident 1 sits up and not considered as rest period for Resident 1. She stated Resident 1 should have been put into bed for rest after meals on 12/21/19 and was not. CNA 1 stated the fall on 12/21/19 could have been preventable if Resident 1 had a reclining back wheelchair (chair with adjustable backrest and/or footrest into a reclined position for users who sleep in chairs frequently) to rest. During an interview with CNA 2, on 1/8/2020, at 3:11 p.m., he stated he was assigned to Resident 1 on the morning of 12/21/19 (date of fall) when Resident 1 leaned forward and fell on the floor. CNA 2 stated he was not aware Resident 1 was done with her lunch meal and was placed by other CNA (unrecalled) in the nurses' station. He stated he was responsible to put Resident 1 back to bed after lunch meal and he did not. During a review of the clinical record for Resident 1, the IDT note dated 12/23/19, at 2:59 p.m., indicated, . IDT met to review fall that occurred on 12-21-19 at 1351 (1:51 p.m.), (Resident 1) was in her wheelchair, in lobby, after lunch. Two nurses were sitting at nurses' station when a loud noise was heard. Both nurses stood up and saw (Resident 1) lying on left side of her body. She (Resident 1) was

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.

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F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) last seen in wheelchair with arms crossed and eyes closed minutes before fall . (Resident 1) was found to have a laceration above her left eyebrow with significant bleeding . (Resident 1 also had a small skin tear to her lip . (Resident 1) transferred out of facility at 1330 (1:30 p.m.) . (Resident 1) returned to the facility . (Resident 1) noted to have 6 stitches on her left eyebrow . IDT recommendations: Encourage (Resident 1) to rest in bed after lunch . During a concurrent phone interview and record review with Minimum Data Set Coordinator (MDSC), on 1/9/20, at 9:49 a.m., she reviewed Resident 1's fall care plan dated 1/20 and stated Resident 1's care plan interventions of rest periods after meals was not in place from 3/22/19 (date of previous fall) to 12/21/19 (date of fall) in the management of fall prevention. MDSC 1 stated Resident 1's care plan was updated only after Resident 1's fall on 12/21/19. MDSC stated licensed nurses were responsible for updating the IDT recommendations to Resident 1's care plan. During a concurrent interview and record with DON, on 1/9/2020, at 10:21 a.m., she reviewed Resident 1's IDT note dated 3/25/19, indicated, . Provide rest periods after meals . and stated Resident 1's fall care plan was not updated by the IDT and did not indicate Resident 1's rest periods after meals had to be in bed or in wheelchair to address Resident 1's fall prevention. During a concurrent interview and record review with DON, on 1/9/2020, at 10:21 a.m., she reviewed Resident 1's IDT note dated 12/21/19 and indicated, . IDT recommendations: Encourage (Resident 1) to rest in bed after lunch . She stated IDT recommended a reclining back wheelchair for Resident 1's care interventions on 12/21/19 to prevent fall and the IDT should have documented the intervention (reclining back wheelchair) to Resident 1's current care plan and did not. During a review of the facility policy and procedure titled, Quality of Care - Accident Hazards/Supervision/Devices dated 7/18, indicated, . Falls . 2. When a resident experiences a fall, the facility will evaluate potential casual factors to aid in the development and implementation of relevant, consistent and individualized interventions to reduce the likelihood of future occurrences. 3. The facility will initiate and implement a comprehensive, resident-centered fall prevention plan for residents at risk for falls or with a history of falls . During a review of the facility policy and procedure titled, Comprehensive Care Plans dated 11/17, indicated, .1. The care plan will be comprehensive and person-centered . 3. The comprehensive care plan will be reviewed and revised by the IDT following both comprehensive and quarterly review assessments . During a review of the facility policy and procedure titled, Assessing Falls and Their Causes dated 10/10, indicated, . The purposes of this procedure are to provide guidelines for assessing a resident after a fall and to assist staff in identifying causes of the fall .1. Review the resident's care plan to assess for any special needs of the resident .4. Falling may be related to underlying clinical conditions and functional decline . During a review of a professional reference titled, The Basics of Reclining Wheelchairs, at http://www.eldercarelink.com/elder-mobility/basics-of-reclining-wheelchairs.htm, dated 2020 (updated), indicated, . Reclining backs and moving seats allow for the most comfort and ease of use .The reclining wheelchair is often larger than standard wheelchairs and might be more difficult to transport. Many reclining wheelchairs can lie flat, allowing the user to sleep in the wheelchair if necessary . is made much easier by a reclining wheelchair that tilts back to a full 90-degree angle .