STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555308	A. BUILDING _____ B. WING _____	**08/13/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LAKE FOREST NURSING CENTER	**25652 OLD TRABUCO ROAD LAKE FOREST, CA 92630**

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 interview, medical record review, and facility document review, the facility failed to provide the necessary care and services to ensure the safety measures were in place to prevent a fall from a wheelchair, resulting in a head injury for one of two sampled residents (Resident 1). * Resident 1 was receiving two blood thinning medications and sustained an unwitnessed fall from his wheelchair, resulting in a intraventricular hemorrhage (bleeding in the brain). Findings: Review of the facility's P&P titled Fall Management dated 6/4/20, showed the facility will assess each resident upon admission, readmission, quarterly, with a change in condition, and after a fall event for any fall risks and will identify appropriate interventions to minimize the risk of injury related to falls using a Fall Risk Assessment. During the admission and readmission, staff will develop a care plan problem initiated by the admitting licensed nurse any resident assessed to be a risk for falls. Upon completion of the other interdisciplinary team member's admission and readmission assessments, the interdisciplinary team will review any additional fall risk indicators and revise the resident's care plan as indicated. The residents and/or family member will receive education on the fall management care plan and will be provided opportunity for feedback. On 7/8/20 at 1340 hours, a telephone interview was conducted with Family Member 1 to inquire about a complaint filed in May 2020. Family Member 1 stated Resident 1 had periods of confusion and always wanted to get up and walk by himself. The family member stated the resident had this behavior in the acute care hospital, prior to his admission to the facility. Family Member 1 stated Resident 1 fell when he was left sitting alone in his wheelchair and without any type of safety belt. The fall caused him to hit his head and caused bleeding in his brain. The Family Member 1 stated prior to Resident 1's fall, she had repeatedly requested facility staff to place the siderails on the resident's bed and a seatbelt in his wheelchair; however, the nurses refused. The family was informed they could hire a sitter to watch the resident. Family Member 1 stated Resident 1 had two family members and one private caregiver stay with resident many hours of the day but not 24 hours a day. On the day Resident 1 fell , a family member was at the facility with the resident until around 1500 hours. Family Member 1 stated she received a telephone call on 9/5/20 at 1700 hours, informing her the resident had sustained a fall from his wheelchair and was transferred to the acute care hospital emergency department via paramedics. Family Member 1 stated Resident 1 sustain a head injury which caused bleeding in his brain and he passed away a few days later. Closed medical record review for Resident 1 was initiated on 7/8/20. Resident 1 was admitted to the facility on [DATE], with a [DIAGNOSES REDACTED]. Review of Resident 1's history and physical examination [REDACTED]. Review of Resident 1's plan of care showed a care plan problem dated 8/28/19, to address Resident 1's high risk for falls. However, there were no interventions about safety precautions while the resident was in his wheelchair. Review of Resident 1's Fall Risk assessment dated [DATE], showed Resident 1 was at high risk for falls and had one or two falls in the past 90 days. Review of Resident 1's Physical Therapy Initial Evaluation dated 8/28/19, showed Resident 1 had impairment in moving all four of his extremities and required maximum assistance for bed mobility and transfers. In addition, Resident 1's sitting and standing balance were poor. Review of Resident 1's Progress Note dated 9/7/19 at 1820 hours, showed a Late Entry written by RN 2. RN 2 documented while passing the medications, RN 2 was called to the nurses' station and found Resident 1 lying on the floor in front of the nurses' station. Resident was assessed and found to be unresponsive, and 911 was called. The paramedic team assessed the resident and transferred him to the acute care hospital ED for further evaluation. Review of Resident 1's Progress Note written by RN 1 showed an Event Note identified as a late entry dated 9/9/19 at 1618 hours. The RN documented that on 9/7/19 at 1645 hours, RN 1 was paged to Nursing Station B for an emergency and 911 was called. RN 1 found Resident 1 was lying on the floor, on his left side, in front of Nursing Station B. The staff informed RN 1 Resident 1 did not respond to his name when called, but when RN 1 arrived, she observed the resident moving his hands and moaning. The paramedic arrived and assessed Resident 1 who responded to the paramedic staff questions. Resident was transferred to the acute care hospital via paramedics. Review of the Care Plan Conference Record form dated 9/9/19, containing four staff members signatures (Social Service, MDS and Physical Therapist and one illegible signature) showed on 9/7/19 at 1645 hours, Resident 1 was observed on the floor in front of the nurses' station. Prior to the resident being found on the floor, Resident 1 was in the activities room. The activity staff stated Resident 1 was returned to the nurses' station at 1630 hours, and there were nursing staff present at the nurses' station at the time. There was no endorsement made from the activities staff to the nursing staff regarding Resident 1. Resident 1 sustained an unwitnessed fall from his wheelchair to the floor and was found laying on the left side. The paramedics were called and Resident 1 was transferred to the acute care hospital. The resident was diagnosed with [REDACTED]. Review of Resident 1's list of medications showed he was receiving [MEDICATION NAME] 75 mg daily and Asprin 81 mg daily (blood thinning medication) for the treatment/prevention of [MEDICAL CONDITION] (blood clot in the legs) and stroke. Review of the plan of care identified a care plan problem to address the use of antiplatelet therapy ([MEDICATION NAME] and Asprin) dated 8/28/19. The interventions showed to to monitor for signs of bleeding; however, there were no interventions to address the resident's risk for injury or bleeding related to falls. Review of Resident 1's the acute care hospital ED record identified a CT scan of Resident 1 head was taken on 9/7/19 at 1906 hours. The CT scan showed a left lateral intraventricular hemorrhage (bleed) and old infarction (lack of blood supply to area due to thinning of the blood vessels or dead tissue) of the right [MEDICATION NAME] and right occipital lobes. Review of the Certificate of Death showed Resident 1 passed away on 9/10/19, with the primary cause of death was cardiopulmonary arrest, intraventricular hemorrhage, and long history of [MEDICAL CONDITION]. On 7/9/20 at 1646 hours, an in interview was conducted with the Activities Assistant. The Activities Assistant stated Resident 1 was in activities most of the time and he had a behavior of trying to stand without assistance. On the day the resident fell , a family member was with the resident before lunch and had asked her to take care of Resident 1 when they left. The Activities Assistant stated on that afternoon, Resident 1 was back in the activities room. Resident 1 remained his usual confused self and would constantly try to stand up from his wheelchair. The Activities Assistant stated at about 1625 hours, when she wheeled the resident to the nurses' station. There were three to four nurses sitting in the nurse station at the time and there were two CNAs in the hallway. The Activities Assistant stated she informed the nurses at the nurses' station that she had brought Resident 1 back could not recall whom she directed her statement to. The Activities Assistant stated every nurse was aware Resident 1 was confused and would always try to get up unassisted. She stated she tried to keep Resident 1 occupied in the activities room so he would not stand up. On 9/7/19 at 1630 hours, the Activities Assistant clocked out and left for the day. On 7/14/20 at 1353 hours, a telephone interview was conducted with RN 1. RN 1 stated she was paged to go to the nurses' station. When she arrived she observed Resident 1 lying on the floor. RN 1 told the nursing staff not to touch the resident and call 911. RN 1 stated it was an unwitnessed fall, and she was not sure if the resident attempted to stand up and fell or what happened. RN 1 stated the nurses were always watching him and

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 -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) he was frequently sitting at the nurses' station. RN 1 was asked what interventions were in place to prevent the resident from standing up unassisted. RN 1 could not recall specifically what interventions were in place for Resident 1. RN 1 stated for the residents who are at risk for falls are often placed in rooms close the nurse station to have frequent visible checks. If it was the resident who had had a history of [REDACTED]. RN 1 stated the facility did not use the siderails as it was more of a risk injury for the residents, and they did not use locking trays in wheelchairs; they had a no restraint policy. On 7/29/20 at 1337 hours, a telephone interview was conducted with RN 2. RN 2 stated Resident 1 was at high risk for falls. RN 2 stated she received report from the morning shift that Resident 1 got up by himself a lot and was kept in the activities room. RN 2 stated on the day Resident fell , she was passing the medications when and was paged to the nursing station. RN 2 stated she found Resident 1 lying on the floor. RN 2 stated Resident 1 did not look good. RN 2 stated she called 911 and Resident 1 was transferred to the acute care hospital. RN 2 stated Resident 1's fall was unwitnessed. The resident had a regular wheelchair, not a tilt back wheelchair. RN 2 was asked what interventions were in place to address when Resident 1 behavior of getting up unassisted. On 8/10/20 at 1235 hours, a telephone interview and concurrent closed medical record review for Resident 1 with PTA 1. The PTA 1 was asked about Resident 1's functional mobility and to explain her note dated 9/7/19. PTA 1 stated Resident 1 needed moderate assistance in transfers and gait training, using hands and assistance to prevent him from falling backward in both sitting to standing or standing to sitting. PTA 1 stated Resident 1 would lean back a lot, which increased his risk of falling. PTA 1 stated if Resident 1 was alone and tried to get up unassisted, he would likely fall. On 8/11/20 at 0956 hours, a telephone interview and closed medical record review for Resident 1 was conducted with the DON and ADON. The DON was asked about Resident 1's fall. The DON stated the Activities Assistant did not inform the nurses when she brought Resident 1 back to the nurses' station. The DON was asked what the interventions were to address the falls risks for a resident who had been assessed to be at high risk for falls. The DON stated the resident should be moved close to the nurse station, have bilateral floor mats at the bedside, and be placed on the Falling Star program; however, it would be based on the individual resident's behavior and medical condition. The DON was asked when the facility would consider providing a Safety Attendant. The DON stated when a resident had multiple falls, poor safety awareness, tried to get up without assistance, and could not be left alone. The DON stated the facility would reach out to family for assistance in providing supervision and provide a Safety Attendant. The DON stated the facility should initiate an IDT and care plan conference with residents' family within 72 hours of the resident's admission. The care conference team would include the case manager, Social Services Director, rehabilitation staff, activities staff along with the resident's family. Additional medical record review failed to find documentation the facility initiate IDT and Care Plan Conference meeting with the family to address Resident 1's high risk for falls and implement the above noted interventions. The DON stated she did not recall discussing Resident 1 with his family to address his behavior or standing up unassisted. The DON verified the findings.