| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **555128** | A. BUILDING _____ B. WING _____ | **06/24/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **DOWNEY COMMUNITY HEALTH CENTER** | **8425 IOWA STREET DOWNEY, CA 90241** |

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 -** 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 interview and record review, the facility failed to adhere to physician's orders and a plan of care to provide one to one (1:1) supervision for one of three sampled residents (Resident 1). Resident 1, who had a high risk for falls, had five falls within six months and the fifth fall resulted in serious injuries that included a fracture (broken bone) nose and facial lacerations (deep cuts) and required a transfer to the general acute care hospital (GACH). This deficient practice resulted in Resident 1 having multiple falls and sustaining a laceration to the left eyelid, skin tears to the bridge of the nose and left forearm, and a nasal (relating to the nose) fracture confirmed at the GACH on 2/7/2020. Resident 1 was readmitted to the facility on [DATE] and 20 hours after readmission, Resident 1 had a sixth fall with minor injuries after not being supervised 1:1 as per the physician's order and the resident's plan of care. Resident 1, who used to walk independently (without assistance), required a wheelchair for mobility. Findings: A review of Resident 1's Face Sheet (Admission Record) indicated the resident was originally admitted to the facility on [DATE] and last readmitted on [DATE]. Resident 1's [DIAGNOSES REDACTED]. A review of Resident 1's Minimum Data Set (MDS), dated [DATE] indicated Resident 1 had the ability to usually understand and be understood by others. The MDS indicated Resident 1 had impaired vision, was independent in bed mobility, transfers and toilet use, and required supervision with setup for other activities of daily living (ADL) including walking, locomotion, hygiene and bathing. Resident 1's balance during transition and walking was steady, but unsteady when turning around without the use of mobility devices. Resident 1 was continent (ability to control) of bowel and bladder. The MDS indicated Resident 1 had no falls since admission and/or entry of prior assessment. A review of Resident 1's Morse Fall Scale (fall risk assessment), dated 7/26/19 indicated Resident 1 had a high risk for falls with a score of 45 (a score of 45 and higher indicated high risk). A review of a Situation Background Assessment and Recommendation ((SBAR) an internal communication form) and Nurse's Progress Note, dated 8/7/19 and timed at 12:45 p.m., indicated Resident 1 was seen on his buttocks on the floor next to the chair in the dining room. The resident was alert and oriented to person and place and ambulating (walking) without assistance. There were no injuries observed at time of incident. A review of Resident 1's care plan titled, Actual Fall/Poor Balance, initiated 8/7/19 indicated the staff would do the following: -Attempt to determine and address causative factors of the fall. -Monitor for 72-hours, document and report when necessary to physician, change in mental status, confusion, sleepiness, inability to maintain posture, agitation. -Provide activities that promote exercise and strength building where possible or 1:1 activity if bedbound. A review of Resident 1's Morse Fall Scale, dated 8/7/19 remained unchanged from 7/26/19 with the resident having a high risk for falls. A review of Resident 1's Interdisciplinary Team ((IDT) group of disciplines working together towards a common goal for a resident) Assessment Form, dated 8/7/19 indicated the team met regarding Resident 1's fall incident on 8/7/19. The resident was unable to explain how he got on the floor. The contributing factors included poor safety awareness, [MEDICAL CONDITION] medications (any drug capable of affecting the mind, emotions, and behavior) and behaviors of sitting on the floor and patio. The IDT plan indicated to continue to monitor the resident for any changes of condition (COC), provide a clutter/ hazard free environment and ensure proper footwear when ambulating. A review of Resident 1's care plan titled, Risk for Falls related to poor communication/comprehension, psychoactive (a substance that can change the consciousness, mood, and thoughts (mood altering)) drug use and unaware of safety, initiated on 8/15/19 indicated the staff to do the following: -Visually monitor Resident 1 every hour during rounds and document any (COC). - Provide safe environment with even floors that are free from spills and/or -Review information on past falls and attempt to determine cause of falls. -Educate resident/family/caregiver as to causes. -Anticipate and meet the resident's needs. -Provide verbal cuing when walking by hallway. A review of a SBAR and a nurse's progress note, dated 9/25/19 and timed at 8:47 p.m. indicated Resident 1 was at the nursing station when he suddenly started sliding down onto the floor hitting the back of his head on the counter. The resident was conscious (aware of surroundings) with eyes open and responsive. A review of Resident 1's care plan titled, Witnessed Fall with no Injuries, initiated on 9/25/19 indicated the staff would do a 72-hour monitoring and neuro checks (an evaluation of a person's nervous systems mental status consisting of motor examination; sensory examination; coordination; reflexes; and gait and station) and medicate for temperature and/or pain as needed. A review of Resident 1's Morse Fall scale, dated 9/25/19, after the resident had the second fall, remained unchanged and scored as a high risk for falls. A review of Resident 1's IDT assessment form, dated 9/26/19 indicated the resident fell on [DATE] at approximately 8:30 p.m. while at the nurses' station while waiting for his medication. The IDT form indicated the staff would continue to provide redirection/ prompting and assistance to Resident 1 as needed for safety monitoring and whereabouts. A review of Resident 1's SBAR and nurses progress note, dated 9/30/19 and timed at 4:30 p.m. indicated Resident 1 fell (third fall) outside in the patio. The resident was alert and oriented, with no injuries noted. A review of Resident 1's care plan titled, Witnessed Fall with no Injuries, initiated on 9/30/19 indicated the staff would do frequent visual checks and 72- hour monitoring with vital signs. A review of Resident 1's IDT assessment, dated 10/2/19 indicated Resident 1 had another fall incident on 9/30/19 on the patio where the resident was seen falling into a sitting position (fourth fall). The plan included to follow up with laboratory results and report to the physician. A review of Resident 1's care plan titled, Risk for Falls, initiated 8/15/19 with a revised date of 11/8/19 indicated to ensure Resident 1 was wearing appropriate footwear when ambulating and provide a safe environment. A review of Resident 1's quarterly MDS, dated [DATE] indicated Resident 1 had no falls since admission and/or entry of the prior assessment (sic). A review of Resident 1's care plan titled, ADLs (activity of daily living (such as grooming, toileting, eating etc.)) self-care performance deficit related to poor insight and requiring limited to extensive assist with ADLs, initiated 1/30/2020 indicated the following interventions: - Extensive assist by one staff with ADLs including toilet use and transfers. - Requires limited to extensive assist in toileting. - May use wheelchair as needed. - Encourage resident to use bell to call for assistance. A review of Resident 1's nurse's note, dated 2/7/2020 and timed at 12:20 p.m. indicated at 10:52 a.m. that day, Resident 1 had a fall incident in the dining room (fifth fall). The note indicated Resident 1 stood up from his wheelchair and tripped over the right footrest of the wheelchair and fell forward and hit his face on the floor sustaining a cut on the left upper eyelid measuring three (3) centimeters ((cm) unit of measurement) by 0.5 cm. Resident 1 also sustained a skin tear on the bridge of the nose measuring 1 cm by 0.5 cm and a skin tear to the left forearm measuring 1.5 cm by 1 cm. Resident 1 was transferred to a GACH on the same day at 1:50 p.m. A review of the GACH's emergency room (ER) note, dated 2/7/2020 and timed at 5:07 p.m. indicated Resident 1 was seen in the ER with chief complaint of status [REDACTED]. A computed tomography scan ((CT Scan) x-ray device of detailed images of internal organs) of the head was done and was negative for orbital fractures or bleed. The laceration was cleaned and repaired with Dermabond (skin adhesive that is used to glue the sides of an incision or injury closed) and steri-strips (used to close superficial rather than deep |

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<br><br>**Level of harm -** Actual harm<br><br>**Residents Affected -** Few | (continued... from page 1)<br>incisions). A review of pictures taken of Resident 1 while in the GACH, provided by the resident's Responsible Party (RP), showed Resident 1 had a repaired laceration to the left eyebrow area, with dark purple bruised areas over the bridge of the nose and under each eyes. A review of Resident 1's Morse Fall Scale, dated 2/7/2020 and timed at 2:48 p.m., indicated the resident had fallen before and now had to use ambulatory aids, such as crutches, cane or a walker. Resident 1 had a weak gait and a change in mental status with overestimating or forgetting his limits. The Morse Fall Scale indicated Resident 1 remained a high risk for falls. A review of Resident 1's care plan titled, Actual Fall and sustained cut to the left upper eyelid, skin tear to nose bridge and skin tear to forearm with [DIAGNOSES REDACTED]. - Encourage resident to call for assistance. - Educate resident regarding safety precaution. - In-service staff regarding proper monitoring of resident for safety. - Transfer resident to acute hospital for evaluation. A review of Resident 1's Physicians Order, dated 2/8/2020 and timed at 3 a.m. indicated to readmit Resident 1 to the facility and resume all previous orders and treatment. A review of a nurse's progress note dated 2/8/2020 timed 3:14 a.m. indicated Resident 1 was readmitted to the facility with a [MEDICAL CONDITION] bone and a laceration of the left eyebrow. Call light placed within reach with frequent visual checks for safety. The note indicated the same day at 10:25 a.m., Resident 1 was awake and alert to name only, non-verbal as baseline status and up in the wheelchair. The vital signs taken and neuro checks done. A review of Resident 1's care plan titled, Resident at risk for falls related to poor communication/comprehension, psychoactive drugs, unaware of safety needs, poor safety awareness, impaired vision, associated medical Diagnoses: [REDACTED]. A review of a SBAR and nurse's progress note, dated 2/8/2020 and timed at 11:50 p.m., indicated Resident 1 had an unwitnessed fall. During the change of shift the resident was found lying on the floor next to the bed. The SBAR indicated Resident 1 being unsupervised made the condition or symptom worse. The resident's mental status changes included new or worsening behavioral symptoms of restlessness and unable to follow directions. The functional status changes compared to the baseline indicated needs more assistance with ADLs for fall prevention. Resident 1 was placed on 1:1 for safety. A review of Resident 1's Medication Administration Record [REDACTED]. A review of Resident 1's care plan titled, Resident at Risk for Falls, revised on 2/9/2020 indicated to provide Resident 1 with a communication board. A review of Resident 1's care plan titled, Fall Incident, dated 2/8/2020 and initiated on 2/9/2020 indicated the staff's interventions included transferring Resident 1 to a room in front of the nurses' station for close monitoring; neuro checks; and monitoring vital signs. A review of Resident 1's Nurse's Progress Note, dated 2/9/2020 and timed at 4:47 a.m. indicated Resident 1 was being monitored after sustaining two falls in two days. The note indicated Resident 1 was received lying in bed unable to verbalize plan for safety. The physician was notified, neuro checks and 1:1 supervision for safety was ordered. A review of Resident 1's nurse's Progress Note, dated 2/9/2020 and timed at 9:22 a.m. indicated Resident 1 was assessed with [REDACTED]. The note indicated the resident was guarding the site and was unable to verbalize pain. The note also indicated there was discoloration of the resident's right hip. An x-ray was ordered for the hip and wrist. The note indicated at 11:53 a.m., on 2/9/2020, Resident 1 was moved to a room closer to the nurse's station. The results of the x-ray of the right wrist and hip results were received on 2/9/2020 at 3:27 p.m. and were both negative for fractures. On 2/21/2020 at 4:38 p.m., during an interview, Resident 1's Responsible Party (RP) stated Resident 1 fell five times while in the facility. The RP stated Resident 1 was non-English speaking and did not talk much. The RP stated Resident 1 had the ability to walk before having so many falls, but after falling many times and twice in one day, the resident now cannot walk anymore and has to use a wheelchair for mobility. On 2/22/2020 at 8:45 a.m., during an interview, the Registered Nurse Supervisor (RN 1) stated Resident 1 had a fall on 2/7/2020 resulting in a nasal fracture and laceration to the left eyebrow. RN 1 stated Resident 1 was transferred to the GACH and returned to the facility on [DATE] and fell again the same day. RN 1 stated Resident 1 had a high risk for falls. On 2/22/2020 at 2:40 p.m., during an interview Certified Nursing Assistant 1 (CNA 1) stated Resident 1 had been walking without any assistance until after his fall on 2/7/2020. CNA 1 stated Resident 1 continued to fall, became weaker and had to use a wheelchair for mobility. CNA 1 stated Resident 1 did not speak English and would only answer yes or no to questions. CNA 1 stated Resident 1 required much assistance with care to prevent falls. A review of the facility's policy and procedure titled, Falls and Fall Risk, revised 4/2018 indicated for the residents identified as high risk for falls, the facility would initiate standard fall prevention protocol, including close monitoring by staff for safety through resident rounding, meeting the residents' toileting needs, adjusting height of bed (low/lowest), use of floor mats on each side of bed if indicated and if possible place in room close to nursing station. |