STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055438	A. BUILDING _____ B. WING _____	**09/10/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ALDERSON CONVALESCENT HOSPITAL	**124 WALNUT STREET WOODLAND, CA 95695**

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 observation, interview, and record review, the facility failed to provide adequate supervision and assistive devices to prevent an accident for 1 of 3 sampled residents (Resident 1), when the care plan for the use of a position change alarm (PCA) was not followed. This failure contributed to a fall for Resident 1 which resulted in a [MEDICAL CONDITION], that required surgery. Findings: According to the Admission Record, Resident 1 was admitted to the facility in mid-2016 with [DIAGNOSES REDACTED]. Review of Resident 1's clinical record included: A care plan, dated 6/10/16, titled Fall - Potential for falls related to history of falls, unsteady gait, .s/p (status [REDACTED]. The care plan interventions included PCAs and fall mats. A quarterly Minimum Data Set (MDS, an assessment tool), dated 6/28/19, indicated Resident 1 required extensive assistance (two or more persons) for all transfers (a move between surfaces such as bed, chair, and wheelchair). A progress note, dated 8/20/19 at 2:57 p.m., written by Licensed Nurse 3 (LN 3), indicated Resident was found on the floor at approx (approximately) 0905 (9:05 a.m.) on her right side. Resident was up in wheelchair prior to fall. A radiology report for an x-ray of Resident 1's hip, dated 8/21/19 at 3:14 a.m., indicated No displaced fracture involving the right hip. Recommend repeat study for persistent clinical concern. IDT (Interdisciplinary Team) Notes, dated 8/22/19, indicated the circumstances of Resident 1's fall. There was no documented evidence a PCA was in use at the time of Resident 1's fall. An addendum radiology report, dated 8/26/19 at 4:06 p.m., indicated Resident 1 had an Acute .right .(hip) fracture . A consultation, dated 8/27/19, by Medical Doctor 1 (MD 1), indicated Resident 1 would proceed with open reduction internal fixation (surgical correction) of the right [MEDICAL CONDITION]. In an observation, on 9/3/19 at 10:55 a.m., Resident 1's room was noted to be directly across from the nursing station. Resident 1's bed had a PCA on the side rail. On 9/3/19 at 1:33 p.m., in a concurrent interview with Certified Nursing Assistant 2 (CNA 2) and CNA 1, CNA 1 stated they try to make sure the residents' PCAs are on. Another intervention to prevent residents from falls included fall mats. CNA 1 stated Resident 1's fall mat was not on the floor at the time of her fall, because she had just returned from breakfast, and was still in her wheelchair. CNA 1 confirmed she did not hear any PCA at the time of Resident 1's fall. On 9/3/19 at 1:33 p.m., in a concurrent interview with CNA 2 and CNA 1, CNA 2 stated she was in another resident's room and did not hear any PCA sound at the time of Resident 1's fall. She stated she was informed by LN 1, Resident 1 was on the floor. In an interview on 9/3/19 at 1: 55 p.m., LN 1 stated fall interventions included PCAs. LN 1 stated when a PCA is heard, .we go, we all respond. LN 1 stated PCAs are tested when residents are placed in wheelchairs. LN 1 stated when Resident 1 fell , LN 1 saw her on the floor, and did not go into the room. LN 1 could not remember if the PCA sounded before she saw Resident 1. In an interview on 9/17/19 at 1:55 p.m., LN 2 stated the facility's best tool to prevent falls was the use of PCAs, which prevented residents from attempting to transfer without help. LN 2 stated CNAs activated PCAs during care of the residents, and were supposed to check the PCAs every 2 hours. LN 2 stated the PCAs were checked visually, if the indicator light on the side of the PCA was blinking, it was working. In an interview on 10/15/19 at 1:39 p.m., the Director of Rehabilitation (DOR) stated he was present in the morning facility meeting on 8/22/19, where Resident 1's fall was discussed. The discussion was documented in the IDT Notes. The DOR acknowledged there was no mention of the presence or use of a PCA at the time of Resident 1's fall in the IDT Notes. The DOR stated documentation of PCA use was usually in the IDT notes. In an interview on 10/15/19 at 2:50 p.m., LN 3 stated interventions to prevent falls included PCAs and fall mats. LN 3 stated she was in another resident's room when Resident 1 fell in her room. LN 3 acknowledged she could not remember hearing a PCA, and it should have been on. In an interview on 10/15/19 at 3:15 p.m., the assistant Director of Nursing (ADON) stated PCAs are checked by CNAs during rounds. The ADON stated PCAs would be checked multiple times a shift for functioning or a weakening battery. The ADON stated if a resident fell , and the PCA did not sound, the explanation was: the PCA was not on the resident, the PCA was set to off, or the PCA was not checked. In an interview on 10/15/19 at 3:25 p.m., the Medical Records Director (MRD) stated the use or checking of PCAs was not documented in the electronic medical record. There was no documented evidence Resident 1's PCA was in use, or sounded at the time of her fall. Review of the facility policy titled Resident Mobility Management, dated 11/13/08, indicated Each resident shall receive adequate supervision and assistive devices as needed to prevent elopement or falls. The prevention shall be accomplished by the use of supervision and one or more of the following devices .(PCAs) that detect movement. The policy further reflected, All (PCAs) have an activating device. I.E motion pull string .before leaving resident alone: 1. Make sure activating device is attached to alarm! 2. Make sure alarm is ON! 3. TEST! .activate device .I.E pull string from connection. Alarm should activate each time. The foregoing procedure shall be done each time a resident is removed from then returned to an alarm. Review of the facility policy titled Fall Prevention Program, dated 6/22/09, indicated .All residents will receive adequate supervision and assistive devices to prevent accidents.

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.