STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555103	A. BUILDING _____ B. WING _____	**07/13/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FRENCH PARK CARE CENTER	**600 E WASHINGTON AVENUE SANTA ANA, CA 92701**

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 and medical record review, the facility failed to provide the necessary care and services to prevent accidents for one of two sampled residents (Resident 1) after multiple unwitnessed falls in the facility. The facility failed to implement the additional interventions and complete the neurological assessment in a timely manner. These failures had the potential for Resident 1 to sustain neurological deficits and additional falls. Findings: Medical record review for Resident 1 was initiated on 5/27/20. Resident 1 was admitted to the facility on [DATE]. Review of the history and physical examination [REDACTED]. a. Review of Resident 1's Interdisciplinary Resident Safety Investigation and Intervention form dated 6/9/20, showed Resident 1 fell on [DATE] at 1130 hours. Under the section for review current interventions, the box was checked to show the new interventions were needed; however, there were no new interventions identified by facility staff. Review of Resident 1's Interdisciplinary Progress Note dated 5/4/20, showed the IDT had met to discuss Resident 1's fall on 5/3/20. The documentation showed the CBC and BMP tests were ordered. On 7/10/20 at 1107 hours, a telephone interview was conducted with the DON. The DON verified the Interdisciplinary Resident Safety meeting notes for 5/3, 6/6, 6/8, and 6/9/2020, were conducted to review Resident 1's falls. The DON verified after the fall on 5/3/20, staff received a physician's orders [REDACTED]. The DON verified no further interventions were added to address the preventative fall interventions for Resident 1. The DON verified after the fall on 6/8/20, the intervention implemented was a suggestion to run more laboratory tests. The DON stated the Hospice agency did not agree with this recommendation and the laboratory tests were not done. The DON verified no further interventions were implemented. The DON was asked if the interventions implemented were sufficient to prevent Resident 1 from falling again. The DON stated, not necessarily. The DON stated the facility knew the resident would probably experience more falls and they were currently trying to prevent her from sustaining major injuries. b. Review of the Resident Admission assessment dated [DATE], showed under Falls Risk Factors, Resident 1 had poor safety judgment. Further review of the medical record showed there were no additional fall risk assessments completed for Resident 1. The facility failed to provide a P&P for falls or fall management when requested. Review of the COC/Interact Assessment Form (SBAR) dated 5/3/20 at 0400 hours, showed Resident 1 sustained an unwitnessed fall. Staff documented Resident 1 was seen sitting against the bed on the floor. Review of the Neurological Assessment form dated 5/3/20, showed a neurological assessment was to be completed for the first 24 hours after the fall, which included assessing the resident every 15 minutes times four, every 30 minutes times two, every hours times two, every two hours times two, and every four hours times four. For the second 24 hours after the fall, the neurological assessment was to be completed every eight hours times 24 hours. However, review of Resident 1's medical record showed the neurological assessment was incomplete. The neurological assessment was initiated on 5/3/20 at 0500 hours and ended at 0700 hours. On 6/30/20 at 1645 hours, a telephone interview was conducted with RN 2. RN 2 stated he was the one who assessed Resident 1 after the resident fell on [DATE]. RN 2 verified Resident 1 fell on [DATE] at 0400 hours. Resident 1 was found sitting on the floor with her back against the bed. When asked about the facility's policy related to falls, RN 2 stated the facility's policy was to assess the resident, complete an incident report, conduct the neurological assessment for 72 hours, and notify the resident's family and physician. When asked if the neurological assessments were completed for Resident 1, RN 2 stated the neurological assessments were initiated immediately after the fall; however, he was unsure if it was completed. On 7/9/20 at 1606 hours, an interview was conducted with the DON. The DON stated the facility did not have a P&P for falls or fall management because all residents were different and the reasons for their falls varied and protocol would change for each resident depending on their specific circumstances. The DON was asked how the nurses would know what to do once a resident had sustained a fall and there was no policy to assist in guiding staff on what to do. The DON stated the staff knew because it was part of their orientation training. On 7/10/20 at 1330 hours, a follow-up telephone interview and concurrent medical record review was conducted with the DON. The DON verified the above findings.

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.