STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555297	A. BUILDING _____ B. WING _____	**09/10/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MANORCARE HEALTH SERVICES-HEMET	**1717 WEST STETSON AVENUE HEMET, CA 92545**

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 record review, the facility failed to ensure provision of safety for one of three sampled residents (Resident A), when: a. Facility staff did not complete an admission fall risk assessment/evaluation, as indicated in the facility's policy and procedure for fall prevention and management; b. Resident A, who had [MEDICAL CONDITION]/[MEDICAL CONDITION] (paralysis of one side of the body), was not provided adequate support by a certified nursing assistant (CNA) during bed mobility and hygiene care. These failures contributed to Resident A's fall incident and subsequent transfer to the acute care hospital for evaluation. Findings: On July 31, 2020, at 9:38 a.m., an unannounced visit to the facility was conducted to investigate a complaint related to quality of care concerns. Resident A's record was reviewed and indicated she was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The admission evaluation, dated May 5, 2020, indicated, .weakness . flaccidity (paralysis in which muscle tone is lacking in the affected muscles and in which tendon reflexes are decreased or absent) . slurred speech . difficulty expressing words . weakness observed: right upper extremity; right lower extremity . The admission notes, dated May 5, 2020, at 10:51 p.m., indicated, Patient was admitted to facility at around 7 PM . notified nurse that patient will say 'My, My, My' when she wants something. Patient is paralyzed on the right side of body. She is able to move her left arm . There was no documented evidence a fall risk assessment/evaluation was conducted during Resident A's admission. The progress notes, dated May 9, 2020, at 12:13 a.m., indicated, .Need(s) extensive assist with bed mobility, ADL's (activities of daily living), feeding and transfer with 2 person assist . The minimum data set (MDS- a comprehensive assessment tool), dated May 12, 2020, indicated the following: - Resident A had a BIMS (Brief Interview for Mental Status- screening test used for mental and cognitive status) score of 7 (a score of 0-7 means severe cognitive impairment); - Resident A required extensive assistance with two persons providing physical assistance for bed mobility and personal hygiene care; - Resident A had functional limitation in range of motion with impairment on one side of her body (right upper and lower extremities). The interdisciplinary (IDT- group of health care professionals) progress notes, dated May 13, 2020, at 1:42 p.m., indicated, .Pt (patient) has right sided weakness and require extensive assist with ADLs . Pt's right hand is dominant however d/t (due to)[MEDICAL CONDITION](stroke) has right sided weakness and has strength in left hand . The progress notes, dated May 19, 2020, at 5:53 a.m., indicated, CNA (certified nursing assistant) reported that patient is on the floor. Patient rolled over to her left side while being changed by CNA. Bed was in lowest position, no apparent injuries seen. Patient was crying, unable to verbalize where her pain was . patient was transferred to hospital ER (emergency room) . The fall incident charting, dated May 19, 2020, at 6:08 a.m., indicated, Date, time of day (exact hour of fall): 5/19/2020 04:30 (4:30 am.) .Disease & Conditions: [MEDICAL CONDITION], loss of arm or leg movement, decline in functional status, [MEDICAL CONDITION]/[MEDICAL CONDITIONS] disorder . The progress notes, dated May 19, 2020, at 6:30 a.m., indicated, Interviewed CNA how the fall incident happened. She said that she was about to change her brief this morning around 4:25 a.m., and as she was turning the patient on her left side, patient slid to the floor and CNA was unable to hold on to the patient. Patient was seen lying on her left side on the floor . The general acute care hospital notes, dated May 19, 2020, at 4:05 p.m., indicated, .admitted : 05/19/2020 05:38 (a.m.) . [AGE] year old female with an underlying history of .[MEDICAL CONDITION] . presented to the ED (emergency department) after a fall off the bed at (name of SNF). Patient was being changed by CNA .and upon rolling patient, the patient rolled off the bed and on to the floor. Patient has severe [MEDICAL CONDITION] (loss of ability to understand or express speech) at baseline and is unable to communicate areas of pain or discomfort . The skilled nursing facility's (SNF) IDT notes, dated May 20, 2020, at 11:00 a.m., indicated, .Patient rolled over to her left side while CNA was changing her. Bed was in lowest position. No apparent injury seen but patient is unable to verbalize if she has pain. Called daughter who desired patient to be sent to ER . Fall was witnessed as CNA was with patient providing hygiene needs when witnessed fall occurred. It was noted that it was one staff member providing care to patient unassisted when patient rolled out of bed . MD (physician) and family were informed of fall and patient was transferred out for further evaluation as ordered . Root cause: positioning and weakness secondary to disease process. IDT recommends wide bed and to maintain two person assist accordingly (toileting, repositioning, etc.) . On July 31, 2020, at 11:54 a.m., Resident A's record was reviewed with the Unit Manager (UM) and confirmed there was no completed fall risk assessment/evaluation upon the resident's admission to the facility. In a concurrent interview with the UM, she stated fall risk assessments should be conducted upon the resident's admission to the facility. On August 10, 2020, at 8:09 a.m., CNA 1 was interviewed regarding Resident A and stated she was the CNA assigned to the resident during the fall incident. She stated she was changing the resident and turned her to the side when the resident slid off the mattress and fell to the floor. She stated, I can't hold her because she was big . her bed was so narrow . couldn't catch her . I'm a small person . She stated the resident had a waffle mattress (air overlay mattress which cradles the body, providing protection and treatment for [REDACTED]. When asked further about the incident, she stated, Could've gone to ask for someone . everybody was busy and we were short . The facility's policy and procedure titled, Falls Practice Guide, dated December 2011, indicated: .INITIAL EVALUATION Upon admission, review hospital discharge records, transfer sheets or other data regarding the patient's history of, or risk factors for, experiencing a fall. Interview the patient and family or responsible party about the patient's history of falls, possible causes of those falls and interventions that did or did not work to prevent further falls .The risk for patient falls is potentially greater upon admission and within the first few days post-admission to a long-term care center compared to other similar environments . According to the publication titled, Patient Safety and Quality: An Evidence-Based Handbook for Nurses, authored by Hughes, dated April 2008, it indicated: .Fall and injury prevention continues to be a considerable challenge across the care continuum. In the United States, unintentional falls are the most common cause of nonfatal injuries for people older than [AGE] years . Falls and related injuries have consistently been associated with the quality of nursing care .They are included as a nursing-quality indicator monitored by the American Nurses Association . In the nursing home setting, the long-term care minimum dataset (LTCMDS) is used for reporting all aspects of care .In addition, residents are evaluated for balance and for the ability to perform activities of daily living (ADLs), with the goal to apply fall-prevention measures should the patient be deficient in these areas .

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE