STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555913	A. BUILDING _____ B. WING _____	**04/17/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ADVANCED HEALTH CARE OF SACRAMENTO	**1411 EXPO PARKWAY NORTH SACRAMENTO, CA 95815**

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 -** Some	**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 implement a systematic approach to falls prevention for 3 of 3 sampled residents (Resident 1, Resident 2, and Resident 3) when the residents sustained falls and there was no documented evidence of an Interdisciplinary Team (IDT) review or root cause analysis. This failure had the potential to place residents at greater risk of repeated avoidable falls. Findings: 1. According to the Resident Face Sheet, Resident 1 was admitted in late 2019 with [DIAGNOSES REDACTED]. A review of the clinical record for Resident 1 included the following documents: A Fall Risk Assessment, dated 12/13/19, indicated Resident 1 was at a moderate to high risk for falls. A Minimum Data Set (MDS, an assessment tool), dated 12/20/19, described Resident 1 as having severe cognitive impairment, scoring 1 out of 15 possible points, on the Brief Interview for Mental Status (BIMS). The MDS indicated Resident 1 was totally dependent on staff for transfers between surfaces and required the physical assistance of 2 or more persons. A review of Resident 1's fall event reports indicated the resident had falls on 12/23/19, 12/28/19, 12/29/19, 12/30/19, 1/3/20, 1/9/20, and 2/19/20. All the falls resulted in no serious injury except the 2/19/20 fall. The 2/19/20 fall resulted in Resident 1 sustaining a non-displaced (maintained proper alignment) [MEDICAL CONDITION] wrist. The 12/28/19, 12/29/19, and 1/3/20 fall reports did not indicate any possible contributing factors for the fall. The 1/9/20 fall report lacked a description of the fall, how the resident was found, and an indication of possible contributing factors. A review of Resident 1's progress notes indicated the absence of an IDT review of any of Resident 1's falls. 2. According to the Resident Face Sheet, Resident 2 was admitted in early 2020 with [DIAGNOSES REDACTED]. A review of the clinical record for Resident 2 included the following documents: A Fall Risk Assessment, dated 2/13/20, indicated Resident 2 was at a moderate risk for falls. A review of the Resident 2's fall event report indicated the resident had a fall on 2/14/20 with no injury. The report did not indicate any possible contributing factors for the fall. An MDS, dated [DATE], described Resident 2 as having severe cognitive impairment, scoring 3 out of 15 possible points, on the BIMS. The MDS reflected Resident 2 needed extensive assistance for transfers between surfaces and required the physical assistance of 2 or more persons. A review of Resident 2's progress notes indicated the absence of an IDT review of Resident 2's fall. 3. According to the Resident Face Sheet, Resident 3 was admitted in early 2020 with [DIAGNOSES REDACTED]. A review of the clinical record for Resident 3 included the following documents: An MDS, dated [DATE], described Resident 3 as having moderate cognitive impairment, scoring 12 out of 15 possible points, on the BIMS. The MDS reflected Resident 3 transferred on 2 or less occasions and required the physical assistance of 2 or more persons. A Fall Risk Assessment, dated 1/11/20, indicated Resident 3 was at a moderate risk for falls. A review of Resident 3's fall event report indicated the resident had a fall on 2/6/20 with no injury. The report lacked a description of the fall, how the resident was found, and/or an indication of possible contributing factors. A review of Resident 3's progress notes indicated the absence of an IDT review of Resident 3's fall. In an interview on 2/27/20 beginning at 2:27 p.m., the Clinical Nurse Manager (CNM) stated there were no IDT notes for any of the residents' falls. The CNM stated there was no new Fall Risk Assessment after a fall, and the Fall Event Report was the new fall risk assessment. The CNM confirmed many of the fall event reports were incomplete. In an interview on 2/27/20 at 4:20 p.m., the Director of Nursing (DON) stated the falls process was something the facility was working on. The DON confirmed there were no IDT notes for the falls. The DON stated she had no investigation files for any of the falls, and it depended on how the resident fell whether or not it would be investigated. The DON confirmed several of the Fall Event reports lacked details related to the fall, such as what the resident was doing at the time of the fall. The DON stated the facility's, Fall Prevention Policy and Procedure, dated 2/27/18, was relevant to the facility's efforts to promote patient safety, except for the information regarding safety alarms. The DON stated there were no safety alarms used in the facility. A review of the facility's, Fall Prevention Policy and Procedure, dated 2/27/18, reflected the absence of a systematic approach to preventing resident falls. The policy did not mention an IDT review of resident falls or a process for evaluating and analyzing fall data to determine the root cause and prevent future falls.

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.