STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555286	A. BUILDING _____ B. WING _____	**03/10/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NEW ORANGE HILLS	**5017 E. CHAPMAN AVENUE ORANGE, CA 92869**

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 -** 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, medical record review, and facility P&P review, the facility failed to provide the necessary care and services to ensure one of two sampled residents (Resident 1) was free from accident hazards. * The facility failed to identify Resident 1 as a high risk for falls when her name outside her door was marked with a star so the staff could easily identify she was at risk for falls. * Resident 1's plan of care failed to reflect the number of persons or assistance needed and the appropriate assistive device to be used when standing or ambulating as noted by the PT. * The facility failed to clarify Resident 1's need for a back brace with her physician. These failures resulted in Resident 1 sustaining a fall with an occipital skull fracture, contributing to Resident 1's death. Findings: According to a report received from the facility, Resident 1 fell on [DATE], and sustained an occipital skull fracture ([MEDICAL CONDITION] at the back of the head) and cerebral hemorrhage/hematoma (bleeding in the brain). Review of the facility's P&P titled Falling Star Program Fall Prevention Policy and Procedure revised 1/2/2020, showed the goal of the Falling Star Program is to prevent falls, reduce both the incidence of falls, and the injuries that may accompany falls. The process included identifying residents at risk for falling and establishing a common method of communication to remind the staff to monitor these residents for fall prevention. Falling stars will be used to identify residents on the Falling Star Program. One Gold Star will be placed on the resident's name plate or on the wall next to the name(s) outside the resident's room. If the Fall Risk Assessment is scored at 10 or greater on a change of condition, the RN Supervisor will initiate the Falling Star Program. Review of the facility's P&P titled Falls and Fall Risk, Managing (undated) showed based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. Closed medical record review for Resident 1 was initiated on [DATE]20. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's Admission/Readmission Screener dated [DATE], showed Resident 1 was admitted from the acute care hospital with low back pain. The assessment showed Resident 1 needed extensive assistance to walk in her room with a walker. The assessment failed to show the number of persons required to assist her. Resident 1 had dizziness, moderate difficulty with hearing, and was moderately impaired with her vision. a. Review of Resident 1's Safety Device/Mobility Device assessment dated [DATE], showed she had unsafe mobility due to poor balance and gait dysfunction, and was at risk for falls. Review of Resident 1's Fall Risk assessment dated [DATE], showed Resident 1 was a high risk for falls. Review of Resident 1's Order Summary Report showed the following physician's orders [REDACTED]. Review of Resident 1's Medication Administration Record [REDACTED]. On [DATE]20 at 0625 hours and [DATE] at 0920 hours, an interview was conducted with CNA 2. CNA 2 stated she had not cared for Resident 1 prior to 1/20/2020. CNA 2 stated she usually received a report on the residents from the previous shift's CNA, but that night, the CNA left before she could get report from him. CNA 2 stated if she had any questions about her residents, she would have asked her charge nurse. CNA 2 stated when she made her rounds, she usually took the resident census sheet and compared it to the resident's name next to the resident's door. CNA 2 stated if a resident was a fall risk, there would be a star next to their name outside the door, but there was no star next to Resident 1's name. CNA 2 stated when she took Resident 1 to the bathroom in the morning, she ambulated without difficulty using her walker. CNA 2 stated Resident 1 wanted to wash her face and brush her dentures at the sink. CNA 2 stated she handed a towel and Resident 1's dentures to her. Resident 1 thanked her and asked her to step out of the bathroom. CNA 2 stated she told Resident 1 she would be right outside the bathroom, and CNA 2 left the door open about an inch so she could see Resident 1 and hear her as she did not want to leave her. CNA 2 stated she heard something and saw Resident 1 turned towards the door to leave the bathroom, so CNA 2 reached out to open the door, and in that moment, Resident 1 fell . CNA 2 stated she had not gotten report from her charge nurse at the beginning of the shift regarding Resident 1 on 1/20/2020. On [DATE] at 0900 hours, an interview was conducted with LVN 6. LVN 6 stated a star placed next to the resident's name outside the door was used to identify a resident who was a high fall risk. On [DATE] at 1105 hours, an interview was conducted with the DON. The DON stated staff would know a resident at risk for falls by a star near their name outside their door. On 3/8/2020 at 0651 hours, a telephone interview was conducted with LVN 8. LVN 8 stated the fall risk assessments were completed upon admission. If a resident was assessed as a high risk for falls, a star was placed on their door and a high fall risk band was put on their wrist to identify them as being at high risk for falls. LVN 8 stated CNAs received report about residents from the previous shift's CNAs as well as from the licensed nurses. When asked if she had explained to CNA 2 what Resident 1's care needs were on 1/20/2020, LVN 8 stated she told CNA 2 to make sure Resident 1 was assisted at all times, which meant a CNA was with her when she went to the restroom. LVN 8 stated she did not remember if Resident 1 could be by herself in the bathroom or not. b. Review of the facility's P&P titled Care Plans - Baseline revised December 2016 showed a baseline plan of care to meet the resident's immediate need shall be developed for each resident within 48 hours of admission. The baseline care plan will be used until the staff can conduct the comprehensive assessment and develop an interdisciplinary person-centered care plan. Review of Resident 1's Physical Therapy Treatment Encounter Notes dated 1/20/2020, showed Resident 1 ambulated with the use of a two-wheeled walker and required contact guard assist (the person assisting the resident maintained contact with the resident either through a gait belt or a hand). Pain exacerbated by standing, reaching, prolonged activity. Review of Resident 1's Occupational Therapy Treatment Encounter Notes dated 1/19/2020, showed Resident 1 was a fall risk and used a back brace for out of bed activities. The documentation showed Resident 1's standing ability while performing ADL care was assessed as poor plus. Review of Resident 1's plan of care showed the following care plan problems to address: - Risk for falls or injury, required assistance or unable to transfer, chronic back pain with a created date of 1/16/20. The interventions included to assist with mobility as required and provide assistive device when indicated. The interventions did not specify what assistance Resident 1 required when ambulating or standing. - Decrease ADL functional activities related to chronic back pain with a created date of [DATE]. The care plan problem showed Resident 1 needed extensive assistance for toileting and grooming. Further review showed Resident 1's plan of care did not address the specific assistance or assistive devices she required when ambulating or standing as reflected by PT and OT's notes on 1/19 and 1/20/2020. On [DATE]20 at 1240 and 1340 hours, an interview was conducted with PT 1. PT 1 stated the PT note dated 1/20/2020, showed Resident 1 required contact guard assist for walking. PT 1 explained contact guard assist meant Resident 1 could walk, but she needed to have the staff's hands on her while she was walking. PT 1 stated contact guard assist meant touching or guiding the resident as needed, and it may or may not require a gait belt on the resident. When asked how he relayed this information to the nursing staff, he stated he spoke to the assigned CNA, LVN, and desk nurse. PT 1 stated he communicated any pertinent resident needs or concerns he had. On [DATE]20 at 1321 hours, an interview was conducted with OT 1. OT 1 stated the OT progress note for Resident 1 dated

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

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F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) 1/19/2020, showed while Resident 1 walked, she helped Resident 1 navigate her walker. OT 1 stated if Resident 1 was standing at the sink and turned to walk out of the bathroom, she should be supervised or have stand by assistance. OT 1 stated Resident 1 could sit on a chair by herself, but she could not be left alone when standing in the bathroom. OT 1 stated due to Resident 1's injuries, her nerves were weak and both legs could give out or buckle at any time. On [DATE] at 0810 hours, an interview was conducted with PTA 1. When asked how PTA 1 communicated a resident's ability, level of assistance required, or assistive device a resident needed to the nursing staff, PTA 1 stated he let the nursing staff know and the nursing staff should have access to the therapy notes. When asked to explain what two-wheeled walker with contact guard assist meant, PTA 1 stated it meant he was not confident in the resident's ability to walk and they needed the walker to stabilize themselves. PTA 1 stated he would not walk out of the room as he was not confident in Resident 1's ability to keep her balance more than two minutes as something might happen. PTA 1 stated when the resident started to move, he would personally be close enough to them to reach them and catch them if they fell . On [DATE] at 0830 hours, an interview was conducted with OT 1. OT 1 explained the initial PT and OT evaluations were often done together and then either one would speak with a nursing staff. When asked to explain standing balance for ADLs is poor plus in her 1/19/2020, note, OT 1 stated it meant the resident needed to have support - literally right there holding on to her. Resident 1 could stand up and wash at the sink a little, then she got tired and would need to sit down as her endurance was poor. On [DATE] at 1025 hours, an interview and concurrent closed medical record review for Resident 1 was conducted with the DSD. The DSD stated if a resident was assessed as a high fall risk, the care plan problem for high fall risk would be initiated by the admitting nurse. The DSD stated each department in the facility should be adding care plan problems for their discipline for a resident. The DSD reviewed Resident 1's plan of care and stated the care plan was not specific enough for Resident 1's mobility or medical equipment needs, and she would like to see the care plan more tailored to Resident 1's specific needs. c. Review of Resident 1's Physical Therapy, PT Evaluation and Plan of Treatment dated [DATE], showed Resident 1 had a back brace which Resident 1's family member took home. Resident 1 was advised by the therapist to have her family member bring the back brace in. The documentation showed Resident 1 felt unsteady when standing, when walking, and was worried about falling. Review of Resident 1's plan of care showed a care plan problem for decreased ADL functional activities related to chronic back pain with [MEDICAL CONDITION] dated [DATE]. The care plan problem showed the use of a brace was not marked. Review of Order Summary Report dated [DATE], for Resident 1 did not show an order for [REDACTED]. On [DATE] at 0810 hours, an interview was conducted with PTA 1. PTA 1 stated when he worked with Resident 1 on 1/20/2020, she did not have her back brace on. PTA 1 stated he was not sure why Resident 1 didn't have the back brace on her that day. On [DATE] at 0830 hours, an interview and concurrent medical record review was conducted with OT 1. OT 1 stated Resident 1's back brace had been brought from home. OT 1 then stated Resident 1 should have worn the back brace. OT 1 stated whenever she got Resident 1 up out of bed, she had Resident 1 wear her back brace. OT 1 stated she would have to check the physician's orders [REDACTED]. On [DATE] at 0920 hours, a telephone interview was conducted with CNA 2. CNA 2 stated she did not see a back brace in Resident 1's room, so she did not put it on Resident 1 when she got her up to the bathroom. Review of Resident 1's SBAR Communication Form and progress note dated [DATE] at 0742 hours, showed the CNA was at the doorway waiting for Resident 1 to finish washing her hands. Resident 1 turned to go to the door and fell , hit the back of her head, and had a small laceration on her scalp. On [DATE] at 1044 hours, a telephone interview was conducted with Resident 1's family member. The family member stated when Resident 1 was at the facility, she was responsive and the family was looking forward to her going home in a week or two. The family member stated Resident 1 told them she was up in the bathroom washing up and lost her balance. The family member stated they were told by the facility staff someone was outside the door but not in the bathroom with her. The family member stated the facility was aware Resident 1 was a fall risk and she should not have been left alone. The family member stated if someone had been there, they could have caught Resident 1 or prevented her from hitting her head. On [DATE]20 at 1110 hours, an interview was conducted with the DON. The DON verified Resident 1's use of a back brace should have been clarified with her physician, her care plan should have been updated to include the PT, and OT assessments or recommendations, and the Falling Star program should have been implemented. Review of the acute care hospital's ED notes dated [DATE], showed Resident 1 was admitted from the emergency room to the intensive care unit with a right-sided occipital fracture with a trace subarachnoid hemorrhage (bleeding into the space surrounding the brain). It showed she had three staples over a 1.5 cm wound on the back of her left head. Review of the CT Angio Chest Trauma result dated [DATE], showed acute-appearing buckle fracture deformities of the right six to eight ribs. Review of Resident 1's Certificate of Death dated [DATE], showed the immediate cause of death was [MEDICATION NAME] force injuries and a fall same level.