STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056066	A. BUILDING _____ B. WING _____	**03/06/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WOODLAND CARE CENTER	**7120 CORBIN AVE. RESEDA, CA 91335**

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: 1. utilize two-person assistance with bed mobility including repositioning 2. develop and implement resident-specific and relevant intervention after a fall incident for one of three sampled residents (Resident 1). This deficient practice resulted in Resident 1 suffering a fall with complaints of pain and being transferred to the General Acute Care Hospital 1 (GACH 1). Findings: A review of the Admission Record indicated the facility admitted Resident 1 on 6/14/19 with [DIAGNOSES REDACTED]. A review of Resident 1's Comprehensive Minimum Data Set (MDS- a standardized assessment and care screening tool) dated 6/21/19 indicated Resident 1's cognition (ability to think, understand and reason) was moderately impaired. The MDS also indicated Resident 1 needed extensive assistance from staff with bed mobility and transfers and required two-person physical assistance. A review of Resident 1's Lift Transfer Reposition assessment dated [DATE] indicated there should be two-persons assisting Resident 1 when repositioning in bed. A review of Resident 1's Change in Condition Evaluation Form dated 6/30/19 indicated Resident 1 had a fall during morning care. Further review of the Summary Investigation Form dated 6/30/19 indicated at 5:30 a.m. Resident 1 was being changed by Certified Nurse Assistant 1 (CNA 1). CNA 1 turned Resident 1 to the side and Resident 1 fell over. Resident 1 complained of four out of ten pain (ten being the highest) back pain. The physician ordered for Resident 1 to be transferred to GACH 1 for further evaluation. A review of Resident 1's Care Plan for falls, dated 6/15/19 indicated Resident 1 is at risk for falls due to weakness. The goal was for Resident 1 not to have any falls with injury for 90 days. Resident 1 had an actual fall on 6/30/19 however there were no resident-specific interventions developed and implemented to prevent further falls. On 1/21/20 at 12:35 p.m., during an interview with the Director of Nursing (DON), she confirmed there was only one CNA repositioning Resident 1. The DON stated there should have been two CNAs repositioning Resident 1 to prevent or minimize accidents. The DON further stated CNA 1 should have called for another staff member to assist in repositioning Resident 1. On 3/5/20 at 3:50 p.m., during a phone interview with the Assistant Director of Nursing (ADON), she stated the fall care plan should have been revised and updated after an actual fall. The ADON further stated facility staff should have been more proactive in developing and implementing resident-specific interventions to prevent further recurrence of fall. A review of the facility's policy and procedure titled, Falls Management, revised 11/01/19, indicated patients determined at risk for falls will receive appropriate interventions to reduce risk and minimize injury. A review of the facility's policy and procedure titled Person-Centered Care Plan dated 11/28/16 indicated it is the policy of the facility to develop and implement a baseline person-centered care plan. Care plans will be reviewed and revised by the interdisciplinary team after each assessment and as needed to reflect the response to care and changing needs and goals and documented on the Care Plan Evaluation Note.
F 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain complete clinical records by failing to document a fall on a Change of Condition Note for one of three sampled residents (Resident 2). This deficient practice placed Resident 2 at risk for unsafe patient care that could lead to a lack in continuity of care and the inability to evaluate the appropriateness of the care delivered. Findings: A review of the Admission Record indicated the facility re-admiited Resident 2 on 1/9/20 with [DIAGNOSES REDACTED]. A review of Resident 2's Comprehensive Minimum Data Set (MDS- a standardized assessment and care screening tool) dated 12/31/19 indicated Resident 1 is alert and required extensive assistance from staff with bed mobility, transfer, and walking. On 1/21/20 at 11:00 a.m., during an interview with Resident 2, she stated on 1/11/20 at 9:45 a.m. she was in the dining room when she stood up, lost her balance and fell . A review of the facility's Fall Log for January 2020 indicated Resident 2 had a fall in the Activity Room on 1/11/2020 at 9:45 a.m. On 1/21/20 at 12:35 p.m., during an interview and concurrent record review of Resident 2's clinical records with the Director of Nursing (DON), she confirmed Resident 2 had a fall on 1/11/20 however there was no documented evidence found indicating a Change of Condition Note was developed for Resident 2. The DON further stated per facility's policy, a Change of Condition Note should be filled out after all falls. The DON stated the Change of Condition Note is especially important after falls because it contains information such as what happened and what interventions were implemented to address Resident 2's fall. A review of the facility's policy and procedure titled, Falls Management, with a revision date of 11/01/19, indicated if a patient falls, the accident/incident is to be documented: a) As a new event in the Risk Management System b) On a Change of Condition note c) On the 24-Hour Report.

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.