STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055604	A. BUILDING _____ B. WING _____	**09/03/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
REDWOOD SPRINGS HEALTHCARE CENTER	**1925 E. HOUSTON AVE VISALIA, CA 93292**

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 0657 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow the Fall and Fall Risk policy and procedure to implement additional interventions for one of three sampled residents (Resident 1) when the resident had repeated falls. This had the potential to result in injury due to the falls. Findings: During a review of the Resident Face Sheet (RFS), undated, the RFS indicated Resident 1 had [DIAGNOSES REDACTED]. and marked by memory disorders, personality changes, and impaired reasoning) without behavioral disturbance . difficulty walking . repeated falls . [MEDICAL CONDITION] (temporary loss of consciousness caused by a fall in blood pressure) and collapse. During a concurrent interview and record review, on 5/21/20, at 10:08 AM, with the Director of Nursing (DON), Resident 1's Care Plan (CP) was reviewed. The following was noted: a. The CP dated 11/16/19, indicated (Resident 1) found on floor (on 11/15/19 fall) . Approach . ROM (range of motion) observation . Refer to IDT (Interdisciplinary Team) & follow recommendation as indicated . Post Rehab (Rehabilitation) Screen . Pain Assessment/Observation as indicated . Neurological observation as indicated . Keep MD (Medical Doctor) & RP (Responsible Party) updated as indicated. b. The CP dated 11/26/19, indicated (Resident 1) had a witnessed fall . Approach . Keep MD & RP updated as indicated . Neurological observation as indicated . Pain Assessment/Observation as indicated . Post Rehab Screen as indicated . ROM observation as indicated . c. The CP dated 11/27/19, indicated (Resident 1) Found on floor . Approach . Keep MD & RP updated as indicated . Neurological Observation as indicated . Pain Assessment/Observation as indicated . Post Rehab Screen as indicated . Refer to IDT & follow recommendations as indicated . ROM observation as indicated . Safety devices as indicated. d. The CP dated 11/29/19, indicated (Resident 1) found on floor . Approach . 1. Rehab to complete post fall screen. 2. MD & RP updated on POC (Plan of Care). 3. Assess for pain, discomfort and delayed injury. 4. Wound treatments as ordered. 5. Neuro checks . There was no documentation that additional interventions to prevent further falls were implemented after each fall. DON confirmed the findings. During a review of the facility's policy and procedure (P&P) titled, Falls and Fall Risk, Managing, dated 1/19, the P&P indicated, . Resident conditions that may contribute to the risk of falls include . h. [MEDICAL CONDITION] and other cognitive impairment . Resident-Centered Approaches to Managing Falls and Fall Risk . If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant . If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on assessment of the nature or category of falling, until falling is reduced or stopped, or until the reason for the continuation of the falling is identified as unavoidable . Monitoring Subsequent Falls and Fall Risk . If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions .

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