STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555716	A. BUILDING _____ B. WING _____	**07/30/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PARKWEST HEALTHCARE CENTER	**6740 WILBUR 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 develop interventions to prevent falls for one of two sample residents (Resident 1). Resident 1 was unable to walk and tried to get out of the wheelchair unattended. Nursing staff where aware of Resident 1's unsafe attempts but did not develop strategies to prevent the resident from standing up and fall. As a result, on August 22, 2018, at 6:30 p.m. Resident 1 got off the wheelchair and fell . Findings: A review of Resident 1's Admission Record (Face Sheet) indicated the facility admitted Resident 1 on January 18, 2018, with a readmitted d June 19, 2018, with [DIAGNOSES REDACTED]. A review of Resident 1's History and Physical (H&P) Examination form dated June 20, 2018, indicated Resident 1 did not have the capacity to understand and make decisions. A review of Resident 1's Minimum Data Set (MDS - standardized assessment and care-screening tool) dated July 14, 2018, indicated Resident 1 was not steady and was only able to stabilize with staff assistance, when moving from a seated to standing position. A review of Resident 1's Care Plan developed on June 19, 2018, for the resident's risk for falls or injury, included in the interventions monitoring the environment for wet spots or items below field of vision, call light within reach, low bed, and landing pads on both sides of the bed. A review of Resident 1's Fall Risk Evaluation form dated July 23, 2018, indicated Resident 1 had a fall risk score of 21 (a total score of 10 or above represented high risk). A review of Resident 1's nursing Progress Note, dated August 22, 2018, indicated at 6:30 p.m., Resident 1 got up from the wheelchair in the hallway by the nursing station and fell on his right side, wearing his eyeglasses, sustaining a laceration to the right eyebrow, of four centimeters (cm) in length, and a scratch to the bridge of the nose. The physician was informed and Resident 1 was sent to a General Acute Care Hospital (GACH) for further evaluation. On August 29, 2018, at 10:14 a.m., during an interview, Licensed Vocational Nurse 1 (LVN) 1 stated Resident 1 was placed in front of the Nursing Station because he was trying to to stand up from his wheelchair. LVN 1 stated Resident 1 would try to get up unassisted. On August 29, 2018, at 10:49 a.m., during an interview, Certified Nurse Assistant 1 (CNA 1) stated Resident 1 tried to get up unassisted and she was the assigned CNA on the day of the fall (August 22, 2018). CNA 1 stated she told her supervisor to watch him because because she needed to take care of another resident. When CNA 1 returned, Resident 1 had already fallen. On October 15, 2018, at 10:15 a.m., during an interview and further record review, the Director of Nursing (DON) was unable to find documentation addressing Resident 1's continued attempts to stand up from the wheelchair. There was no care plan with interventions to implement to prevent Resident 1 from falling when getting out of the wheelchair. A review of the facility's policy titled, Falls-Clinical Protocol, revised on September 2012, indicated falls should be categorized as those that occur while upright and attempting to ambulate. Under Treatment/Management, the policy indicated if underlying causes cannot be readily identified or corrected, staff will try various relevant interventions, based on assessment of the nature or category of falling, until falling reduces or stops or until a reason is identified for its continuation (for example, if the individual continues to try to get up and walk without waiting for assistance).

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.