DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

ACCEPTED 7/11/17 #369224

PRINTED: 06/22/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555128	A. BUILDING _____ B. WING _____	C 06/16/2017

HEALTH FACILITIES INSPECTION DIVISION ADMINISTRATION
2017 JUL 10 PM 3:21
RECEIVED

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOWNEY COMMUNITY HEALTH CENTER	8425 IOWA STREET DOWNEY, CA 90241

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F 000	INITIAL COMMENTS The following reflects the findings of the Department of Public Health during an Entity Reported Incident investigation: Intake # CA00538128 - Substantiated Category: Quality of Care: Resident Safety/Falls Representing the Department of Public Health: 36535 The Inspection was limited to the specific components investigated and does not represent the findings of a full Inspection of the facility.	F 000		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment	F 323	**This Plan of Correction constitutes the facility's written credible allegation of compliance. Preparation and/or execution of this Plan of Correction does not constitute admission of agreement by the Provider of the truth of the facts alleged or the conclusion set forth on the Statement of Deficiencies. This Plan of Correction is prepared and/ or executed solely because required by the provisions of the health and safety code section 1280 and 42 CFR 483.** ***F323W*** ***What corrective action will be accomplished for those residents found to have been affected by the deficient practice;*** Resident #1 had a fall risk assessment completed on 06/19/17. The care plan was reviewed and updated on 06/19/17 to reflect interventions to reduce and prevent falls.	06/19/17 06/19/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
M Schaffer	Administrator	6/29/17

...ency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that h... ...eguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days ...llowing 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 ...ys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ...ogram participation.

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F 323	Continued From page 1 from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to: 1. complete a fall risk reassessment to identify hazard(s) and risk(s) to prevent accidents after Resident 1 fell on 5/30/17 and 6/3/17 and 2. modify Resident 1's care plan to reflect interventions to address specific underlying cause of fall incidents for one of three sampled Residents (Resident 1). These deficient practices had the potetial to have been the cause of another fall incident for Resident 1 causing an acute distal end left forearm fractures (broken bone). These also had the potential to result in further falls. Findings: A review of the Admission Face sheet indicated Resident 1 was initially admitted to the facility on 2/11/13 with diagnosis of Parkinson's disease (degenerative disorder affecting the motor system with symptoms that included shaking, rigidity, slowness of movement and difficulty with walking and gait), generalized muscle weakness, paranoid schizophrenia (subtype of schizophrenia, mental disorder characterized by abnormal social behavior and failure to	F 323	***How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;*** All residents have the potential to be affected by the practice. Staff were in serviced on fall prevention strategies by Judith Hoffman RN,BSN DON and by Rosario Soriano DSD on June 27,2017 6/28 and 6/29/17 RNCMs were in serviced by the Director of Nursing (DON) on following the P&P for RNCM assessment with appropriate Interdisciplinary Team (IDT) referrals after each fall with care plan review and revision of intervention as needed by Judith Hoffman RN,BSN,DON on June 27, 2017 ***What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;*** The facility has implemented a Problem Identification model in the facility with RN Care Management of its' residents.	06/27/17 06/28/17 06/29/17 06/27/17

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F 323	Continued From page 2 understand what is real in which the patient has delusions [false beliefs]), and dementia (long term and often gradual decrease in the ability to think and remember severe enough to affect a person's daily functioning) A review of Resident 1's Minimum Data Set ([MDS] assessment and care screening tool), dated 5/30/17, indicated a brief interview of mental status ([BIMS] brief screener that aids in detecting cognitive impairment) score of 3 (a score of 0-7 represents severely impaired cognition). Resident 1 also had difficulty communicating words and misses some part/intent of message. Resident 1 required extensive assistance (resident involved in activity and staff provide weight bearing support) with bed mobility, transfer, walking, locomotion, dressing, toilet use, personal hygiene, and bathing. Resident 1 was also assessed as occasionally incontinent with bowel and bladder. On 6/15/17 at 3:05 p.m., Resident 1 was observed with a cast on his left arm and was lying down in his bed which was in a low position. A bed alarm was observed on the side of his bed. Floor mats were observed on each side of his bed. Resident 1 was communicative and responded to simple direct questions. Resident confirmed that he fell on 6/3/17, but does not remember the details. Resident stated he does not have any pain and he felt fine. On 6/15/17 at 3:12 p.m., during interview, licensed vocational nurse (LVN 1) stated Resident 1 had a previous fall on 5/30/17 while ambulating in the hallway. According to LVN 1, aside from the hourly rounding, keeping the environment free of clutter, call light within	F 323	RN Care Managers (RNCM) have been assigned to each resident. The RNCM will oversee resident care with assessment and care planning. RNCMs will review changes in condition including falls and will assure that care plans have been reviewed and revised to include interventions to prevent a reoccurrence of falls. Any identified concerns will be brought to the immediate attention of the Director of Nursing (DON) for correction. ***How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan of correction is integrated into the quality assurance system.*** The DON will report findings on care plan updates to the QA Committee on a monthly basis.	07/12/17

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F 323	Continued From page 3 Resident 1's reach, frequent visual checks, reminding the Resident to be careful when turning, Resident 1 was transferred to a room in front of the nurse's station for close monitoring to prevent further falls or injury. LVN 1 stated that the care plan was supposed to be updated, wherein interventions are added or changed, after each fall incident to prevent further falls or injury. On 6/15/17 at 3:22 p.m., during interview, licensed vocational nurse (LVN2) stated he responded to the call of the program assistant on 6/3/17 at around 6:40 p.m. LVN 2 stated he saw Resident 1 on the floor face down. LVN 2 said he asked Resident 1 how he fell, but he did not give him a response. LVN 2 assessed Resident 1 who denied that he was in pain. Resident 1 did not have any bumps or bruises, but LVN 2 noticed a swelling on Resident 1's left hand. LVN 2 stated he notified the physician and received an order for x-ray (photographic or digital image of the internal composition of something, especially a part of the body) of the head and left wrist. On 6/15/17 at 3:30 p.m., during interview, program assistant (PA) stated she was at the nurse's station, which was infront of Resident 1's room, when the incident happened. According to the PA, she heard a sound in the room so she rushed in and saw Resident 1 on the floor near the bed with his face down. PA stated the charge nurse and other staff came to help. Resident 1 was assisted back to bed. On 6/15/17 at 3:41 p.m., during interview, program specialist (PS) stated she was stationed with the other program specialist on each end of the hallway to be able to supervise both sides of	F 323		

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F 323	Continued From page 4 the unit. PS stated her role included to answer call lights, assist residents, monitor, and supervise residents who are at risk for falls. On 6/16/17 at 10:40 a.m., during interview, registered nurse care manager (RNCM) stated the fall risk assessment should be completed concurrently with the MDS and after each incident of fall. A review of the facility form titled, "Fall Risk Assessment," dated 5/23/17 indicated Resident 1's score was 22 (a score of 10 and above represents high risk for fall). Further review of the form indicated that it was not completed after Resident 1's fall incidents on 5/30/17 and 6/3/17. On 6/16/17 at 11:15 a.m., during a concurrent record review and interview with RNCM, she confirmed that the "Fall Risk Assessment" form was not and should have been completed after Resident 1's incidents of fall on 5/30/17 and 6/3/17. RNCM stated that completing it was important so Resident 1's risks for fall can be identified and can be used as a tool to determine interventions when updating the care plan to prevent further falls and injury. A review of the clinical record, dated 5/30/17, indicated that Resident 1 had a fall incident at approximately 8:00 p.m.. Further review indicated Resident 1 had fallen to the floor while ambulating in the hallway. According to a staff, Resident 1 was observed ambulating when staff called his name that prompted him to turn around causing him to lose balance. Resident 1 fell to his right side and bumped his forehead on the floor.	F 323		

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F 323	Continued From page 5 X-ray results of Resident 1's facial bone was negative for fracture. A review of Resident 1's care plan titled, "At Risks for Falls," dated 5/23/17, indicated staff interventions included to provide assistive devices when indicated, visual monitoring every 1-2 hours during rounds and document any change of condition, ¼ side rails up, and keep environment free of slip/trip/fall hazards. A review of Resident 1's other care plan titled, "Status Post Fall, Potential for Pain," dated 5/30/17, indicated staff interventions to monitor and assess for bodily pain, aches, discomfort, note location and severity of pain, medicate as ordered, and visual check every hour. The care plan did not reflect interventions to address specific underlying cause of fall. A review of the clinical record, dated 6/3/17, indicated that Resident 1 had a fall incident at approximately 6:40 p.m. Resident 1 was found lying on the floor in his room. Further review indicated that Resident 1 got agitated when asked how he fell. Resident 1 was noted without any injuries except for slight swelling of the left wrist according to the assessment that was performed by the licensed staff. Neurological check and monitoring was initiated for Resident 1. Physician was notified and gave an order for an x-ray of the skull and left wrist. A review of Resident 1's wrist x-ray radiology report, dated 6/4/17, indicated an acute distal end left forearm fractures (two broken bones of the forearm). The facial bone x-ray results indicated that the osseous (composed of bone) structures	F 323		

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F 323	Continued From page 6 were unremarkable. Maxillary sinuses (the largest of the air-filled spaces that surround the nasal cavity, located under the eyes) were unremarkable. No blowout fracture was seen. A review of Resident 1's other care plan titled, "Status Post Fall, Potential for Pain," dated 6/3/17, indicated staff interventions to monitor and assess for bodily pain, aches, discomfort, note location and severity of pain, medicate as ordered, and visual check every hour. The care plan did not reflect interventions to address specific underlying cause of fall. On 6/16/17 at 11:28 a.m., during a concurrent record review and interview with the director of nursing, she stated that the interventions which were implemented for Resident 1, after each fall incident, should have been documented on the care plan. A review of the facility's policy and procedure titled, "Assessing Falls and Their Causes," dated 10/2010, indicated that when a resident falls, the completion of a fall risk assessment should be recorded in the resident's medical record. A review of the facility's policy and procedure (P&P) titled, "Managing Falls and Falls Risk," revised 7/2012, indicated that if falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant. P&P stipulates that the staff will identify interventions related to resident's specific risks and causes to minimize the resident falling and try to minimize complications from falling.	F 323		