O I'M EMIS	ENT OF DEFICIENCIES N OF CORRECTION	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	FORMAPP OMB NO. 093
	or someonor	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETE
NAME O	F PROVIDER OR SUPPLIER	555771	5. WING		10/15/20
i i				STREET ADDRESS, CITY, STATE, ZIP COL	DE 19/10/20
	VOOD GARDENS SMF	8 6		350 CALLOWAY DRIVE, BUILDING C BAKERSFIELD, CA 93312	
(X4) ID PREFIX TAG	- (CAUD DEFIDIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	MOULD BE CORE
F 000	INITIAL COMMENT	S	F 000	The following is the Plan	of
F 323 SS=D	abbreviated standar Entity Reported Incidence Representing the Day 14748, HEEN The inspection was in reported incident inversement the finding facility. One deficiency was is reported incident 364 483.25(h) FREE OF AHAZARDS/SUPERVI	dent: 364133 epartment: imited to the specific entity estigated and does not s of a full inspection of the essued as a result of entity 133. ACCIDENT SION/DEVICES	F 323	Correction for Glenwood Skilled Care Center regard Statement of Deficiencies October 25, 2013. This Plate Correction is not to be con an agreement with the find conclusions in the Statement Deficiencies, or any related or fine. Rather, it is submitted confirmation of our ongoing to comply with statutory an regulatory requirements. In document, we have outlined actions in response to identifications. We have not provide detailed response to each all or finding, nor have we identificating factors. We remain	ling the dated in of strued as ings and int of isanctions ted as g efforts id this il specific ified ed a legation intified in
	adequate supervision prevent accidents.	as free of accident hazards chiresident receives and assistance devices to	1	committed to the delivery of health care services and will continue to make changes an improvements to satisfy that objective. This Plan of Cone constitutes my written credib allegations of compliance for	quality 5
f e i ti	Based on interview an alied to ensure one readequate assistance dinitigate falls, which restrictured pelvis (ringhe lower end of the tru	evices to prevent and/or sulted in repeated falls and like structure of bones at nk).	Linu	deficiencies noted Allum Sum Al	2010/16/C
leficiency s safeguard	stajement ending with an as s provide sufficient protection		he institution m Except for nursi	ay be excused from correcting providing ing homes, the findings stated above an ine above findings and plans of corrections an approved plan of corrections is ret	B DISCIDEDINE SO HAVE
	ENU(!.		71	Press of Press COSTOL 18 LEC	QUISING TO CONTINUED

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	NT OF DEFICIENCIES,	(A1) PROVIDER/SUPPLIER/CLIA	(X2) HU	LYIPLE CONSTRUCTION	OMB NO. 0938-03
		IDENTIFICATION NUMBER:	A. BUILD		COMPLETED
		555771	B. WING	•	C.
NAME OF	PROVIDER OR SUPPLIER		1 02 27/196	STREET ADDRESS, CITY, STATE, ZIP CODE	10/15/2013
GLENW	OOD BARDENS SHE	30 T	-	350 CALLOWAY DRIVE, BUILDING D	
				BAKERSFIELD, CA 93312	
OXA) ID PREFIX TAG		TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CHOSS-REFERENCED TO THE APPR	Thorne I (C)
=			 	DÉFICIENCY	
F 323	Mario da Front pag	re 1	F 32	TOOLGOLG I WAS USINGTE	ered to
	Findings:		4	the emergency room 07/13/2013.	-
.	The facility reported t	hat on 7/31/13 at 3 AM .	٠	. 07/13/2013.	
1	with a skin tear on he	Observed sitting on the floor		All residents have the	
1	I CONCELLED DICTOR DISCO	11150 was dii		potential to be affected.	1
	the Emergency Room fracture was ideasifed		22 22	Director of nursing with	the
1	fracture was identified	(Ert) Where a pelvic		Interdisciplinary team	
İ	Durino 1			reviewed incidents of fal	15 10 28 13
	During an interview wi 2:55 PM: she stated at	th Resident A on 8/9/13 at		with in the last 30 days.	10
ļī	nove."	he had "pain only when !	-	Completed 10/28/2013.	. *
	nesida e			All residents identified	
	A evidence was found	clinical record for Resident		using floor mats and ala	9d o:
		of four previous falls, two		were identified. This	nns
			25	information will be relay	
			92	the certified nursing	red to
		ated \$/29/15 atready atem. The GCPN for a		assistants tolsing	
				assistants taking care of	the 5
14 (17)	IN TO 11 - 11 - 11 - 11 - 11 - 11 - 11 - 1	COT OF OTO		residents by placing the	
	care pien dated 5/17/1 se of a low bed and m			information on the inside of the closet doors.	part.
	- a, H 10% Neg 91(1) W	lass.		Alabas will be all a later to the	
Ð	uring a review of the "(CNA (Certified Nurses)		Alarms will be checked daily	
				CNAs	12/24/2013
0 10000	results fresults fres	IDO IO the entries of and		CNA	
pre	evented with the use of	fall could have been		CNAs will be trained on	(out
30.000	0., 1.001 1991 1197	DDDD DGTE AL	9	checking the function of the	(WIII)
· na	ve been in place, as no	oted above).		alarms.	N 1
Du	ring an interview with (: SNA i (Docido e a a a	×		13
100000000000000000000000000000000000000	- ' - U I O III II II II II I I I I I I I I I	1 AB 10/7/80 1.30 D.		Jewly admitted residents	R
			V	vill all be evaluated for fall	
	a vicedied on the CON	N form, that meant they I	. ii	sk during the admission	2
n-5001 (DS	99) Previous Varsions Obsolats	Event ID: ROSW11		R 프리크 : 1 : 1 : 1 : 1 : 1 : 1 : 1 : 1 : 1 :	on sheet Page 2 of 3 -
		x 2			
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STATEMENT OF CORRECTION AND PLAN OF CORRECTION NAME OF PROVIDER OR SUPPLER GLENWOOD GARDENS SINF COUNTY SUBJECT ADDRESS, CITY, STATE, MICROSE STREET ADDRESS, CITY, STATE, MICROSE SAKERS, FILE, OR AND STATE, MICROSE SAKERS, FILE, MICROSE SAKERS, FILE, MICROSE SAKERS, FILE, MICROSE SAKERS, F	DEPAR CENTE	TMENT OF HEALT) IRS FOR MED,CARI	HAND HUMAN SERVICES E'& MÉDICAID SERVICES			FORM APPROVE OMB NO. 0938-039
STREET ADDRESS, CITY, STATE, IT CODE SE CALLOWAY DRIVE, BULCONG SE CALLOWAY DRIVE, BULCONG C SAKERSFIELD, CA SS312 PROVIDERS FLANCE CORRECTION OF CORRECTION ADDITION SAKERSFIELD, CA SS312 PROVIDERS FLANCE CORRECTION SACHESTICA, CA SS312 PROVIDERS FLANCE CORRECTION OF CORRECTION SACHESTICA, CA SS312 PROVIDERS FLANCE CORRECTION SACHESTICA NUTSE SACHEST	STATEMEN	T OE DEFICIENCIES	(XII) FROVIDER/SUPPLIER/CUA			
STREET ADDRESS, CITY, STATE, 2F CODE SE CALLOWAY DRIVE, BULLOWN O SAKERSFIELD, CA STATE PROVIDER FLANCE AND CONSTRUCTION OF SAKERSFIELD, CA STATE PROVIDERS FLANCE ACTOR SHOULD BE CARRESTED. CA STATE PROVIDERS FLANCE ACTOR SHOULD BE CARRESTED. CA STATE PROVIDER FLANCE ACTOR SHOULD BE CARRESTED. CA STATE				a wine		C
Set CALLOWAY DRIVE, BUILDING C BAKERSFIELD, CA 333178 SUMMARY STATEMENT OF DESCRIPTION SUMMARY STATEMENT OF DESCRIPTION SEACH SERVICE ACTION SHOULD BE SEACH	NAME OF	PROVIDER OR SUPPLIER		1 6. 17 1143	SYREET ADDRESS, CITY, STATE, ZP CODE	1 10/16/2013
F 323 Continued from page 2 were not in use at the time of the fall. When (the fall) happened there was no bed alarm or mattress (on the fillor). These should have been it resident's equipment to use with a resident. PM resides the more of the continue to the resident's equipment and CNA i did not ask the rurse. In the CNA is supposed to ask the nurse. After each fall, the IDT will be responsible to review and update the and make changes to the Care Plan as needed. IDT will review and update the and make changes to the Care Plan each Quarter. Guidelines will be post inside closet door. Nursing staff have been re inserviced on the community's fall prevention program by			· ·	ļ		20
Fraction of the second waster at practical and the second properties a	FECTIVE AN	OOD GENDENS SHE	•	1	BAKERSFIELD, CA 93312	
were not in use at the time of the fall. "When (the fall) happened there was no bed alarm or mattress (on the floor). There should have been I really don't know why (none were provided)." During an interview with Registered Nurse (RN) 1 (Resident A's nurse at the time of the fall) on 1077/13 at 4.53 PM, she was asked how CMA's are supposed to know what equipment to use with a resident. RN 1 replaced she did not check the resident's equipment and CNA 1 did not ask her about it. The CNA is supposed to ask the nurse." Nurse. A care plan will be developed to address potential risks for fall. Residents with a fall incident will receive a clinical status review by a registered nurse along with the interdisciplinary team the day after the fall or the Monday immediately after the incident. All current residents will continue to be reviewed quarterly for fall risk and care plans will be updated as appropriate. After each fall, the IDT will be responsible to review and update the and make changes to the Care Plan as needed. IDT will review and update Resident's Care Plan each Quarter. Guidelines will be post inside closet door. Nursing staff have been re inserviced on the community's fall prevention program by	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	K (EACH CORRECTIVE ACTION SHOLL CROSS-REFERENCED TO THE APPR	JED BE COMPLETION
ine director of nursing.		were not in use at it fall) happened there mattress (on the flot really don't know violating an interview (Resident A's nurse 10/7/13 at 4:53 PM, are supposed to knowith a resident. RN the resident it. "The County her about it."	the time of the fall. "When (the e was no bed alarm or or). There should have been why (none were provided)." with Registered Nurse (RN) 1 at the time of the fall) on she was asked how CNA's ow what equipment to use 1 replied she did not check ment and CNA 1 did not ask		process by a Registered Nurse. A care plan will I developed to address potential risks for fall. Residents with a fall inci will receive a clinical stareview by a registered nurseless with the interdisciplinary team the after the fall or the Monda immediately after the incident. All current resid will continue to be review quarterly for fall risk and plans will be updated as appropriate. After each fall, the IDT wiresponsible to review and update the and make chato the Care Plan as needed will review and update Resident's Care Plan each Quarter. Guidelines will be post inside closet door. Nursing staff have been serviced on the communications.	dent tus tus rise day orgoing ents red care Il be nges d. IDT vold e

FORM: CMS-2667(02-89) Previous Versions Obsolets

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STATEMENT OF DEFICIENCIES AND FLAN OF SUBFISCTION		MED.CARE & MEDICAID SERVICES CIENCIES (XI) PROVIDER/SUPPLIER/SUA SOCION DENTIFICATION NUMBER:		IPLE CONSTRUCTION VG	(X3) DATE SURVEY COMPLETED	
		555771	6. WING		C 10/16/2013	
JAME OF	PROVIDER OR SUPPLIES	3	STREET ADDRESS, CITY, STATE, ZIF			
RLENW	ODD GARDENS SNE	1		350 CALLOWAY DRIVE, BUILDING C BAKERSFIELD, CA 93312	- 35 G	
(X+) ID PREFIX TAG	; (EACH DEFICIENC	ATEMENT OF DEPICIENCIES DY NUST BE PRECEDED BY FULL USC DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COFR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY	HOULD BE COMPLETION	
	were not in use at fall) happened their mattress (on the fix I really don't know. During an interview (Resident A'e nurse 10/7/13 at 4:53 PM are supposed to know the resident sequip	age 2 the time of the fall. "When (the life was no bed alarm or port). There should have been, why (none were provided)." with Registered Nurse (RiN) 1 at the time of the fall) on, she was asked how CNA's low what equipment to use I replied she did not check oment and CNA 1 did not ask CNA is supposed to ask the	*** ***	The Director of Nursing all the interdisciplinary team weach fall incident the day a incident or the Monday after weakend of the incident for of care meeting. Approache care plan will be reviewed modified as needed to meet resident's needs. Falls will tracked by the Director of Pevery month. The report of findings will be reported to QAPI committee monthly from the property of th	will review from the the transfer the transfer the transfer to the and transfer the transfer the transfer the transfer the transfer the transfer tr	
				months for ongoing compli- monitoring		
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