POC ACCEPTABLE YES NO Reviewed By: Judy Williams HFEN Name

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

PRINTED: 08/30/2013
FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055475	A. BUILDING _____ B. WING _____	C 08/29/2013

Fax Original Facility Notified Name: Date: 9/13/13 Time: 1500 Notified By: Name

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELNESS CONVALESCENT HOSPITAL	812 WEST MAIN STREET TURLOCK, CA 95380

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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health-Licensing and Certification during an Abbreviated Survey to investigate Entity Reported Events: CA00359160 and CA00359444. Representing the California Department of Public Health - Licensing and Certification: Federal ID 32306 RN, HFEN. The inspection was limited to the specific entity reported incidents investigated and does not reflect the findings of a full inspection of the facility. No deficiency was issued for the Entity Reported Event: CA00359160 One deficiency was issued for the Entity Reported Event: CA00359444. The following Entity Reported Events were reviewed during the Abbreviated Survey: CA00357557 and CA00359144. No deficiency was issued for Entity Reported Events: CA00357557 and CA00359144.	F 000	The preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of truth of the facts alleged or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. The plan of correction constitutes my written credible allegation of compliance for the deficiencies noted. *Facility acknowledges no deficiencies issued for CA00359160, CA00357557 and CA00359144.* POC for CA00359444:	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323	F323 483.25 (h) FREE OF ACCIDENT HAZARDS / SUPERVISION / DEVICES **Corrective Action:** Resident 2 care plan and fall interventions were updated. Resident 3 care plan and fall interventions were updated. The IDT reviewed falls, including Residents 2 & 3, with QAPI Root Cause Analysis and goals established 8/12/13. Residents 2 & 3 continue to reside at the facility. **Residents Affected:** All residents, who are at risk for falls, have the potential to be affected.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Don A Wessels	Administrator	9/11/13

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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.

CA DEPT. OF PUBLIC HEALTH
LICENSING & CERTIFICATION - FRESNO

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F 323	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record and administrative document review, the facility failed to ensure each resident received adequate supervision to prevent accidents when Care Plans were not updated and interventions not implemented for 2 of 2 sampled residents (Residents 2 and 3.) This failure placed residents at risk of repeated falls and injury or death. Findings: The clinical record review was conducted on 7/3/13. Resident 2 was admitted with a diagnosis including Generalized Weakness, Congestive Heart Failure, Osteoporosis, Dementia with behavioral disturbances and Depression. Resident 2's Mimimum Data Set, (MOS, a complete assessment of the resident designed to give a accurate picture of the residents capability,) indicated Resident 2 had memory problems and severe cognitive impairment for decision making. The MOS indicated Resident 2 had a history of falls. Resident 2's "Physician Order"' for the cycle 7/1/13 through 7/31/13, indicated "Monitor every shift that call light and personal fall alarm is in place and working properly." Resident 2's careplan "Self Care Deficit," dated 4/16/12, indicated Resident 2 required assistance for all activities of daily living. Resident 2's nurse notes from 7/29/12 through	F 323	**Systemic Changes:** Arm bands for all residents who are at risk for falls were changed to Yellow Arm Bands 7/19/13. The Administrator reviews and endorses all incident reports [related to falls] weekly to ensure Root Cause Analysis [RCA] assessments are completed [or a RCA is identified]. The Director of Nursing or designee will review and endorse all care plans, following resident falls, to ensure interventions are addressed and updated. The Director of Staff Development or designee Inserviced nursing staff on fall prevention 8/12/13 & 8/14/13. The Director of Nursing inserviced licensed staff on fall prevention 9/18/13. The IDT met and implemented a QAPI goal of, "reducing falls with injury [and improving quality of life] 75% in 90 days through RCA & PDSA [Plan, Do, Study, Act Cycle for Performance Improvement]. Resultant actions include: increased evening nursing assistant hours; increased evening activity assistant hours; creation of resident specific [e.g. activity centers & devices] interventions; and IDT/administration review of each fall and updated, personalized interventions.	

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F 323	Continued From page 2 6/3/13, had document 13 falls during that time period. There is no documentation of interventions attempted or new interventions for the ongoing falls. There was no documentation the Interdisciplinary Team had met to review the falls. The facility provided document titled "Incident Report Log," indicated Resident 2 had three falls in 2013. The clinical record review was conducted on 7/3/13 for Resident 3. Resident 3 was admitted with a diagnosis including Alzheimer's Disease, Dementia with behavioral disturbance and psychosis, Anxiety and Depression. The MDS dated 6/4/13, indicated resident 3 had severe impaired cognitive skills for decision making. The assessment indicated Resident 3 needed extensive assistance to perform activities of daily living. Resident 3 was unable to stand and balance without staff assistance to stabilize her. The primary means of ambulation was a wheelchair. The MDS indicated Resident 3 had a history of falls. Resident 3's "Fall Risk Assessment," done quarterly indicated, a score above 10 on all the assessments. A score above 10 represented a high risk of falling. Resident 3's "Physician Order'" for the cycle 7/1/13 through 7/31/13, indicated "Monitor every shift that call light and personal fall alarm is in place and working properly." The facility program titled "Sliding Penguin Program," (a program to alert the staff of a	F 323	**Monitoring:** The Director of Nursing or designee will review all falls for RCA, updated care plans and personalized interventions timely to ensure resident safety, compliance, and measure accomplishment of QAPI goal and effectiveness of PDSA cycle and Performance Improvement. The outcome of this monitoring will be reported to the quarterly QAPI meeting for further review and possible action. **Alleged compliance: 9/27/13**	

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F 323	. Continued From page 3	F 323		

: resident that is a fall risk) dated 8/7/12 and 6/28/13, indicated Resident 3 was a fall risk and needed monitored more closely.

Resident 3's careplan "At risk for falls...," dated 4/21/13, had not been updated with new interventions for the falls on 5/21/13 and 6/5/13.

Resident 3's careplans dated 5/21/13 and 6/5/13, reveal falls and injuries relating to the falls. An X-ray dated 6/5/13, performed to rule out a fracture, revealed "...subacute ...fracture with cortical irregularity and deformity of the distal fifth metatarsal bone."

. The facility provided document titled "Incident : Report Log," indicated Resident 3 had three falls in 2013.

The facility policy and procedure titled, "Fall Prevention Program" dated 1/11 and reviewed 1/12 with no changes, indicated, "Any residents identified as "at risk" for falls shall have an individual plan of care that includes interventions to prevent falls from occurring. All high fall risk residents will further be identified through a different colored arm band than low/no fall risk residents and will have appropriate signs hung above bed to identify them as fall risk to all staff members." "1. Fall Prevention . . .d. The IDT, if indicated, will further update care plans to minimize the risk of falls." "2. Post-Falls . . . e. Following a resident's fall, the IDT (including Rehab if appropriate) will complete a post fall assessment within 72 hours or as soon as practicable. The assessment will include review of possible causal factors.. IDT will summarize findings and recommendation in the IDT progress notes and review and revise care plan." The

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F 323	Continued From page 4 document was not reviewed or revised for 2013. The DON stated that she had planned to review and revise the policy and procedure but had no done so. On 7/17/2013 at 2 p.m., during an interview, the Director of Nurses (DON) stated that the facility had not followed its policy for dealing with falls for Resident 2 and Resident 3. The DON stated the facility had not done all it should have done to prevent the falls for Resident 2 and Resident 3.	F 323		