

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055298 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 09/08/2009 |
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| NAME OF PROVIDER OR SUPPLIER FALLBROOK HOSP. DISTRICT SKILLED NURSING FACILITY | STREET ADDRESS, CITY, STATE, ZIP CODE 325 POTTER AVENUE, FALLBROOK, CA 92028 SAN DIEGO COUNTY |
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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| | <p>The following reflects the findings of the Department of Public Health during a Complaint Investigation visit.</p> <p>Representing the Department of Public Health: [REDACTED]</p> <p>CLASS AA CITATION -- ACCIDENTS 08-1896-0006541-F Complaint(s): CA00191586</p> <p>F323 Each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Resident 1 was assessed to be at high risk for falls upon admission to the facility.</p> <p>The facility failed to implement a plan of care to protect Resident 1 from falls. Resident 1 fell and sustained an intertrochanteric fracture of the left femur (a crack in the proximal femur) requiring surgery. Resident 1 died of medical complication from the left femur fracture.</p> <p>Findings: [REDACTED]</p> <p>On 6/16/09 the medial record of Resident 1 was</p> | | | |
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Event ID: I6J511

9/8/2009

11:58:15AM

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. Except for nursing homes, the findings 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.

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| | <p>Continued From page 1</p> <p>jointly reviewed with Licensed Nurse 1 (LN1) who provided the initial assessment for Resident 1. LN 1 completed a Fall Risk Assessment Tool and an Admission Assessment Tool on the date of admission [REDACTED]. The facility Fall Risk Assessment Tool has two categories: Low Risk (completed for all patients) and At Risk (completed for a fall score of 10 or greater) with the appropriate interventions listed under each section. LN 1 scored Resident 1 as a 14, indicating At Risk for falls. According to the Fall Risk Assessment Tool, the interventions for patients with a fall score of 10 or greater (At Risk) included clip alarm, pressure sensitive alarm, bed in low position and mattress on the floor.</p> <p>[REDACTED]</p> <p>[REDACTED]</p> <p>[REDACTED]</p> <p>[REDACTED]</p> <p>[REDACTED]</p> <p>[REDACTED] LN 1 stated she was aware Resident 1 had a history of falls, and the facility automatically instituted fall precaution interventions for patients at risk to fall. LN 1 stated the interventions were: "low bed, mattress on the floor and bed sensor or tab alarms." According to LN 1 she had instructed the CNA's to institute fall precautions before the patient even arrived at the facility, because she "knew he was a high risk." LN 1 further stated that she had not followed up with the CNA's to ensure they had implemented the appropriate fall interventions.</p> <p>[REDACTED]</p> | | | |

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