STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055816	A. Building B. Wing	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chapman Care Center	12232 Chapman Ave Garden Grove, CA 92840

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** 48853 Based on interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services to prevent a fall incident for one of two sampled residents (Resident 1). * Resident 1's shower chair wheels were not locked when arriving at the shower room; therefore, when the resident removed his cover and leaned forward, the shower chair moved and tilted forward, causing the resident to fall on his left knee and sustaining a fracture. This failure had the potential to negatively impact the resident's well-being. Findings: Review of the facility's P&P titled Fall Risk and Prevention of Injury to include Pathological Fractures revised 03/2019 showed it is the policy of the facility to identify residents that are at risk for falls and to implement a plan of care in an attempt to prevent falls. This includes minimizing the risks for pathological fractures. Under the section for approaches to prevent falls and/or fractures, it includes locking the brakes on beds, gurneys, or wheelchairs. Review of the facility's P&P titled Falling Start Program revised 7/2018 showed to identify the residents who are at high risk for falls, to try to prevent falls and to attempt to increase supervision for the residents assessed to be high risk for falls. Under the section for Prevention, the general safety precautions and interventions should be used for the residents and include locking the brakes on beds, gurneys, or wheelchairs. Medical record review for Resident 1 was initiated on 4/4/24. Resident 1 was readmitted to the facility on [DATE], with diagnoses of paraplegia. Review of Resident 1's History and Physical examination dated 10/10/23, showed Resident 1 had the capacity to understand and make decisions. Review of Resident 1's quarterly MDS assessment dated [DATE], showed the following: - Section C - Cognitive Patterns showed Resident 1's BIMS score was 15 (cognitively intact) (continued on next page)

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Section GG - Functional Limitation in Range of Motion showed Resident 1's upper extremity has impairment on one side (shoulder, elbow, wrist, and hand), and the lower extremity has impairment on both sides (hip, knee, ankle, and foot) - Section GG - Functional Abilities and Goal showed Resident 1 was dependent on chair/bed-to-chair transfer and tub/shower transfers Review of Resident 1's Care Plan showed a care plan problem initiated on 10/8/23, addressing Resident 1's high risk for falls related to lack of body coordination, paraplegia, weakness, polypharmacy (regular use of at least five medications), impaired mobility, balance problem, and impaired vision. Further review of the document showed Resident 1's care plan interventions did not include locking of the brakes on the beds, gurneys, or wheelchairs to prevent falls as the general safety precaution and prevention for falls as per the facility's P&Ps. Review of Resident 1's Licensed Personnel Weekly Progress Notes dated 3/27/24 at 1615 hours, showed Resident 1 had a fall incident in the shower room. Resident 1 was wheeled by the CNA to shower room. Resident 1 bent forward to remove his poncho; however, the shower chair tilted forward and rolled back, and Resident 1 fell forward and landed on his left knees. Resident 1 was transferred to the acute care hospital via paramedics as per the physician's order. Review of the medical record showed on 3/27/24, the resident was transferred to the acute care hospital for evaluation. Review of the hospital CT scan of the left knee dated 3/27/24, showed the resident sustained the comminuted fracture (bone is broken into more than two pieces) tibial plateau (flat top portion of the tibia - shinbone) involving both medial and lateral tibial plateau and slight depression of the medial tibial plateau was seen. Further review of the medical record showed Resident 1 returned to the facility on the same day, 3/27/24, with the immobilizer applied to the left knee and an instruction to follow up with the orthopedist. Review of the facility's Conclusion Summary dated 3/29/24, showed during an interview with CNA 1, CNA 1 stated due to timing, Resident 1 had just arrived at the shower room, and the CNA had not yet locked the shower chair wheels. When Resident 1 shifted his weight, the entire shower chair flipped forward. During the interview conducted on 3/19/24, with Resident 1, Resident 1 stated the shower chair wheels were not locked. On 4/4/24 at 0814 hours, an interview was conducted with Resident 1. Resident 1 stated he was going to take the shower when he fell . Resident 1 further stated the shower chair break was not on, and as he was trying to remove his poncho, the shower chair was not in the right place, then the shower chair slid and tilted forward. On 4/4/24 at 1310 hours, a telephone interview was conducted with CNA 1. CNA 1 stated he was assigned to Resident 1 for the afternoon shift on 3/27/24. CNA 1 stated Resident 1 preferred not to recline the shower chair. However, CNA 1 stated he failed to lock the brakes of the shower chair, and when Resident 1 tried to remove his cover to prepare for the shower, Resident 1 fell forward and landed on his knees. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/4/24 at 1336 hours, an interview was conducted with the ADON. The ADON stated Resident 1 had poor trunk control and required two persons' assistance with transfers. The DON verified the shower chair brakes were not locked when Resident 1 fell in the shower room. On 4/4/24 at 1645 hours, the Administrator and ADON was informed of the above findings.