STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056301	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Modesto Care Center	1900 Coffee Road Modesto, CA 95355

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48713 Based on interview and record review the facility failed to follow facility's policies and procedures and meet professional standards of quality for one of three sampled Residents (Resident 1), when staff did not document Resident 1's change of condition and post fall assessment for unwitnessed fall with injury on 9/26/24. This failure had the potential to result in the inaccurate assessment of Resident 1 and had the potential for falls and delay in care. Findings: During a review of Resident 1's Admission Record (a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), the AR indicated Resident 1 was admitted to the facility on [DATE] with diagnoses for acute gastroenteropathy (Inflammation of the lining of the stomach and the intestines), abnormalities of gait (walking) and mobility (movement), muscle weakness, encephalopathy (damage or disease that affects the brain), diarrhea, history of falling, depression (condition that causes a persistent feeling of sadness and loss of interest in activities), nausea, hyperlipidemia (high levels of fats in the blood), Parkinson's disease (brain disorder that causes uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), sleep apnea (disorder that causes your breathing to stop or get very shallow), hypertension (condition in which the blood vessels have persistently raised pressure), atherosclerotic heart disease (thickening or hardening of the arteries), gastro-esophageal reflux disease (GERD- digestive disorder that occurs when stomach contents flow back into the esophagus), Barrett's esophagus (condition where the lining of the lower esophagus is damaged by stomach acid) and benign prostatic hyperplasia (a noncancerous condition that causes the prostate gland to enlarge). During a review of Resident 1's Minimum Data Set [MDS a resident assessment tool used to identify cognitive (mental processes) and physical functional level assessment] dated 10/2/24, the MDS indicated, Resident 1's Brief Interview for Mental Status (BIMS screening tool used to assess resident cognitive level) score was 12 out of 15 (0 - 7 indicated severe cognitive impairment [memory loss, poor decision making skills] 8-12 moderate cognitive impairment, (13 -15) cognitively intact) which indicated Resident 1 had moderate cognitive impairment. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056301	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/10/2024
NAME OF PROVIDER OR SUPPLIER Golden Modesto Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1900 Coffee Road Modesto, CA 95355	

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of Resident 1's Nursing Note dated 9/26/24, the nursing note indicated, .at 0235 the writer was walking the hall to clock in after lunch the resident kneeling to floor near the door for asking for phone the writer made him to sit on floor called for help by the time he hold the door to stand by himself and slipped out but did not hit the head or anywhere but patient complains of pain on left little finger and stating that it is broken so informed supervisor . send him to the hospital . During a concurrent interview and record review on 10/10/24 at 11:29 a.m. with Licensed Vocational Nurse (LVN) 1, Resident 1's Nursing Note dated 9/26/24, was reviewed. The nursing note indicated, .at 0235 the writer was walking the hall to clock in after lunch the resident kneeling to floor near the door for asking for phone the writer made him to sit on floor called for help by the time he hold the door to stand by himself and slipped out but did not hit the head or anywhere but patient complains of pain on left little finger and stating that it is broken so informed supervisor . send him to the hospital . LVN 1 stated Resident 1 had an unwitnessed fall on 9/26/24 with injury causing dislocation of the left-hand pinky. LVN 1 stated there was no other documentation regarding the fall on 9/26/24. LVN 1 stated it was the facility process to document a change of condition, complete a skin assessment and initiate neuro checks for an unwitnessed fall. During an interview on 10/10/24 at 12:08 p.m. with LVN 2, LVN 2 stated the facility process for falls was for the charge nurse (CN) to document and assess the resident for injury, initiate neurological checks, complete a post fall assessment, change of condition assessment, and monitor resident for delayed injury for 72 hours. LVN 2 stated complete and accurate documentation was important to know what happened and what interventions were initiated. LVN 2 stated complete documentation was used to provide a safe environment and initiate the proper plan of care for Resident 1. During a concurrent interview and record review on 10/10/24 at 12:31 p.m. with Director of Nursing (DON), Resident 1's Nursing Note dated 9/26/24 was reviewed. The nursing note dated 9/26/24, .at 0235 the writer was walking the hall to clock in after lunch the resident kneeling to floor near the door for asking for phone the writer made him to sit on floor called for help by the time he hold the door to stand by himself and slipped out but did not hit the head or anywhere but patient complains of pain on left little finger and stating that it is broken so informed supervisor . send him to the hospital . The DON stated Resident 1 had an unwitnessed fall 9/26/24, was sent to the acute care hospital and diagnosed with a dislocated left-hand pinky. The DON stated there was no change of condition assessment completed, no post fall assessment or skin assessment and there were no neurological checks initiated by the nurse on shift the day of the fall on 9/26/24. The DON stated it was the facility process for all documentation to be completed and to properly assess Resident 1 for possible injury. The DON stated complete and accurate documentation was important, to paint a picture of what happened, what was initiated and how to treat Resident 1. The DON stated when the documentation was not completed, there was a risk for inaccurate assessment of Resident 1 to accurately initiate a plan of care. During an interview on 10/10/24 at 2:14 p.m. with the Administrator (ADM), the ADM stated it was important to have thorough documentation to complete an accurate assessment and treat residents appropriately. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056301	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/10/2024
NAME OF PROVIDER OR SUPPLIER Golden Modesto Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1900 Coffee Road Modesto, CA 95355	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Charting and Documentation, dated 7/2017, the P&P indicated, . all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care . the following information is to be documented in the resident medical record . treatments or services performed, changes in the resident's condition, events incidents or accidents involving the resident . documentation in the medical record will be objective, not opinionated, or speculative, complete, and accurate . During a professional reference review titled, Lippincott Manual of Nursing Practice 11th Edition dated 2020, pages 15 indicated, . Standards of Practice . General Principles . These standards describe what nursing is, what nurses do, and the responsibilities for which nurses are accountable . A deviation from the protocol should be documented in the patient's chart with clear, concise statements of the nurse's decisions, actions, and reasons for the care provided, including any apparent deviation. This should be done at the time the care is rendered because passage of time may lead to a less than accurate recollection of the specific events . Common Departures from the Standards of Nursing Care . Legal claims most commonly made against professional nurses include the following departures from appropriate care: .follow physician orders, follow appropriate nursing measures, communicate information about the patient . document appropriate information in the medical record . and follow physician's orders that should have been questioned or not followed . Common Legal Claims for Departure from Standards of Care . Failure to implement a physician's . order properly .

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(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 - 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 48713

Based on interview and record review the facility failed to ensure residents received adequate supervision to prevent accidents according to the facility' s policy and procedure (P&P) for one of three sampled residents (Resident 1), when the facility had knowledge of Resident 1' s history of falls and Parkinson's disease (brain disorder that causes uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination) on admission and did not provide interventions and supervision to prevent an unwitnessed fall with injury on [DATE] and an unwitnessed fall with injury on [DATE].

These failures resulted in Resident 1 sustaining injuries including dislocation (move from its proper place or position) of the fifth finger of the left hand , Right posterior (back) parafalcine subdural hematoma (collection of blood or bleeding that forms between the brain ' s surface and the covering that occurs after a head injury) a collection of blood), laceration (tearing) to the posterior head and intracranial bleed (bleeding within the skull) with hospitalization in the intensive care unit due to a traumatic brain injury (injury caused by force) and could have contributed to Resident 1's death on [DATE].

Findings:

During a review of Resident 1's Admission Record (AR- a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), the AR indicated Resident 1 was admitted to the facility on [DATE] with diagnosis for . abnormalities of gait (walking) and mobility (movement), muscle weakness, encephalopathy (damage or disease that affects the brain), history of falling, Parkinson ' s disease , sleep apnea (disorder that causes your breathing to stop or get very shallow), hypertension (condition in which the blood vessels have persistently raised pressure) .

During a review of Resident 1's Minimum Data Set [MDS a resident assessment tool used to identify cognitive (mental processes) and physical functional level assessment] dated [DATE], the MDS indicated, Resident 1's Brief Interview for Mental Status (BIMS screening tool used to assess resident cognitive level) score was 12 out of 15 (0 - 7 indicated severe cognitive impairment [memory loss, poor decision making skills] ,d+[DATE] moderate cognitive impairment, (13 -15) cognitively intact) which indicated Resident 1 had moderate cognitive impairment.

During a record review of Resident 1 ' s Fall Risk Evaluation dated [DATE], the assessment indicated, . If the total score is 10 or greater, the resident should be considered at High risk for potential falls. Prevention protocol should be initiated immediately and documented on the care plan . The evaluation indicated Resident 1 ' s fall risk score was 21.

During a review of Resident 1 ' s At risk for Falls Care plan (CP) dated [DATE], the CP indicated, . At risk for fall or injury due to impaired balance, impaired mobility, impaired safety awareness, weakness . assist with activities of daily living (ADL) and mobility needs, ongoing as needed . Fall assessment to be completed on admission, quarterly and as needed, low bed .

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NAME OF PROVIDER OR SUPPLIER: Golden Modesto Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 1900 Coffee Road Modesto, CA 95355	

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(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 - Actual harm Residents Affected - Few	During a review of Resident 1 ' s Nursing Note dated [DATE], the nursing note indicated, . Patient continues to climb out of bed, refusing to listen to being redirected. Patient appears to be agitated and saying he wants to go home and will go home . During a record review of Resident 1's Nursing Note dated [DATE], the nursing note indicated, .At 0235 (2:35 a.m.) the writer was walking the hall to clock in after lunch the resident kneeling to floor near the door for asking for phone the writer made him to sit on floor called for help by the time he hold the door to stand by himself and slipped out but did not hit the head or anywhere but patient complains of pain on left little finger and stating that it is broken so informed supervisor . send him to the hospital . During a concurrent interview and record review on [DATE] at 11:29 a.m. with Licensed Vocational Nurse (LVN) 1, Resident 1 ' s Nursing Note dated [DATE], was reviewed. The nursing note indicated, .At 0235 the writer was walking the hall to clock in after lunch the resident kneeling to floor near the door for asking for phone the writer made him to sit on floor called for help by the time he hold the door to stand by himself and slipped out but did not hit the head or anywhere but patient complains of pain on left little finger and stating that it is broken so informed supervisor . send him to the hospital . LVN 1 stated Resident 1 had an unwitnessed fall on [DATE] causing a dislocation of the left-hand pinky. LVN 1 stated there was no other documentation regarding the fall on [DATE]. LVN 1 stated it was the facility process to document a change of condition, complete a skin assessment and initiate neuro checks for an unwitnessed fall. During a review of Resident 1 ' s Fall Care Plan dated [DATE], the CP indicated, . Fall on [DATE] with injury due to poor safety awareness, non-compliance as evidenced by continuously self-ambulating (walking) without calling for assistance . interventions, neuro-checks every shift for 72 hours from initial occurrence . placed in fall program . The care plan indicated the facility staff did not implement the intervention for neuro checks following Resident 1 ' s fall on [DATE] as documented in the care plan. During a review of Resident 1 ' s Fall Program Care Plan dated [DATE], the CP indicated, . Fall program . blue bracelet, blue fall intervention sign above the head of bed, blue name sign by the door, Non-skid footwear, low bed . During a review of Resident 1 ' s Interdisciplinary Team Note (IDT- team that consists of various staff that are involved with resident ' s care), dated [DATE], the note indicated, . Resident has had episodes of confusion after wife has gone home including non-compliance with care, impulsivity as evidenced by self-transferring and ambulation (walking) without assistance and making false accusations towards staff since admission . During a review of Resident 1 ' s Order Summary Report, dated [DATE], the order summary indicated, . Fall interventions in place: nonskid footwear, low bed every shift . The order summary indicated the facility staff did not implement intervention for nonskid footwear and low bed until three days after the creation of the fall care plan. During a review of Resident 1 ' s Nursing Note dated [DATE], the note indicated, . resident had unwitnessed fall . resident has left side head injury. Pressure applied to the injury. Medical doctor (MD) notified and received order to send to hospital . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056301	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/10/2024
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(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 - Actual harm Residents Affected - Few	During an interview on [DATE] at 12:08 p.m. with LVN 2, LVN 2 stated the facility process was to identify residents were a fall risk upon admission and initiate fall precautions, which included bed in low position, non-slip socks and frequent monitoring. Resident 1 ' s fall program was not initiated until 11 days after admission to the facility. LVN 2 stated the facility process for falls was for the charge nurse (CN) to assess the resident for injury, initiate neurological checks, complete a post fall assessment, change of condition assessment, and monitor resident for delayed injury for 72 hours. LVN 2 stated when Resident 1 was exhibiting behaviors that included attempting to self-transfer or ambulating without assistance, it was expected that a 15-minute monitoring would have been initiated or a staff member assigned to monitor Resident 1, but there was no order for these interventions. LVN 2 stated there were interventions that could have been initiated that included floor mats next to bed, redirecting Resident 1 by providing activities or talking, taking Resident 1 to the nurse ' s station for supervision and a one on one for safety. During an interview on [DATE] at 12: 21 p.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated Resident 1 was confused, attempted to self-transfer, unable to use his call light and difficult to re-direct. CNA 1 stated that Resident 1 ' s spouse would visit with Resident 1 approximately ,d+[DATE] hours a day and during this time, Resident 1 ' s spouse alerted staff if Resident needed assistance. CNA 1 stated when Resident 1 ' s spouse was in the facility, Resident 1 was calm with no behaviors. CNA 1 stated that when Resident 1 ' s spouse would leave the facility, Resident 1 would exhibit behaviors. CNA 1 stated it would have been beneficial for Resident 1 to have been assigned a one-on-one staff member for his safety. CNA 1 stated it was important to monitor all residents who are a high risk for falls and who exhibit behaviors such as Resident 1, to ensure they are not falling or injuring themselves. During an interview on [DATE] at 12:28 p.m. with CNA 2, CNA 2 stated Resident 1 was confused, unsteady when attempting to stand or walk and at risk for falls. CNA 2 stated that when she was assigned Resident 1, she was afraid he was going to fall due to behaviors of self-transferring and unsteadiness. CNA 2 stated, Resident 1 was wheeled to sit with CNA 2 during most of the morning shift to monitor Resident 1. CNA 2 stated it would have been beneficial for Resident 1 to have had a one-on-one staff member after Resident 1 ' s spouse left the facility, to monitor Resident 1 for his safety. CNA 2 stated it was important to monitor Resident 1 because he had a history of falls. (continued on next page)

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(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 - Actual harm Residents Affected - Few	During a concurrent interview and record review on [DATE] at 12:31 p.m. with the Director of Nursing (DON), Resident 1 ' s Fall Risk Evaluation dated [DATE], Nursing Note dated [DATE], Fall Program Care Plan dated [DATE], and Nursing Note dated [DATE] were reviewed. The fall risk evaluation indicated, . if the total score is 10 or greater, the resident should be considered at High risk for potential falls. Prevention protocol should be initiated immediately and documented on the care plan . The evaluation indicated Resident 1 ' s fall risk score was 21. The nursing note dated [DATE] indicated, . patient continues to climb out of bed, refusing to listen to being redirected. Patient appears to be agitated and saying he wants to go home and will go home . The nursing note dated [DATE], .at 2:35 a.m. the writer was walking the hall to clock in after lunch the resident kneeling to floor near the door for asking for phone the writer made him to sit on floor called for help by the time he hold the door to stand by himself and slipped out but did not hit the head or anywhere but patient complains of pain on left little finger and stating that it is broken so informed supervisor . send him to the hospital . The Fall program CP indicated, . Fall program . blue bracelet, blue fall intervention sign above the head of bed, blue name sign by the door, Non-skid footwear, low bed . The care plan was created until five days after Resident 1 ' s fall on [DATE]. The intervention for nonskid footwear and low bed was initiated 8 days after Resident 1 ' s fall on [DATE], when the physician order was documented. The DON stated Resident 1 ' s fall risk score was at 21 on admission, indicating Resident 1 was a high risk for falls. The DON stated Resident 1 had an unwitnessed fall [DATE], was sent to the acute care hospital and diagnosed with a dislocated left-hand pinky. The DON stated there was no change of condition assessment completed, no post fall assessment or skin assessment and there were no neurological checks initiated by the nurse on shift the day of the fall on [DATE]. The DON stated it was the facility process for all documentation to be completed and to properly assess Resident 1 for possible injury. The DON stated, as a result, she was not made aware of Resident 1 ' s fall with injury until [DATE], 4 days later. The DON stated that the fall program which included, a blue bracelet, blue sign above Resident 1 ' s bed, blue name band at the door and low bed, was initiated on [DATE] for Resident 1. The DON stated the fall program should have been initiated upon admission but, was not initiated until after the fall on [DATE] due to DON not being aware Resident 1 had a history of falls. The DON stated Resident 1 would exhibit behaviors manifested by attempting to self-transfer, non-compliant with personal care and non-compliant with using the call light for assistance when his spouse would leave the facility. During a concurrent interview and record review on [DATE] at 12:47 p.m., with the DON, Resident 1 ' s Change of Condition (COC) assessment dated [DATE] and Nursing Note dated [DATE], were reviewed. The COC indicated Resident 1 had an unwitnessed fall on [DATE] with injury. The nursing note indicated, . Resident had unwitnessed fall . resident has left side head injury. Pressure applied to the injury. Medical doctor (MD) notified and received order to send to hospital . The DON stated Resident 1 was found lying on the floor in his room with a left side abrasion to the head. The DON stated she was not aware of the details of the fall as they were not documented and did not know if bed was in a low position at the time of Resident 1 ' s fall on [DATE]. The DON stated there were no floor mats and there was no monitoring protocol put in place for Resident 1. The DON stated Resident 1 ' s intervention was to initiate the fall program to help staff identify Resident 1 as a fall risk. The DON stated she was aware Resident 1 was attempting to walk without assistance but did not identify a pattern of behaviors until after Resident 1 ' s fall on [DATE]. (continued on next page)

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(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 - Actual harm Residents Affected - Few	During a phone interview on [DATE] at 2:15 p.m. with LVN 3, LVN 3 stated Resident 1 had an unwitnessed fall on [DATE] and was transferred to the acute care hospital. LVN 3 stated Resident 1 was exhibiting behaviors that included attempts to self-transfer. LVN 3 stated Resident 1 was a high risk for falls and was taken to the nurse ' s station for a one-on-one monitoring. LVN 3 stated the one-on-one monitoring was an intervention that was implemented for that night shift while behaviors were present. LVN 3 stated Resident 1 requested to go back to bed and was taken by CNA 3 to his room. LVN 3 stated Resident 1 was assisted back to bed and was left in his room without monitoring. LVN 3 stated that approximately 30 minutes later, CNA 3 reported Resident 1 had an unwitnessed fall and was found lying on the floor. LVN 3 stated when Resident 1 was experiencing behaviors manifested by attempts to self-transfer, confusion, or restlessness, it was important to monitor Resident 1 for safety and not left alone while the behaviors were present. LVN 3 stated when a resident was admitted to the facility with a history of falls, the fall program should have been initiated immediately for prevention of falls. Resident 1 ' s fall program was initiated on [DATE], eight days after admission to the facility. During a telephone interview on [DATE] at 2:26 p.m. with Registered Nurse (RN) 1, RN 1 stated Resident 1 had an unwitnessed fall on [DATE]. RN 1 stated Resident 1 had behaviors manifested by attempting to self-transfer from the bed to wheelchair. RN 1 stated Resident 1 required frequent re-orientation after Resident 1 ' s spouse would leave the facility. RN 1 stated Resident 1 was at a high risk for falls and was concerned that Resident 1 ' s room was too far from the nurse ' s station. RN 1 stated Resident 1 had episodes of being confused, was oriented to self and situation at times. RN 1 stated that when a resident is admitted to the facility with a history of falls, the fall program should be initiated immediately for resident safety. Resident 1 ' s fall program was initiated on [DATE], eight days after admission to the facility. During a review of Resident 1 ' s Emergency Department Note dated [DATE], the note indicated, . unwitnessed, patient found on ground (in facility), positive for head strike with laceration to left head, patient reports loss of consciousness . Glasgow Coma Scale (GCS- 13 a clinical scale used to measure a person ' s level of consciousness after a brain injury. Score levels ,d+[DATE] are sever traumatic brain injury [TBI], , d+[DATE] moderate TBI, and ,d+[DATE] mild TBI) 14 per emergency medical systems patient is at baseline . 3 centimeter (unit of measure) laceration to posterior (back) scalp . Computed tomography scan (CT- diagnostic imaging procedure produces images of the inside of the body) impression: Right posterior parafalcine subdural hematoma measures up to 5 millimeters (unit of measure) . will be admitted to the trauma service for ground level fall causing intracranial bleed . During a record review of Resident 1 ' s critical Care Note, dated [DATE], the note indicated, . Patient is seen and examined at bedside. Alert and following commands. Appear slightly confused with garbled speech. Close to baseline per family at bedside. Does not recall falling . considering patient has had multiple falls over the past few weeks as well as his underlying Parkinson ' s and other comorbidities (the condition of having two or more diseases at the same time), I have recommended a palliative care evaluation . During a review of Resident 1 ' s Palliative Care Consultation Note, dated [DATE], the note indicated, . met with [Family] . at baseline they feel he (Resident 1) experiences hallucinations at times. [Family member] expressed concerns about patient having dementia . he has had several falls .that other issues such as his impulsiveness and falling might be his undoing . (continued on next page)

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(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 - Actual harm Residents Affected - Few	During a review of Resident 1 ' s hospital Trauma Surgery Discharge Summary, dated [DATE], the summary indicated, . Closed head injury, Palliative care patient, Syncope (fainting), Scalp laceration, Subdural hematoma, Ground-level fall, traumatic brain injury (TBI) . Injuries were found to be non-operative. He remained neurologically intact to baseline until [DATE] when he became unresponsive . On [DATE], patient reported dyspnea (difficulty breathing) to the CNA at bedside after mobilizing with physical therapy (PT). CNA called staff and rapid response. Patient was unresponsive, pale, cyanotic(blue) with agonal (not getting enough oxygen and gasping for air) breathing in pulseless electrical activity (PEA- condition when there is no pulse, no heartbeat, and no breathing). During a review of the facility ' s policy and procedure (P&P) titled, Falls and Fall Risk, Managing, dated , d+[DATE], the P&P indicated, . Based on previous evaluations and current data, the staff will identify interventions related to the residents specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling . once a review is completed resident may be placed on the fall program. The individuals that have two or more falls in 90 days or fall with injury will be automatically placed on the fall program . the facility can use the following interventions but not limited to these interventions for the resident. falling matt, 1:1, bed in lowest position, moving resident closer to the nurse ' s station, call lights within reach . or any other interventions that are resident centered . During a review of the facility ' s P&P titled, Safety and Supervision of Residents, dated ,d+[DATE], the P&P indicated, . Resident safety and supervision and assistance to prevent accidents are facility-wide priorities . our individualized, resident-centered approach to safety addresses safety and accident hazards for individual residents .the care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices . resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the individual residents assessed needs and identified hazards in environment. The type of frequency of resident supervision may vary among residents and over time for the same resident .