STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555144	A. Building B. Wing	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St. Pauls Health Care Center	235 Nutmeg Street San Diego, CA 92103

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 - Some	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** 46235 Based on observation, interview and record review, the facility failed to complete post fall assessments and resident centered fall preventive measures for four of four residents reviewed for complete resident records. (Residents 1, 2, 3 and 4) This failure had the potential for residents to have repeated fall incidents. Findings: 1. Resident 1 was admitted to the facility on [DATE] with diagnoses including unspecified abnormalities of gait and mobility according to the facility's Face Sheet. During an observation and interview on 6/13/24, at 9:01 A.M. with Resident 1, Resident 1 stated she returned to the facility from the hospital because she fell . Resident 1 stated she did not remember how and where she fell but stated she broke her hip and was pointing on the left hip. A review of Resident 1's Clinical Notes Report, dated 6/7/24 at 7:23 A.M. a Licensed Nurse documented, . resident was found on the floor of the entryway to her room . An interview with Certified Nurse Assistant (CNA) 1 was conducted on 6/13/24, at 9:11 A.M. CNA 1 stated Resident 1 had a green sticker next to Resident 1's name on the doorway because of a recent fall incident. CNA 1 further stated that Resident 1 was a fall risk because Resident 1 forgot to call for assistance and needed supervision with transfers. An interview and joint record review was conducted on 6/13/24, at 9:42 A.M. with the MDS nurse (MDSN- a nurse who assessed and evaluated the quality of care being given to residents). The MDSN reviewed Resident 1's clinical notes and confirmed Resident 1had a fall incident on 6/7/24. The MDSN reviewed Resident 1's Fall Risk Assessment, dated 3/25/24 and stated Resident 1 scored an 11 which indicated high fall risk. The MDSN stated a score greater than 10 was considered high risk for falls. The MDSN further reviewed Resident 1's records and stated there was no post fall assessment completed after Resident 1's fall on 6/7/24. The MDSN stated fall assessments should be completed upon a resident's admission, quarterly and after each fall incident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 1's risk for fall care plan and IDT (Interdisciplinary Team- team members with various areas of expertise who work together toward the goals of their residents) notes were reviewed by the MDSN. The MDSN stated the care plan, and the IDT notes did not indicate new interventions to prevent further falls. 2. Resident 2 was admitted to the facility on [DATE] with diagnoses including unsteadiness on feet and muscle weakness according to the facility's Face Sheet. During an observation on 6/13/14, at 9:20 A.M., Resident 2's name tag on doorway had a green star sticker. Resident 2 was observed in bed with a blanket over her head. On 6/13/24, at 9:34 A.M. Licensed Nurse (LN) 1 was interviewed. LN 1 stated the green star sticker on Resident 2's door tag indicated Resident 2 fell within 30 days and was a fall risk. During a review of Resident 2's Clinical Notes Report, dated 6/8/24 at 7:00 P.M. a Licensed Nurse documented, .resident was heard by CNA calling for help. CNA responded and found resident on the floor next to the bed . An interview and joint record review was conducted on 6/13/24, at 10:09 A.M. with the MDSN. The MDSN reviewed Resident 2's clinical notes and stated there was no post fall assessment completed for the 6/8/24 fall incident. The MDSN further stated Resident 2's risk for fall care plan and IDT notes dated 6/10/24 did not indicate new interventions to prevent falls. 3. Resident 3 was admitted to the facility on [DATE] with diagnoses including Parkinsonism (brain condition causing slowed movements, stiffness, and tremors) and abnormalities of gait and mobility according to the facility's Face Sheet. During an observation on 6/13/24, at 9:24 A.M., Resident 3's door tag had a green star sticker next to Resident 3's name. During an interview with LN 1 on 6/13/24, at 9:34 A.M., LN 1 stated Residents with green star stickers next to names on doorways indicated residents had a fall within the last 30 days. A review of Resident 3's Clinical Notes Report, dated 5/2024 at 7:48 P.M. a Licensed Nurse documented, Resident had an unwitnessed fall in his room. He fell on his buttock with no open skin tear or bleeding . An interview and joint record review was conducted on 6/13/24, at 10:16 A.M. with the MDSN. The MDSN reviewed Resident 3's clinical record and stated Resident 3 had a fall incident on 5/19/24 and on 5/20/24. The MDSN further stated there was no post fall assessment for the 5/20/24 fall incident. 4. Resident 4 was admitted to the facility on [DATE] with diagnoses including hemiplegia (total or partial paralysis of one side of the body) following cerebral infarction (disrupted blood flow to the brain) according to the facility's Face Sheet. During an observation and interview on 6/13/24, at 9:25 A.M. Resident 4 was in bed with a transfer pole next to bed. Resident 4 stated he fell a month ago because he got up on his own. Resident 4's door tag was observed with a green star sticker next to Resident 4's name. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 4's Clinical Notes Report, dated 4/29/24, at 1:26 P.M., a Licensed Nurse documented, .Rt (resident) attempted to transfer from WC (wheelchair) to bed and slid to the floor. An interview and joint record review was conducted on 6/13/24, at 10:25 A.M. with the MDSN. The MDSN confirmed Resident 4's fall incident on 4/29/24. The MDSN reviewed the Fall Risk assessment dated [DATE] which indicated a score of 13, high risk. The MDSN stated there was no post fall risk assessment done for the 4/29/24 fall incident. On 6/13/24, at 11:18 A.M. the MDSN was interviewed regarding post fall documentation. The MDSN stated staff were expected to complete the post fall assessment to determine the resident's risk. The MDSN further stated care plan should be updated post fall for staff to be aware and prevent resident falls. On 6/14/24, at 10:06A.M. the charge nurse (CN) was interviewed regarding documentation of residents' falls. The CN stated fall risk assessments were completed on admission, quarterly and after a fall. The CN stated fall risk assessments should be completed to determine if the score had increased, then the care plan should be completed after a resident's fall for new interventions. A review of the facility's undated policy and procedure (P&P) titled, Falls-Clinical Protocol was conducted. The P&P indicated, .The staff and physician will continue to collect and evaluate information until either the cause of the falling is identified, or it is determined that the cause cannot be found or is not correctable . The facility's P&P did not provide guidance for staff regarding completion of post fall assessments and fall preventive measures documentation in the resident's care plan.