

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555473	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/05/2024
NAME OF PROVIDER OR SUPPLIER  Alta Gardens Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  13075 Blackbird Street Garden Grove, CA 92843	

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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49258</b></p> <p>Based on observation, interview, medical record review, and facility P&amp;P review, the facility failed to ensure one of two final sampled residents (Resident 2) was provided a floor mat as per the resident's care plan to prevent or minimize the injury in case of a fall. This failure had the potential to place the resident at risk for serious injury.</p> <p>Findings:</p> <p>Review of the facility's P&amp;P titled Falls Management revised 3/15/24, showed the residents will be assessed for risk of falling as part of the nursing assessment process, interventions to reduce risk and minimize injury will be implemented as appropriate and implement and document the resident-centered interventions according to the individual risk factors in the resident's plan of care.</p> <p>On 6/4/24 at 1435 hours, an observation and concurrent interview was conducted with Resident 2. Resident 2 was observed awake and sitting in her bed with the right side of the bed against the wall. Resident 2 was observed without a floor mat on the floor. Resident 2 stated she fell last month but could not recall the exact date. Resident 2 further stated she could not remember if she ever had a floor mat beside her bed.</p> <p>Medical record review for Resident 2 was initiated on 6/4/24. Resident 2 was admitted to the facility on [DATE], and readmitted on [DATE].</p> <p>Review of Resident 2's H&amp;P examination dated 7/3/23, showed Resident 2 had the capacity to understand and make decisions.</p> <p>Review of Resident 2's MDS dated [DATE], showed Resident 2 required substantial to maximal assistance with mobility and transfers.</p> <p>Review of Resident 2's Assessment Outcome for Admission/Readmitted d 7/3/23, showed a fall risk was identified for the resident.</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 2's Care Plan initiated on 7/3/23, showed a care plan problem addressing Resident 2's risk for falls related to confusion, attempt to self-transfer multiple times, needed constant redirection, required substantial to maximum assistance with ADL care, and occasionally incontinence of bowel and bladder. The care plan interventions included to implement the floor mat to the right side of the bed.</p> <p>Review of Resident 2's Change of Condition Evaluation dated 5/14/24, showed Resident 2 had an episode of fall. The resident had a skin tear to the right hand.</p> <p>On 6/4/24 at 1500 hours, an observation and concurrent interview was conducted with CNA 1. CNA 1 stated he had been taking care of Resident 2 for a long time as he was permanently assigned to the station where Resident 2 had been staying. CNA 1 further stated Resident 2 had never had a floor mat in her room.</p> <p>On 6/4/24 at 1545 hours, an observation and concurrent interview was conducted with LVN 1. LVN 1 stated she had known Resident 2 for a while as she was assigned most of the time to the station where Resident 2 was. LVN 1 stated the care plan was person-centered and the interventions should be followed. LVN 1 stated Resident 2 had never used a floor mat in her room.</p> <p>On 6/4/24 at 1620 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 verified Resident 2's care plan interventions included to place the floor mat on the right side of the bed. RN 1 further stated Resident 2 should have the floor mat placed at the bedside. RN 1 was informed and acknowledged the above findings.</p>		