STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555479	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Delano District Skilled Nursing Facility	1509 Tokay Street Delano, CA 93215

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** 37697 Based on interview and record review, the facility failed to implement their fall intervention for one of three sampled residents (Resident 1). This failure had the potential for Resident 1 to have serious injury or harm. Findings: During a review of Resident 1 ' s ADMISSION RECORD (AR), dated 8/5/24, the AR indicated, Resident 1 was admitted to the facility on [DATE], diagnosis including Hemiplegia (inability to move one side of the body), hemiparesis (one sided muscle weakness), cerebral infarction (disrupted blood flow to the brain), aphasia (difficulty reading, speaking, understanding and writing due to damage of the brain), muscle weakness, history of falls. During a review of Resident 1 ' s Minimum Data Set (MDS- an assessment tool) under the section BIMS (Brief Interview for Mental Status - an assessment of cognition [mental processes including perception, memory, and thought], dated 7/1/24, the BIMS indicated, Resident 1 was not able to be assessed due to being rarely/never understood. During a review of Resident 1 ' s Fall Risk Assessment (FRA - an assessment tool for falls), dated 7/1/24, the FRA indicated, Resident 1 was high risk for falls. During an interview on 8/8/24 at 11:27 a.m. with Registered Nurse (RN), RN 1 stated on 7/31/24, Resident 1 had a fall incident in her room. RN 1 stated Resident 1 was observed on the floor and noted with bleeding to her right pinky finger. RN 1 stated Resident 1 was sent out to the hospital via ambulance for higher level of care treatment. During a review of Resident 1 ' s SBAR Communication Form and Progress Note (CFPN), dated 7/31/24, the CFPN indicated, Unwitnessed fall, per CNA (Certified Nursing Assistant) (not identified) heard alarm, went to check, found resident on the floor in restroom. With Supervisor (not identified) went to check resident (1), on the floor side lying position facing the bathroom door. Denies hitting her head and no (complaints of) pain. Body assessment done, noted with skin tear and bump to right forearm and laceration (cut) to her right pinky with moderate to severe bleeding. Pressure dressing applied. (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1 ' s KARDEX (KX - a document that guides coordinated care for a resident), dated 9/14/20, the KX indicated, Resident 1 is to have documentation completed by staff every two hours to indicate staff had interacted with her, anticipated her needs, and checked the alarms she had in place for prevention of falls. During a review of Resident 1 ' s Progress Notes (PN), dated 7/31/24, the PN indicated, Resident 1 had returned from the hospital with a diagnosis of laceration and fracture (break in bone) of the right pinky finger. During a concurrent interview and record review on 8/8/24 at 12:10 p.m. with Director of Nursing (DON), Resident 1 ' s Facility Electronic Medical Record (FEMR) was reviewed. DON stated there was no documentation done every two hours for Resident 1 indicating staff had interacted with her, anticipated her needs, and checked her alarms as indicated in the KX. DON stated there is an electronic task indicated in the FEMR for staff to do every two-hour charting, but it had not been done. DON stated there was no other evidence the staff had been interacting with Resident 1, anticipating her needs, and checking her alarms. During a review of the facility ' s policy and procedure (P&P) titled, Resident Fall, dated 4/29/14, the P&P indicated, PURPOSE: To investigate causal factors for falls, and to provide prompt intervention to assess for injury, and to restore and maintain safety for residents after a fall . It is the policy of DDSNF to promptly respond to all residents after a fall to provide necessary care and treatment to medically stabilize, and to initiate prompt interventions to prevent or reduce further falls with or without injury. If needed, additional intervention will be included which may help minimize the fall. During a review of the facility ' s P&P titled, Documentation & Confidentiality, dated 9/5/08, the P&P indicated, The resident's Medical Record shall be current and kept in detail consistent with good medical and professional practice based on the service provided each resident. Document resident's response to treatment, medications, nursing interventions.