STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055070	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seacrest Post-Acute Care Center	1416 West 6th Street San Pedro, CA 90732

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45743 Based on interview and record review, the facility failed to ensure documentation was completed and correct when the hand sink in the bathroom for one of three sampled residents (Resident 1) fell off the wall causing Resident 1 to fall to the floor, breaking her hip and causing her to sustain a bump to her left eye and the left side of the back of her head. This deficient practice resulted in confusion regarding the timeline of events related to Resident 1's fall, and the inability to determine what Resident 1's actual assessment was after her fall including the subsequent discovery of Resident 1's injuries. This deficient practice had the potential for a delay in evaluation and treatment and non-continuity of care. Findings: During a review of Resident 1's Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE], with diagnoses including cerebral infarction [stroke] occurs when blood flow is disrupted to the brain) affecting Resident 1's left side, dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), glaucoma (chronic, progressive eye disease), and a history of failing. During a review of Resident 1's Minimum Data Set ([MDS] a standardized assessment and care screening tool) dated 12/28/2023, the MDS indicated Resident 1's cognitive (the ability to think, reason, and understood) skills for daily decision-making were severely impaired. The MDS indicated Resident 1 required moderate to maximal assistance for activities of daily living ([ADL] activities related to personal care that include, bathing, dressing, getting in/out of bed, walking, toileting and eating). The MDS indicated Resident 1 was 4'7' tall and weighed 100 pounds (lbs.) During a review of Resident 1's Change of Condition (COC) dated 3/10/2024 and timed at 8:29 a.m., the COC indicated Resident 1 sustained a fall and was noted with a bump and discoloration on her left eye and a bump and discoloration to the back left side of her head. Continued review of this COC indicated the time of 8:29 a.m. was approximately three hours after the Resident 1's fall. (continued on next page)

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

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 1's Nursing Notes, dated 3/10/2024, the Nursing Notes indicated no documentation of Resident 1's fall at 5:30 a.m., or an assessment of Resident 1's status after her fall to include possible injuries, vital signs what first aid was administered, signs or symptoms of pain, swelling, bruising, deformity, and/or decreased mobility, details of the fall, the condition in which the resident was found, and notification of the physician and family. During a review of Resident 1's Nursing Notes, dated 3/10/2024 late entries were at 8:40 a.m., (over three hours after Resident 1 fell). The late entries were as follows: 1. 5:35 a.m. - the late entry indicated Resident 1 was noted in a wheelchair, in a puddle of water in her room and the sink broke off the wall in the bathroom with water running from the pipe. Continued review of this late entry indicated no assessment of Resident 1 after her fall and incorrect documentation of what actually occurred. 2. 6:30 a.m. - the late entry indicated Resident 1 was in her wheelchair in front of the nursing station and she requested pain medication. Continue review of this late entry indicated no assessment of where Resident 1's pain was, how much pain she was in or why Resident 1 requested pain medication. 3. 7 a.m. - the late entry indicated Resident 1 requested an ice pack for her eye. At this time the nurse noticed discoloration and slight swelling and a bump on the left side of Resident 1's face near her left eye and back of her head on the left side. The late entry indicated a Certified Nursing Assistant (CNA) was asked by the nurse, what happened to Resident 1 in regard to her face, head discoloration and bump on the left side of her head. The CNA (CNA 1) stated when Resident 1 was washing herself in the bathroom and holding on to the sink for balance the sink fell off the wall and Resident 1 lost her balance, hit her head on the wall and slid to the floor. Continued review of this late entry indicated there was no knowledge by the nurse who documented it, that Resident 1's fall/injury was reported. During a review of Resident 1's Skin Observation Tool assessment, dated 3/10/2024 and timed at 8:30 a.m., (three hours after Resident 1 fell and two hours after Resident 1 requested pain medication), the Skin Observation Tool assessment indicated Resident 1 was noted with redness, discoloration, and a bump on the left side of her face near her left eye and on the left side of the back of her head. During a review of Resident 1's Pain Tool assessment, dated 3/10/2024 and timed at 5:26 p.m., (almost twelve hours after Resident 1's fall and 11 hours after Resident 1 requested pain medication), the Pain Tool assessment indicated Resident 1 had pain in her left hip pain on a scale of 3 out of 10 (an 11 point scale where pain is rated zero to 10; 0=no pain, 1-3=mild pain, 4-6=moderate pain, and 7-10=severe pain, and 10=worst imaginable pain) and was unable to perform active range of motion ([ROM] the direction a joint can move to its full potential) on left leg due to pain. Continued review of Resident 1's Pain Tool assessment indicated no documentation that Resident 1's left eye and head bump and discoloration were assessed for pain, although Resident 1 requested pain medication on 3/10/2024 at 6:30 a.m., and the left eye and head injury were assessed on 3/10/2024 at 7 a.m. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's investigative statements from staff with knowledge of Resident 1's fall. The investigative statements indicated there was no written statement of Resident 1's condition by Licensed Vocational Nurse 1 (LVN 1) after LVN 1 was called to the room by CNA 1 after Resident 1 fell . During a review of CNA 1's Statement of the Incident (Resident 1's fall), dated 3/10/2024, the Statement of the Incident indicated Resident 1was assisted to the sink to wash up and as she was holding on the sink broke of the wall, resulting in Resident 1 falling (5 a.m. - 5:30 a.m.), hitting her head, and sliding to the floor. The Statement of the Incident indicated about half an hour later (5:30 a.m. - 6 a.m.) Resident 1 had a bump on the left side of her head and her left eye had discoloration. During an interview on 4/10/2024 at 11:20 a.m., the Director of Nursing (DON) stated LVN 1 completed an Incident Report regarding Resident 1's fall on 3/10/2024 but confirmed the Incident Report was not part of Resident 1's clinical record and was only for the facility's internal use. The DON stated after reviewing Resident 1's clinical record (Nursing Notes, COC, Pain assessment, Skin assessment) that there was no assessment by LVN 1 of Resident 1 after Resident 1 fell . The DON stated Resident 1's fall and assessment should have been documented by LVN 1 on the Interact and Nursing Notes. The DON stated LVN 1 was interviewed about Resident 1's fall but there was no written statement made by her. During a review of the facility's Policy and Procedure (P/P), titled Change in a Resident's Condition or Status, revised 2/2021, the P/P indicated the nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. If a significant change n the resident's physical or mental condition occurs, a comprehensive assessment of the resident's condition will be conducted. During a review of the facility's P/P, titled Assessing Falls and Their Causes, revised 3/2018, the P/P indicated if the resident has just fallen, evaluate for possible injuries to the head, neck, spine, and extremities, obtain and record vital signs as soon as it is safe to do so. If there is evidence of injury, provide appropriate first aid and/or obtain medical treatment immediately. Document any observed signs or symptoms of pain, swelling, bruising, deformity, and/or decreased mobility. After an observed or probable fall, clarify the details of the fall, such as when the fall occurred and what the individual was trying to do at the time the fall occurred. When a resident falls, the following information should be recorded in the resident's medical record: the condition in which the resident was found, assessment data, including vital signs and any obvious injuries, interventions, first aid, or treatment administered, and notification of the physician and family, as indicated.

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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 0921 Level of Harm - Actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45743 Based on interview and record review, the facility failed to ensure the hand sink in a resident's bathroom was inspected during daily rounds by the maintenance staff and/or the facility's administrative staff, to ensure it was mounted securely to the bathroom wall and did not detach and fall off the wall causing a resident to fall and sustain injuries for one of three sampled residents (Resident 1). This deficient practice resulted in the hand sink in Resident 1's bathroom detaching from the wall and falling to the floor when Resident 1 placed her hands on it while washing her face. Resident 1 fell to the floor and sustained a left hip fracture, a bump with discoloration to her left eye and a bump with discoloration to the left side of the back of her head. This deficient practice had the potential for Resident 1 to sustain more critical injuries including death. Findings: During a review of Resident 1's Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE], with diagnoses including cerebral infarction [stroke] occurs when blood flow is disrupted to the brain) affecting Resident 1's left side, dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), glaucoma (chronic, progressive eye disease), and a history of failing. During a review of Resident 1's Minimum Data Set ([MDS] a standardized assessment and care screening tool) dated 12/28/2023, the MDS indicated Resident 1's cognitive (the ability to think, reason, and understood) skills for daily decision-making were severely impaired. The MDS indicated Resident 1 required moderate to maximal assistance for activities of daily living ([ADL] activities related to personal care that include, bathing, dressing, getting in/out of bed, walking, toileting and eating). The MDS indicated Resident 1 was 4'7' tall and weighed 100 pounds (lbs.) During a review of Resident 1's Change of Condition (COC) dated 3/10/2024 and timed at 8:29 a.m., the COC indicated Resident 1 sustained a fall and was noted with a bump and discoloration on her left eye and a bump and discoloration to the back left side of her head. (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 0921 Level of Harm - Actual harm Residents Affected - Few	During a review of the facility's Incident Investigation Summary, dated 3/10/2024 and timed at 5 a.m., the Incident Investigation Summary, indicated Resident 1 was washing up, while supervised by a Certified Nursing Assistant (CNA 1) when the toilet sink fell off the wall and Resident 1 lost her balance and slid on her left side. The Incident Investigation Summary indicated Resident 1 most likely hit her left orbital external side (the outer portion of the resident's left eye) on a paper towel dispenser, then hit her left mid upper parietal (back of her head) side on the wall, before she slid to the floor. The Incident Investigation Summary indicated at that time Resident 1 had no pain or injuries. On reassessment (time not indicated), Resident 1 was noted with red discoloration and bumps to her left exterior-lateral orbital region and left mid-upper parietal part of her head. Resident 1 complained of minimal tolerable pain on a scale of 3 out of 10 (an 11 point scale where pain is rated zero to 10; 0=no pain, 1-3=mild pain, 4-6=moderate pain, and 7-10=severe pain, and 10=worst imaginable pain). Later in the evening (time not indicated), Resident 1 complained of pain to her left hip when crossing her left leg above her right leg. During a review of Resident 1's Nursing Notes, dated 3/10/2024, the Nursing Notes indicated no documentation of Resident 1's fall or an assessment of Resident 1 after her fall. During a review of Resident 1's Nursing Note dated 3/10/2024 and timed at 2:31 p.m., the Nursing Note indicated Resident 1 verbalized pain to her left hip. The Nursing Note indicated Resident 1's physician was notified and an order for a Stat (immediate) X-ray (an imaging study that takes pictures of bones and soft tissues) was obtained. During a review of Resident 1's X-ray Results Report, dated 3/10/2024 and timed at 4:37 p.m., the X-ray Results Report indicated Resident 1 had an acute (a condition that is severe and has a sudden onset) left hip fracture. During a review of Resident 1's Physician's Order dated 3/10/2024 and timed at 5:16 p.m., the Physician's Order indicated to transfer Resident 1 to a General Acute Care Hospital (GACH) for evaluation related to her fall. During a review of Resident 1's GACH records dated 3/10/2024, the GACH records indicated Resident was admitted to the GACH on 3/10/2024 with a diagnosis of a left intertrochanteric femoral neck (region on top of the thigh bone that connects to the hip bone) fracture, secondary to a mechanical fall (a fall caused by an external force). During a review of the GACH's Hospital Course, dated 3/10/2024, the Hospital Course indicated given Resident 1's frailty, advanced age, poor baseline mobility, and dementia, Resident 1's Family Member (FM) and DPOA, requested conservative, nonoperative management. Resident 1 would return to custodial care for pain management and hospice consultation. Resident 1 was at high risk for mortality (death), either with surgery or without surgery. During a telephone interview on 3/27/2024 at 12 p.m., CNA 1 stated, she escorted Resident 1 to the bathroom (3/10/2024) in her wheelchair and placed her in front of the hand sink and stood her up so she (Resident 1) could wash her face. CNA 1 stated Resident 1 turned on the water in the sink and placed her hands on the sink when the sink fell to the ground. CNA 1 stated Resident 1 landed on her left hip and bumped the left side of her head. CNA 1 stated she could not recall if there was anything wrong with the hand sink prior to Resident 1 using it. (continued on next page)

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F 0921 Level of Harm - Actual harm Residents Affected - Few	During an interview on 3/27/2024 at 1:30 p.m., the Maintenance Supervisor stated it takes a lot of weight to force a sink off the wall and Resident 1 should not have been able to pull it from the wall. The Maintenance Supervisor stated the maintenance staff conducts daily rounds of the facility to identify any issues that the maintenance department needs to address. The Maintenance Supervisor stated he was not aware of any problems with the hand sink in Resident 1's bathroom. During an interview with Licensed Vocational Nurse 1 (LVN 1) on 3/27/2024 at 2:56 p.m., LVN 1 stated she was summoned to Resident 1's room by CNA 1 and found Resident 1 on the floor, and the bathroom sink on the floor with water coming out of the pipes. LVN 1 stated she assessed Resident 1 and noticed discoloration to Resident 1's left eye and on the back of her head. During an interview with the Administrator (ADM) on 3/28/2024 at 12:44 p.m., the ADM stated, safety rounds are conducted daily by all staff to identify any hazards. The ADM stated he was not aware of any problems with the hand sink in Resident 1's bathroom and if there was a problem with the sink it should have been reported immediately to the maintenance department so it could have been repaired. During a review of the facility's policy and procedure (P/P) titled Safety and Supervision of Residents, revised 7/2017, the P/P indicated the facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. During a review of the facility's P/P title Maintenance Service, revised 12/2009, the P/P indicated the maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. Functions of the maintenance personnel include but are not limited to: maintaining the building in good repair and free from hazards.