

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055163	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2025
NAME OF PROVIDER OR SUPPLIER Montecito Heights Healthcare & Wellness Centre, LP		STREET ADDRESS, CITY, STATE, ZIP CODE 4585 N. Figueroa St. Los Angeles, CA 90065	

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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36395</p> <p>Based on interview and record review the facility failed to ensure the assistive signaling devices used to prevent falls were monitored for placement and function for one of two sampled residents (Resident 1). For Resident 1, the facility failed to:</p> <ol style="list-style-type: none"> 1. Monitor the placement and functioning of the bed alarm when initially applied on 12/23/24. 2. Monitor the placement and functioning of the wheelchair alarm when initially applied on 1/3/25. <p>Monitoring for the placement and function for the bed and wheelchair alarms started on 3/18/25.</p> <p>These deficient practices had the potential for the assistive devices to malfunction without the facility's knowledge and had the potential for Resident 1 to leave the bed and/or the wheelchair without the facility's knowledge and may lead to accident.</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record indicated the facility admitted Resident 1 on 1/28/23 and readmitted on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities), difficulty walking and generalized muscle weakness.</p> <p>During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool) dated 3/4/25 indicated Resident 1 had severely impaired cognitive skills. Resident 1 needed moderate assistance (helper does more than half the effort) with toileting hygiene, shower/bathe self, lower body dressing, putting on/off footwear, supervision with oral hygiene, upper body dressing, personal hygiene and set up with eating.</p> <p>During a review of Resident 1's physician order dated 12/23/24 at 5:39 p.m., indicated the physician gave order to apply bed alarm for Resident 1's safety.</p> <p>During a review of Resident 1's physician order dated 1/3/25 at 5:31 p.m., indicated the physician gave order to apply wheelchair alarm for Resident 1's safety.</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055163	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2025
NAME OF PROVIDER OR SUPPLIER Montecito Heights Healthcare & Wellness Centre, LP		STREET ADDRESS, CITY, STATE, ZIP CODE 4585 N. Figueroa St. Los Angeles, CA 90065	
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>During a review of Resident 1's Care Plan initiated on 6/14/23 indicated Resident 1 had an actual fall with no injury related to poor balance, poor communication/comprehension and unsteady gait. The care plan indicated Resident 1 had another fall on 12/22/23 with no injury. The care plan goal indicated Resident 1 will resume usual activities without further incident through the review date. Interventions included bed alarm for safety that was initiated on 12/23/24 and wheelchair alarm for resident safety initiated on 1/3/25.</p> <p>During a review of the Informed Consent indicated Resident 1's responsible party (RP) gave consent on 12/23/24 for the bed alarm and the RP gave consent for the wheelchair alarm on 1/3/25.</p> <p>During a review of the Medication Administration Record (MAR, a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for 3/25 indicated the monitoring for the function and placement of the wheelchair and bed alarms started on 3/18/25 during the evening shift.</p> <p>During a telephone interview on 3/19/25 at 10:54 a.m., licensed vocational nurse (LVN 1) stated it is important to monitor the wheelchair and bed alarms so we know if it's working and should be in proper position. LVN 1 further added when the wheelchair or bed alarms are triggered it would notify the staff that Resident 1 was getting out of the bed or wheelchair, and we have to respond immediately.</p> <p>During an interview on 3/19/25 at 11:38 a.m., LVN 2 stated the wheelchair and bed alarms are checked for placement every shift for functioning because the batteries could die and for safety of Resident 1.</p> <p>During an interview on 3/19/25 at 11:53 a.m., the director of nursing (DON) confirmed that the monitoring of the functioning and placement of the wheelchair and bed alarms started on 3/18/25.</p> <p>During a review of the facility Policy titled Signaling Device reviewed on 3/24/24 indicated, for checking the placement and functionality of the signaling device.</p> <p>a. The placement will be verified every shift.</p> <p>b. Functionality of the signaling device should be verified daily</p> <p>c. The licensed nurse will document the placement and functionality in the resident's medical record.</p>		