STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055181	A. Building B. Wing	04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Gabriel Conv Center	8035 E Hill Drive Rosemead, CA 91770

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** 46779 Based on observation, interview and record review, the facility failed toensure one of three sampled residents (Resident 1) was free from injury after sustaining a fall in the facility. 1. Certified nurse assistant (CNA)1 failed toreport to licensed nurses that Resident 1 was found on the floor in Resident 1 ' s room, by the foot of the bed on 3/24/24. 2. Registered Nurse 1 failed to immediately conduct an assessment onResident 1 after Resident 1 was found on the floor on 3/24/24. 3. CNA 1 failed to ensure Resident 1 was safely transferredto the bed after sustaining a fall. CNA1 transferred Resident 1 back to bed, alone, without licensed nurses assessing Resident 1 for any other injuries. 4. RN1 failed tonotify the physician and implement the facility ' s fall protocols immediately after Resident 1 ' s unwitnessed fall on 3/24/24. These deficient practices had resulted in the delay of care and services to Resident 1 who experienced pain in the left leg and sustained aleft hip fracture that required a surgical intervention. Findings: Areview of Resident 1 ' s Admission Record indicated the facility originally admitted Resident 1 on 11/22/2019 and readmitted on [DATE] with diagnoses that included dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life) and displaced fracture of base of neck of left femur (a type of hip fracture [a partial or complete break in the bone]). Areview of Resident 1 ' s Fall Risk Assessment, dated 3/14/2024, indicatedResident 1 was at high riskfor fall. (continued on next page)

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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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 1's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 3/18/2024, indicated Resident 1 had moderately impaired cognitive (ability to think and reasonably) impairment and memory. The MDS indicated Resident 1 was independent with oral hygiene, required supervision or touching assistance with eating, toileting hygiene, upper body dressing, lower body dressing, putting on/taking off footwear, chair/bed-to-chair transfer, toilet transfer, walk 10 feet, walk 50 feet with two turns, and walk 150 feet, and required partial/moderate assistance with shower/bathe self. Areview of Resident 1 ' s MDS, dated [DATE], indicatedResident 1 had severely impaired cognitive (ability to think and reasonably) impairment and memory. The MDS indicated Resident 1 required supervision or touching assistancewith eating, oral hygiene, chair/bed-to-chair transferand toilet transfer, requiredpartial/moderate assistancewith upper body dressing, and requiredsubstantial/maximal assistancewith toileting hygiene, shower/bathe self, lower body dressing, putting on/taking off footwear. The MDS indicated walk 10 feet, walk 50 feet with two turns, and walk 150 feet were not attempted due to medical condition or safety concerns. Areview of Resident 1 ' s) Changeof Condition (COC)/Interact Assessment Form Situation, Background, Action, and Response(SBAR), dated 3/24/2024 at 1:11 AM, indicatedthere was no documentation of CNA 1 reporting Resident 1 ' s fall to registered nurse (RN)1. A review of Resident 1 ' s COC/SBAR dated 3/24/2024 at 9:00 AM, indicatedat 10 AM, Resident 1 complained of pain in theleft leg with purplish discoloration on right forearm. The COC/SBARindicated Resident 1 ' s roommate informed licensed vocational nurse (LVN)2 that Resident 1 fell last night on 3/24/24 during the night shift (11 PM-7AM). During a review of Resident 1 ' s 72 Hours neurological assessment check (Neuro check, a routine practice by the registered nurse to assess the mental status and level of consciousness) List, dated3/24/2024, indicated the facility initiated the 72 hours neuro-check on Resident 1 at 10 AM on 3/24/2024 (10 hours after Resident 1 ' s unwitnessed fall). Areview of Resident 1 ' s Progress Notes, dated 3/26/2024, indicatedResident 1 complained of pain in theleft leg during physical therapy and that the staff obtained an order for an x-ray (an imaging test that takes pictures of bones and soft tissues to help providers diagnose and treat medical conditions) to rule out a fracture. Areview of Resident 1 ' s Physical Therapy Treatment Encounter Note(s), dated 3/27/2024, indicatedx-ray to left leg on 3/26/2024 revealed acute left femoral neck fracture and no weight bearing to the left leg at this time. Areview of Resident 1 ' s Radiology (a branch of medicine that uses imaging technology to diagnose and treat disease) Results Report, dated 3/26/2024, indicatedResident 1 sustained an acute fracture of the neck of the femur, with mild displacement. Areview of Resident 1 ' History and Physical (H&P) from the general acute care hospital (GACH), dated 3/27/2024, indicated Resident1 sustained a left hip fracture and was admitted to the GACH for pain management and possible surgical repair of the fractured left hip. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Areview of Resident ' s Progress Note of Surgery Orthopedics from the GACH, dated 3/28/2024, indicatedResident 1 and family did not want to proceedwith surgery at this time. During a telephone interview on 4/10/2024 at 1:14 PM with CNA 1, CNA 1 statedhe was conducting his rounds when he found Resident 1 sitting on the floor mat on the floor. CNA1 stated Resident 1 was at the foot of the right side of her bed between the times of 12:00 and 1:00 AM on 3/24/2024. CNA 1 stated assisting Resident1 back to bed, by carrying Resident 1 by himself. CNA1 stated Resident 1 was smacking thebedside rail with her [NAME] moaning. CNA1 stated informingRN (Registered Nurse) 1 that he found Resident 1 at the foot of her bed and that Resident 1 was agitated. CNA 1 stated Resident 1 continued to act restlessly for the rest of the night, and that Resident 1 was very agitated. During an observation on 4/10/2024 at 1:35 PM in Resident 1 ' s room, Resident 1 was lying on the bed with a blue abduction wedge pillow (designed to separate the legs of a patient. It is often used after hip surgery to prevent the new hip from popping out) Resident 1 had a bruise at left upper inner thigh. During an interview on 4/10/2024 at 2:04 PM with Resident 2, Resident 2 statedshe was the roommate of Resident 1. Resident 2 statedshe was awaken up by a loud thud sound around 1AM on 3/24/24. Resident 2 statedshe saw Resident 1 seated on the floor by the foot of Resident 1 ' s bed. Resident 2 statedshe did not see how Resident 1 fell out of the bed and no staff was present when the fall happened. Resident 2 statedthe staff came in after the fall and found Resident 1 was on the floor. A review of Resident 2 ' s Admission Record indicated Resident 2 was admitted to the facility on [DATE] with a diagnoses of malignant neoplasm of the pancreas (cancer of the pancreas), unnary tract infection(UTI, bladder infection) , and diabetes (high blood sugar). A review of Resident 2 ' s History and Physical dated 3/17/2024 indicated Resident 2 had the capacity to understand and make decisions. A review of Resident 2 ' s MDS, dated [DATE], indicatedResident 2 had no cognitive impairment. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 4/10/2024 at 2:29 PM with Registered Nurse 1, RN 1 stated CNA 1 approached her and told her that Resident 1 was restless and if Resident 1 had any medication for restlessness at 12:00 AM on 3/24/2024. RN 1 stated CNA 1 did not tell her that he found Resident 1 sitting on the floor by the foot of the bed and or that Resident 1 fell out of bed. RN 1 stated when she went to assess Resident 1, Resident 1 was restless on the bed, but did not see any visible injuries on Resident 1. RN1 stated Resident 1 did not complain of any pain at that time, but RN 1 stated unawareness of Resident 1 falling out of bed. RN 1 stated she did not ask questions to clarify if Resident 1 had a fall when CNA 1 told her Resident 1 was at the foot of her bed. RN 1 stated she did not conduct a post fall assessment and did not report to other staff and the physician that Resident 1 sustained a fall during her shift from 11:00 PM on 3/23/2024 to 7:00 AM on 3/24/2024 because she was not aware of the fall. RN 1 stated she was informed about Resident 1's fall when she returned to work at 11:00 PM on 3/24/2024. RN 1 stated it was around 9:00 AM on 3/24/2024, the morning shift CNA found Resident 1 with a bruise on the right arm and reported to the mornign shift LVN. RN1 stated the morning shift LVN went to check on Resident 1 and Resident 2 reported to the mornign shift LVN that Resident 1 fell out of the bed the night before. RN 1 stated morning shift LVN initiated the fall protocol on Resident 1 at 10AM on 3/24/2024. RN 1 stated CNA 1 should have reported Resident 1's fall to RN1 and CNA1 to prevent a delay in treatment, and that CNA1 should not move Resident 1 back to the bed by himself before any licensed nurses assessed Resident 1, to prevent further injury to Resident 1. During a telephone interview on 4/10/2024 at 2:49 PM with CNA 1, CNA 1 statedhe informed RN 1 that She (Resident 1) was at the foot of her bed. CNA 1 statedhe did not report to RN1 that Resident 1 was found seated on the floor or that Resident 1 had a fall. During a telephone interview on 4/10/2024 at 3:51 PM with the Physical Therapist (PT), the PT stated Resident 1 was at high riskfor fall prior to her recent fall on 3/24/24. The PT stated conducting a fall assessment on Resident 1 after being notified that Resident 1 fell . The PT statedwhile conducting the fall assessment, Resident 1 was in a lot of pain so the PT notified the physician to obtain x-ray order. The PT stated the results of the Xray indicated Resident 1 had a left hip fracture. During an interview on 4/10/2024 at 4:20 PM with Licensed vocational nurse (LVN) 1, LVN 1 statedif a resident was found on the floor for an unwitnessed fall, CNAs should report to licensed nurses immediatelyand not to move the resident. LVN 1 statedlicensed nurses should assess the resident for injury, change of level of consciousness (LOC), vital signs, skin integrity, and neuro-check, then, notify the physician and responsible party. LVN 1 stated CNAs should not move the resident until the licensed nurse assess the resident for possible fracture and head injury. LVN1 stated it was not until after an assessmentwas conducted and the resident was cleared to be moved, should the CNA safely move a resident after being found on the floor. During an interview on 4/11/2024 at 10:59 AM with CNA 2, CNA 2 stated when as resident was found on the floor, CNAs must report to the charge nurse and the RN supervisor immediately by stating what where and what positionthe resident was found. CNA 2 stated CNAs should not move or touch the resident until the licensed nurses assessed the resident and gave instruction to move the resident because moving the resident without proper assessment could cause more injury to the resident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/11/2024 at 11:09 AM with RN 2, RN 2 stated Resident 1 was at high riskfor fall. RN 2 stated when a resident had a fall either a witnessed or unwitnessed fall, the licensed nurse should follow the fall protocol immediately, which included assessing the resident for pain and injury RN 1 stated CNAs should report to the licensed nurse immediately when a resident was found on the floor. RN 1 stated the resident should not be moved or touched the resident until the licensed nurse completed theassess ment and determined it was safe to move the resident to prevent further injury. During an interview on 4/11/2024 at 1:18 PM with the Director of Nursing (DON), the DON statedaccording to the facility ' s fall protocol and the standardsof practice, CNA 1 should report to RN 1 that Resident 1 was found sitting on the floor at the foot of the bed. The DON stated CNA 1 should not move Resident 1 back to the bed by himself without an assessment conducted from the licensed nurses. The DON stated by moving Resident 1 without the proper assessment from the licensed nurse could cause more injury to the resident. The DON statedResident 1 was restless on 3/24/2024 after the fall. The DON statedRN 1 did not know that Resident 1 had fall during her shift and did not start the fall protocol on Resident 1 until 10:00 AM on 3/24/2024 when Resident 2 informed the staff. The DON stated Resident 1 ' s 72 hours neurological assessment, which could determine any change of LOC, was not started immediatelyafter Resident 1 ' s fall. The DON statedit was not until 10 AM (10 hours after Resident 1 ' s fall) on 3/24/24 was the neurocheck initiated. The DON statedthe nurse documented Resident 1 had pain at her left leg on 3/24/2024, but the facility did not obtain an x-ray for Resident 1 ' s left leg until the PT noticed Resident 1 had a lot of pain to her left leg and called the doctor for an order for anx-ray of left leg on 3/26/2024. The DON statedthe x-ray results on 3/26/24 of Resident 1 ' s left leg indicatedResident 1 sustained a hip fracture and Resident 1 was transferred to an acute hospital on 3/27/2024. The DON stated Resident 1 ' sfamily member refused any surgical intervention and Resident 1 returned to the facility on [DATE]. The DON statedafter a fall, the licensed nurse should immediately follow the fall protocol by conducting post fall assessment, neuro-check assessment and fall risk assessment, and notifying the doctor immediatelyto provide appropriate interventionsand prevent any delay of treatment. During a telephone interview on 4/11/2024 at 3:13 PM with CNA 1, CNA 1 stated he saw Resident 1 was sitting on the floor at the foot of her bed and he tried to help her by assisting her back to her bed, but he did not know that he should not move or touch Resident 1 until the licensed nurses assessed the resident. CNA 1 statedhe worked for a registry company, and he did not receive regular in-service training at the facility as other facility ' s permanent staff. During a review of the updated facility ' s P&P titled, Incidents/Accidents, the P&P indicatedincidents/accidents will be reported to the charge nurse. During a review of the updated facility ' s P&P titled, Fall, the P&P indicatedMD and responsible party will be notified as soon as possible after the incident occurred, and of any significant change noted. The P&P indicatedas soon as an incident of fall occurs, the charge nurse will carefully assess the resident for possible injuriesand a neurological assessment will be conducted for 72 hours to determine any significant changein resident ' s LOC.