STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055192	A. Building B. Wing	09/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence St Elizabeth Care Center	10425 Magnolia Blvd North Hollywood, CA 91601

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 0656 Level of Harm - Potential for minimal harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33636 Based on observation, interview and record review, the facility failed to update and revise the residents ' care plan (a document outlining a detailed approach to care customized to an individual resident ' s need) after a fall by failing to include physician ordered interventions for one of two sampled residents (Residents 1). These deficient practices had the potential to result in inconsistent implementation of the care plan that may lead to a delay in or lack of delivery of care and services. Findings: A review of Resident 1 ' s Admission Record indicated, Resident 1 was admitted to the facility on [DATE] with diagnoses including CVA (stroke) with hemiplegia (paralysis of one side of the body), aphagia (a disorder that results from damage to portions of the brain that are responsible for language), and muscle weakness. A review of Resident 1 ' s Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 8/30/23, indicated the resident had the ability to make self-understood and understand others. The MDS indicated the resident required extensive assistance with bed mobility, transfer, dressing, and personal hygiene and was totally dependent on staff with locomotion on & off unit, toilet use, and bathing. The MDS indicated the resident did not have any history of falls. A review of Resident 1 ' s Physician Orders (a document containing orders prescribed by the doctor), dated 9/10/23 indicated the following orders: -Toapply right and left floor mats during each shift to prevent injury from falls. -Initiate falling star program: during each shift bed alarm sensor to alert staff when/if resident tries to get out of bed without assist. A review of the Progress Note dated 9/02/23, indicated Resident 1 was confused. A review of Resident 1 ' s Care plan created on 8/18/23 and revised on 9/07/23, indicated the resident is at risk for falls related to activity intolerance, balance concerns, compounding co morbid conditions. (continued on next page)

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

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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 0656 Level of Harm - Potential for minimal harm Residents Affected - Some	The interventions included the following: -To evaluate for unmet needs causing restlessness (sleep pattern different than is used to, full bladder, hunger, cold) -To Provide/assist ADLs/tasks. -To keep the bed in position appropriate for height to allow for safe transfer. To encourage resident to attend activities. -Frequent observation for safety and comfort -PT/OT evaluation related to recent fall -Monitor left occipital hematoma and notify MD and family for significant changes of condition -To initiate neuro checks for 72 hours A review of the Fall Risk assessment dated [DATE] indicated Resident 1 ' s fall risk score was 6 (at risk for falls, a score above 8 represented high fall risk). A review of the Fall Risk assessment dated [DATE] indicated Resident 1 ' s fall risk score was 7 (at risk for falls, a score above 8 represented high fall risk). During a concurrent record review and interview with the DON on 9/25/23, at 9:27 am, the DON stated, on 9/07/23, at 8:29 pm, Resident 1 was found lying on the floor at the foot of his bed in his room. A hematoma was noted to the occipital region of his head according to the incident report and IDT record. He was transferred to GACH right away for further evaluation and returned to the facility on [DATE]. Per Generalized Acute Care Hospital (GACH) ' s report, R 1 needed no interventions for recovery other than monitoring. Upon readmission to the facility on [DATE], the DON did body check and found out there was no hematoma or laceration. The occipital bone area was flat with some discoloration. During an interview on 9/25/23, at 2:04 pm with RN 1 (Registered Nurse 1), RN 1stated the resident has a pad alarm and landing mat after the fall. RN 1 stated that Resident 1 ' s care plan should have been updated so that the staff will be able to evaluate if the interventions were effective or needed to be revised to prevent repeated falls. A review of review facility ' s Policy and Procedures titled, Resident Care Plan, dated 09/2023, the Policy and Procedures indicated, The initial and/or updated care plan shall be measurable, specific, realistic, and with achievable goals. Other disciplines coordinate care plan goals, changes, and updates with nursing staff. Another Policy titled, Fall prevention and intervention, revised 5/2018, indicated to assess risk of falling, prevent, or reduce occurrences of falls, and implement interventions.