STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055202	A. Building B. Wing	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rosemead Healthcare Center	4096 Easy Street El Monte, CA 91731

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 - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 44027 Based on observation, interview, and record review, the facility failed to provide care and services to prevent a fall (move downward, typically rapidly and freely without control, from a higher to a lower level) for one of two sampled residents (Resident 1) by failing to: 1. Ensure Certified Nursing Assistant (CNA) 1 provided two-person physical assistance (help from two persons) to transfer (moving a resident from one place to another) Resident 1 from the bed to the shower chair (a seat for the tub or shower) when CNA 1 used the Hoyer lift (a mechanical device used by staff to lift and transfer residents from a bed to a chair or one location to another). 2. Ensure CNA 1 followed the facility's policy and procedure titled, Total Mechanical Lift, dated 10/1/2023 when CNA 1 transferred Resident 1 with the Hoyer lift/mechanical lift. As a result, on 7/20/2024, at 11:30 a.m., Resident 1 fell from the shower chair to the floor when CNA 1 removed the Hoyer lift strap from Resident 1's left shoulder. Resident 1 sustained a laceration (a tear, cut, or gash) to the right frontal (forehead) area of Resident 1's head. Resident 1 was transferred to General Acute Care Hospital (GACH) 1 on 7/20/2024 at 12:20 p.m. for further evaluation and had a right frontal head laceration repair with three sutures (a stitch or row of stitches holding together the edges of a wound or surgical incision). Findings: During a review of Resident 1's Admission Record (AR), the AR indicated, the facility originally admitted Resident 1 on 12/6/2022, and readmitted Resident 1 on 4/12/2024, with diagnoses including type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar), urinary tract infection (UTI, an infection in any part of the urinary system, including the kidneys, bladder, or urethra), and hemiplegia (muscle weakness on one side of the body that can affect the arms, legs, and facial muscles) and hemiparesis (paralysis [loss of the ability to move] on one side of the body) following cerebral infarction (also called ischemic stroke, refers to damage to tissues in the brain due to a loss of oxygen to the area). (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 - Actual harm Residents Affected - Few	During a review of Resident 1's untitled Care Plan (CP) initiated on 11/11/2023, the CP indicated, Resident 1 was at risk for falls related to lack of coordination, hemiplegia, and dementia (group of symptoms affecting memory, thinking, and social abilities). The CP interventions included for staff to anticipate and meet Resident 1's needs and educate Resident 1 and caregivers about safety reminders and what to do when a fall occurred. During a review of Resident 1's Fall Risk Assessment (FRA) dated 4/12/2024, the FRA indicated, Resident 1 was at high risk for falls due to total dependence on staff for activities of daily living and need for two or more persons physical assistance with bed mobility and transfer. During a review of Resident 1's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 7/2/2024, the MDS indicated, Resident 1 had moderately impaired cognition (the ability to think and process information). The MDS indicated, Resident 1 was dependent (helper did all the effort) on staff for toileting hygiene, showering/bathing, and upper and lower body dressing. The MDS indicated, Resident 1 was dependent on staff for chair/bed-to-chair transfers (the ability to transfer to and from a bed to a chair) and tub/shower transfer (the ability to get in and out of a tub/shower). During a review of Resident 1's Progress Notes (PN) dated 7/20/2024, timed at 11:30 a.m., the PN indicated, on 7/20/2024, at 11:30 a.m., CNA 1 was lowering Resident 1 from the Hoyer lift to the shower chair when Resident 1 bumped the right frontal area of Resident 1's head on the doorknob of Resident 1's bathroom. The PN indicated, Resident 1 sustained a small laceration (location not indicated) and started bleeding. The PN indicated, Registered Nurse (RN) 1 called 911 (number to call for emergency medical services) and Resident 1 was transferred to GACH 1 for further evaluation. During a review of Resident 1's GACH 1 Emergency Department Narrative (ED Narrative) dated 7/20/2024, timed at 12:45 p.m., the ED Narrative indicated, Resident 1 was brought in by emergency medical services (EMS, a system that responds to emergencies in need of highly skilled pre-hospital clinicians) from the facility for evaluation of a head injury after a mechanical fall. The ED Narrative indicated, Resident 1 experienced a fall while being transferred by nursing staff (CNA 1) resulting in a one (1) centimeter (cm, unit of measurement) laceration on Resident 1's head. The ED Narrative indicated, Resident 1's wound was a linear (arranged in or extending along a straight or nearly straight line) horizontal (flat or level, parallel to the ground) laceration on the right frontal area of the head. The ED Narrative indicated, the wound was closed with three sutures. During a review of Resident 1's GACH 1 Computed Tomography Scan (CT scan, medical imaging technique used to obtain detailed internal images of the body) Report of Resident 1's head, dated 7/20/2024, timed at 2:27 p.m., the CT scan Report indicated, Resident 1 had a hematoma (a localized bleeding outside of blood vessels) on the right frontal scalp (skin covering the head) of Resident 1's head. During a review of CNA 1's Corrective Action Memo (Memo), dated 7/25/2024, the Memo indicated, CNA 1 did not follow directions for two-person physical assistance for Hoyer lift transfer which resulted in Resident 1 being injured. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 8/5/2024 at 10:16 a.m. with RN 1, RN 1 stated on 7/20/2024, during the day shift (7 a. m. to 3 p.m. shift), the day Resident 1 fell , a staff member (unable to identify), notified RN 1 that RN 1's assistance was needed in Resident 1's room. RN 1 stated when RN 1 arrived in Resident 1's room, Resident 1 was lying on the floor and bleeding from the right side of Resident 1's head. RN 1 stated RN 1 called 911 immediately then the paramedics (person trained to give emergency medical care to people who are injured or ill, typically in a setting outside of a hospital) arrived and transferred Resident 1 to GACH 1. RN 1 stated Resident 1 returned to the facility after 3 hours with sutures on the right (frontal) area of Resident 1's head. RN 1 stated CNA 1 had been using the Hoyer lift to transfer Resident 1 to the shower chair with two-person physical assistance in the past. RN 1 stated on 7/20/2024, (at 11:30 a.m.), CNA 1 used the Hoyer lift on Resident 1 without assistance from another staff member. RN 1 stated two staff members needed to be present and assisting always when using the Hoyer lift to transfer Resident 1 and any resident in general. During an interview on 8/5/2024 at 10:46 a.m. with the Director of Rehabilitation (DOR), the DOR stated Resident 1 had been in the facility for a long time. The DOR stated Resident 1 was completely dependent on staff and always required the use of the Hoyer lift for transfers. The DOR stated two-person physical assistance was always required when using the Hoyer lift to transfer Resident 1. The DOR stated the first staff member operated the Hoyer lift while the second staff member maintained the resident's (Resident 1's) stability during and after the transfer. The DOR stated there was a risk for the Hoyer lift to tip over, or the sling (a device which consists of cable, chain, rope, or webbing and placed under the resident and attached to the mechanical lift to facilitate lifting) holding Resident 1 could break when only one staff member used the Hoyer lift to transfer Resident 1. During an interview on 8/5/2024 at 11 a.m. with the Director of Staff Development (DSD), the DSD stated the facility used a buddy system (an arrangement in which individuals are paired or teamed up) that provided a two-person team when operating the Hoyer lift to transfer residents. The DSD stated the CNAs (all CNAs) were aware that the CNA who covered the other CNA's break time was also the CNA who would assist when transferring a resident (in general) with the Hoyer lift. The DSD stated Hoyer lift transfers required two staff members to be present always. The DSD stated the first staff member operated the Hoyer lift while the second staff member guided the resident during and after the transfer to ensure the resident (any resident in general) was safe. During a concurrent observation and interview on 8/5/2024 at 1 p.m. with Resident 1, in Resident 1's room, Resident 1 was lying in Resident 1's bed with the head of the bed elevated. There was a thin line on the right side of Resident 1's head near the hair line with no visible sutures. Resident 1 stated Resident 1 could not move or get out of the bed by herself. Resident 1 stated the facility staff (CNAs) used a machine (Hoyer lift) to get Resident 1 out of the bed. Resident 1 stated CNA 1 was using the machine when Resident 1 fell from the (shower) chair (on 7/20/2024 at 11:30 a.m.). Resident 1 stated CNA 1 was using the machine by herself (CNA 1) when Resident 1 fell . Resident 1 stated she experienced some pain (unable to rate and describe pain) on her back when Resident 1 fell . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview on 8/5/2024 at 1:20 p.m. with CNA 1, CNA 1 stated on 7/20/2024, at 11:30 a.m. , CNA 1 used the Hoyer lift to transfer Resident 1 in the shower chair. CNA 1 stated after CNA 1 transferred and placed Resident 1 in the shower chair using the Hoyer lift, CNA 1 began to remove the Hoyer lift sling from underneath Resident 1's legs. CNA 1 stated while CNA 1 was removing the Hoyer lift straps (a strip of flexible material, used to fasten and secure the sling, to hang onto the Hoyer lift) from behind Resident 1's left shoulder, Resident 1 fell from the shower chair to the floor and hit Resident 1's head on the doorknob of Resident 1's bathroom door (bathroom door was near the foot of Resident 1's bed). CNA 1 stated CNA 1 transferred Resident 1 from the bed to the shower chair with the Hoyer lift without assistance from another CNA. CNA 1 stated Resident 1 probably would not have fallen when two CNAs were operating the Hoyer lift during the transfer of Resident 1. During an interview on 8/5/2024 at 2:05 p.m. with the Treatment Nurse (TN), the TN stated on 7/20/2024, unable to recall time, the TN responded to Resident 1's room to assist Resident 1 after Resident 1 fell . The TN stated Resident 1 had a laceration on the right (frontal) side of Resident 1's head. The TN stated the TN was unable to measure Resident 1's laceration right after the fall because of the amount of blood coming from the laceration. The TN stated the TN applied pressure to Resident 1's head laceration until the paramedics arrived at the facility. The TN stated Resident 1 had sutures on Resident 1's head when Resident 1 returned from GACH 1 (on 7/20/2024 at 3:41 p.m.). During an interview on 8/5/2024 at 2:43 p.m. with the Director of Nursing (DON), the DON stated Resident 1 was at the facility for at least two years and always required total care (staff did all the effort when providing care). The DON stated Resident 1 always needed a Hoyer lift during transfers. The DON stated CNA 1 admitted that CNA 1 messed up (mishandle a situation) when CNA 1 transferred Resident 1 from the bed to the shower chair using the Hoyer lift without assistance from another CNA. During a review of the facility's P&P titled, Total Mechanical Lift, dated 10/1/2023, the P&P indicated, a mechanical lift was used appropriately to facilitate transfers of residents. The P&P indicated, at least two people were present while resident was being transferred with the mechanical lift.