STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055253	A. Building B. Wing	04/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St. John of God Retirement	2468 South St Andrews Place Los Angeles, CA 90018

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43237 Based on interview and record review, the facility failed to implement its abuse policy and procedure (P&P) by failing to report an injury unknown origin to the California Department of Public Health (CDPH) within two hours for one out of three sample residents (Resident 1). This deficient practice resulted in a delay in the investigation by the CDPH. Findings: During a review of Resident 1 ' s Admission Record, The Admission record indicated Resident 1 was admitted to the facility on [DATE], with diagnoses that included dementia (a disorder that affected memory and other mental functions), hypothyroid (a disorder of the thyroid gland), and legal blindness. During a review of Resident 1 ' s History and Physical (H&P) dated 11/3/2023, the H&P indicated Resident 1 did not have the capacity to understand and make medical decisions. During a review of Resident 1 ' s Minimum Data Set ([MDS] a standardized care assessment and care screening tool), dated 2/1/2024, the MDS indicated Resident 1 was dependent on staff for activities of daily living (ADL ' s) such as personal hygiene, lower body dressing, transfer (moving between surfaces to and from bed, chair, and wheelchair) and bed mobility (how resident moves from lying to turning side to side). The MDS indicated Resident 1 was always incontinent of bowel and bladder and dependent on a wheelchair for mobility. During a review of Resident 1 ' s Situation, Background, Assessment, and Recommendation ([SBAR] Tool for communication between staff) Communication Form dated 3/11/2024, the SBAR indicated, Resident 1 complained of right knee pain and was not able to recall when the pain started. The SBAR indicated an unnamed Certified Nurse Assistant (CNA) found the resident with both legs dangling and noted with slight swelling to the resident ' s right knee. During a review of Resident 1 ' s Radiology Results dated 3/12/2024, the Result indicated Resident 1 had an acute (sudden onset) medial supracondylar fracture of the distal femur (when the thigh bone is broken at the knee). (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1 ' s SBAR Communication Form dated 3/12/2024, the SBAR form indicated Resident 1 ' s right knee radiograph ([Xray]-medical imaging that creates pictures of the bones and tissue) report resulted with abnormal findings (acute medial supracondylar fracture of the distal femur. The SBAR indicated the physician was notified and orders were obtained to transfer Resident 1 to the general acute care hospital (GACH). The SBAR also indicated, the Director of nursing (DON) was made aware. During an interview on 4/1/2024 at 9:00 a.m. with Resident 1, Resident 1 stated she did not know what happened to her or how she sustained the fracture to her knee. During an interview on 4/12/2024 at 11:34 a.m. with the DON, the DON stated Resident 1 ' s fracture was considered an injury of unknown origin and should have been reported to the CDPH immediately or within two hours, however, was not done. The DON stated it was important to ensure injuries of unknown origin were reported to the CDPH timely to ensure the incident was investigated and to ensure safety of the resident. During a review of the facility ' s P&P titled, Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, dated 4/2021, the P&P indicated, all reports of abuse (including injuries of unknown origin), neglect, exploitation or theft of resident ' s property were reported to local, state, and federal agencies (as required by current regulations and thoroughly investigated by facility management. The P&P indicated If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source was suspected, the suspicion must be reported immediately to the administrator and to other officials according to the state law. The P&P indicated, the facility Administrator, or the individual making the allegations immediately reports his or her suspicion to the State licensing/certification agency responsible for surveying/licensing the facility.