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	05/22/2024

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36331 Based on interview and record review, the facility failed to complete the 72-hour neuro checks (assessment how resident speaks, thinks, walks, moves, or interacts with the examiner) as indicated in the facility's policy and procedure, for 1 of 3 sampled residents, (Resident 1). This failure had the potential to delay interventions if Resident 1 displayed changes in neurological status (a person's mental status, coordination, ability to walk, and how the muscles, sensory systems, and deep tendon reflexes work). Findings: A review of Resident 1's admission record, dated 5/7/2024, the indicated Resident 1 was originally admitted to the facility on [DATE] and was readmitted on [DATE]. Resident 1's diagnoses included muscle weakness, dementia ((impaired ability to remember, think, or make decisions that interferes with doing everyday activities), cerebral infarction (stroke), and urinary tract infection (UTI, an infection in any part of your urinary system: kidneys, bladder, ureters). A review of Resident 1's Minimum Data Set (MDS-a care planning and assessment tool), dated 2/29/2024, indicated Resident 1 had unclear speech, understood sometimes, and responds adequately to simple direct communication only. The MDS indicated Resident 1 was dependent (helper does all the effort) on staff for toileting hygiene, sit to stand (the ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed) and chair/bed-to chair transfer (the ability to transfer to and from a bed to a chair or wheelchair). A review of Resident 1's Change of Condition Evaluation (COC) forms indicated Resident 1 fell on [DATE] at 6:45 p.m., 4/22/24 at 8:30 a.m., and on 4/28/2024 at 12:31 p.m. A review of Resident 1's 72 hours neuro checks indicated the neuro check was initiated on 4/20/2024 at 6:45 p.m. The neuro check indicated when Resident 1 fell on [DATE] at 8:30 a.m., the neuro check was continued from 4/20/2024. The neuro check entry indicated neurocheck was started on 4/22/2024 at 12 noon, three and half hours delayed from the second incident Resident 1 fell . The neurochecks did not indicate it was completed / continued for 72 hours (until 4/25/24 at 8:30 a.m.). (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055253	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/22/2024

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

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 5/10/24 at 12:20 p.m., with the Director of Nursing (DON), the 72 Hour Neuro Check entries dated 4/20/2024 to 4/24/2024, and 4/28/24 were reviewed. The DON stated staffs should have started a new 72-hour neuro check form after the 2nd fall incident. A review of the facility's policy and procedure (P&P) titled, Neurological Assessment , dated 4/2012, indicated, the neurological assessment procedures indicated to perform neurological checks with the frequency as ordered or per fall protocol. A review of the facility's P&P titled, Fall Reduction (General), dated 4/2013, indicated, the resident shall be assessed for any neurological deficits due to the fall and a neurological assessment shall be done for 72 hours.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36331 Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1), who was assessed at risk for falls, did not have a fall, by failing to ensure: 1. Staff implemented Resident 1's physician's order which indicated to apply a soft belt (a device that is placed on a person's waist to prevent them from falling out of a bed or a chair) on Resident 1 when up in a wheelchair for safety. 2. Staff followed Resident 1's care plan titled Restraint: Soft belt while up on wheelchair for safety, which indicated to apply a soft belt on the resident while up on a wheelchair for safety, to prevent falls and injuries. 3. Staff followed the facility's policy and procedure (P&P) titled Soft/ Self Release Belt, which indicated a wheelchair soft self-release belt was to be used on a resident for safety. As a result, Resident 1 fell on [DATE], (the 3rd fall in 8 days) sustained a fracture (broken bone) on the nasal bridge, which required hospitalization at a general acute care hospital (GACH), for evaluation and treatment. Findings: A review of Resident 1's Admission Record, indicated Resident 1 was originally admitted on [DATE] and readmitted on [DATE]. Resident 1's diagnosis included muscle weakness, dementia (impaired ability to remember, think, or make decisions that interfere with everyday activities), cerebral infarction (stroke), and urinary tract infection (UTI- an infection in the kidneys, bladder, ureters). A review of Resident 1's Minimum Data Set (MDS-a care planning and assessment tool) dated 2/29/2024, indicated Resident 1 had cognitive (ability to think and reason) impairment. The MDS indicated Resident 1 was dependent (helper does all the effort) on staff for toileting hygiene, sit to stand (the ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed) and chair/bed-to chair transfer (the ability to transfer to and from a bed to a chair or wheelchair). A review of Resident 1's quarterly fall risk evaluation dated 2/26/2024, indicated Resident 1 had a low risk for fall due to gait and balance problems and the use of antipsychotic medications. A review of Resident 1's care plan titled At risk for falls/injuries related to advanced age, dementia, and impaired mobility, dated 3/25/2024, indicated staff's interventions included to keep Resident 1 in frequently monitored areas when up in a wheelchair for closer staff monitoring, observe the resident's location through periodic visual checks and provide safety reminders. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 1's care plan titled The resident uses bed/wheelchair alarm (device to notify staff when a resident attempts to get out of bed or wheelchair unassisted) related to poor safety awareness, dated 3/26/2024, indicated staff's interventions to anticipate and intervene potential causes which have precipitated (caused) prior falls, discuss with the resident/ family members the risks and benefits of the restraint, and evaluate the need for ongoing use and the continuing need of the restraint. A review of Resident 1's change in condition (COC) evaluation form dated 4/22/2024, indicated on 4/22/2024 at 8:30 a.m., Resident 1 was found by the charge nurse (unidentified)sitting on the floor mat at the bedside. The COC indicated Resident 1 sustained a laceration (skin tear) on the forehead and abrasion (skin scrape) on the right knee. The COC indicated a neuro check (observing how a person speaks, thinks, walks, moves, or interacts with the examiner) was done and first aid treatment was provided. A review of Resident 1's care plan titled Resident had an actual unwitnessed fall related to safety non-compliance, dated 4/22/2024, indicated Resident 1 had an unwitnessed fall 4/22/2024 with a lacerated forehead. The care plan indicated on 4/28/2024 Resident had another unwitnessed fall with bleeding and swelling on the nose. Resident 1's the care plan did not indicate changes made to the interventions for safety after Resident 1 fell on [DATE]. A review of Resident 1's Fall Risk Evaluation report dated 4/22/2024 indicated Resident 1 who had intermittent (on and off) confusion, had 1-2 falls in 3 months, and was chair bound. The report indicated Resident 1 required the use of assistive devices such as a wheelchair and a walker. The report indicated Resident 1 had a fall risk score of 15 (a score of 10 and above indicated high fall risk). A review of Resident 1's Interdisciplinary Team (IDT, group of healthcare professionals working together to provide residents with the care they need) Fall Review report dated 4/23/2024 indicated the IDT met and discussed Resident 1's unwitnessed falls on 4/20/2024, and 4/22/2024, which resulted in injuries upon body checks (locations not indicated). The IDT report indicated on 4/20/2024, Resident 1 was found sitting on a floor mat by his bed. The IDT report indicated on 4/22/2024, Resident 1 was found right side lying on a floormat by his bed, awake but unable to follow simple instructions. The report indicated Resident 1 had an impaired cognition, and impaired activities of daily living (ADLs) functioning with a history of falls. The IDT report indicated Resident 1 could not state what happened. The IDT report indicated the following recommendations: 1. Skilled rehabilitation services for safety with functional mobility and transfers. 2. Frequent visual checks. 3. Redirection and reorientation. 4. Monitor the resident in close one on one observations at all times. 5. Anticipate and provide the resident's needs on time. 6. Use of bed/wheelchair alarm. 7. The resident will be in front of the nursing station when up in a wheelchair. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 1's physician order dated 4/23/2024, indicated to apply soft belt restraint when up in wheelchair. A review of Resident 1's IDT Fall Review report dated 5/3/2024 indicated on 4/28/2024 (time not indicated), Resident 1 had an unwitnessed fall. The report indicated a Charge Nurse (unidentified) observed Resident 1 wheeling himself in the hallway, then, heard a thud (dull)sound by Room A, and the resident was observed on a right-side lying position, on the hallway floor, near Room A. The report indicated Resident 1 was awake, unable to answer or follow simple instructions. The report indicated Resident 1 had nasal bleeding and swelling, without pain or discomfort. The report indicated preventive measures in placed prior to Resident 1's fall on 4/28/2024, included bed and wheelchair alarm, floor mats, siderails, bed in low position, visual checks, and call light placed within reach. The report did not indicate the use of a soft belt when in a wheelchair, per Resident 1's physician's order dated 4/23/2024. The IDT summary and new recommendations indicated the physician ordered a self-release belt (a seat belt on a resident's wheelchair that the resident can fasten and release without assistance) while on wheelchair. A review of Resident 1's Medication Administration Record (MAR) dated 4/23 to 4/28/2024, did not indicate Resident 1 was monitored for the use of a soft belt. A review of Resident 1's care plan titled, Restraint: Soft belt while up on wheelchair for safety, dated 4/23/2024, indicated staff will apply a soft belt on Resident 1 while the resident was on a wheelchair, for safety. Staff's interventions included to apply a soft belt when up on wheelchair to prevent Resident 1 from falls/injuries if the resident got up unassisted due to poor safety awareness and poor balance. A review of Resident 1's COC Evaluation form dated 4/28/2024, indicated on 4/28/2024 at 12:31 p.m., Resident 1 was found by an unidentified licensed nurse, on a right-side lying position (the third fall in two weeks), on the floor, by the nurses' station. The COC indicated Resident 1 had nasal bleeding and swelling with no pain. The COC did not indicate Resident 1 had a soft belt restraint on, at the time of fall. A review of Resident 1's nasal bones radiology (process of taking pictures to diagnose and treat diseases) result, dated 4/28/2024, at 4:37 p.m., indicated Resident 1 had a fracture on the bridge of the nose. A review of Resident 1's GACH records, dated 4/29/2024, at 1:29 a.m., indicated Resident 1 was admitted to GACH with diagnoses of acute fall at a skilled nursing facility, acute contusion (bruise to the brain), acute fracture of the nasal bone, abrasions of the forehead and the face and periorbital (around the lining of eyes) ecchymosis (bleeding underneath the skin.). The GACH records indicated Resident 1 was referred to an ear, nose, throat specialist due to the nasal fracture and contusion. During a concurrent interview and record review on 5/21/2024 at 2:38 p.m. with the Director of Nursing (DON), Resident 1's care plan titled Resident had an actual unwitnessed fall related to safety non-compliance, dated 4/22/2024, was reviewed. The DON stated, the care plan's interventions did not make sense. The DON stated Resident 1's care plan was not updated after the resident fell on [DATE], (2 days after the first fall dated 4/20/2024). The DON stated there were no additional interventions after the second fall on 4/22/2024, to prevent Resident 1 from falling the third time on 4/28/2024 (6 days after the second fall). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review on 5/22/2024 at 2:05 p.m. with the DON, Resident 1's MAR dated 4/23 to 4/30/2024 was reviewed. The DON stated the MAR did not indicate Resident 1 had a soft belt when sitting in a wheelchair. The DON stated the MAR did not indicate Resident 1 was monitored for the application or use of a soft belt. The DON stated staff failed to carry out Resident 1's physician's order for the use of a soft belt. The DON stated these failures might have contributed to Resident 1's fall on 4/28/2024. During a telephone interview on 5/22/2024 at 5 p.m. with CNA 3, CNA 3 stated on 4/28/2024 at 12:30 p.m., Resident 1 was on a wheelchair by the nursing station. CNA 3 stated the wheelchair alarm was turned on for Resident 1. CNA 3 stated Resident 1 did not have a soft belt on him (Resident 1) while sitting on the wheelchair. CNA 3 stated Resident 1's recent fall on 4/28/2024, could have been prevented had the soft belt been applied on the resident. CNA 3 stated she was not aware Resident 1 had an order for a soft belt. A review of the facility's P&P titled, Fall Reduction (General) , dated 3/2024, indicated it is the policy of the facility to reassess all residents with falls every time a fall occurred. The P&P indicated residents will be assessed for a need of restraint/ safety device to minimize recurrence of falls such as alarms and self-releasing belts. A review of the facility's P&P titled, Soft/ Self Release Blet , dated 3/2024, indicated a wheelchair soft/ self-release belt was allowed for a resident to use to promote resident safety. A review of the facility's P&P titled, Care Plans, Comprehensive Person-Centered , dated 4/2013, indicated a comprehensive, person-centered care plan included measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs was developed and must be implemented for each resident.