

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055288	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/05/2026
NAME OF PROVIDER OR SUPPLIER Autumn Hills Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 430 N.Glendale Ave Glendale, CA 91206	

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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on observations, interviews and reviews, the facility failed to ensure monitoring and supervision was provided to one of three sampled residents (Resident 1), who was assessed as a high-fall-risk resident, by failing to: Develop and implement individualized care plan interventions to minimize the occurrence of falls in accordance with the Policy and Procedure (P&P) titled Falling Star Program. Identify specific monitoring required while Resident 1 was on the Falling Star Program. Conduct resident observations in accordance with the P&P for the Falling Star Program. Perform and document scheduled safety round as indicated by the P&P for the Falling Star Program. Determine and identify the type and frequency of supervision required in accordance with the facility's P&P for Safety and Supervision. Ensure interventions were implemented and documented in accordance with the facility's P&P for Safety and Supervision. These deficient practices resulted in Resident 1 sustaining two unwitnessed falls at the facility on 12/15/2025 and 1/25/2026, with the second fall requiring transfer to the General Acute Care Hospital (GACH) on 1/25/2026 where Resident 1 was diagnosed with a left femur fracture and had to undergo open reduction internal fixation (ORIF - surgery to repair a severely broken bone) surgery on 1/26/2026. During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted the resident on 1/27/2025, with diagnoses of unsteadiness on feet (poor balance), a history of falling and osteoarthritis (bones breaks over time from lack of cushion). During a review of Resident 1's History and Physical (H&P) dated 8/28/2025, the H&P indicated Resident 1 had a fluctuating capacity to understand and make decisions but was in cognitive decline (problems with a person's ability to think, learn, remember, use judgement, and make decisions). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 10/31/2025, the MDS indicated the resident had moderately impaired cognition. MDS indicated that Resident 1 was partial/moderate assistance for activities of daily living (basic self-care tasks). During a review of Resident 1's Fall Risk Collection record dated 12/15/2025, the Record indicated that Resident 1 was at a high risk for falls with a score of 14 (Score of 14 or above represents a higher risk of falling exist and resident requires increased supervision. During a review of Resident 1's Care Plan for Self transfer without using call light, dated 6/30/2025, the Care Plan indicated to continue use of pad alarm (a pressure-sensitive, wearable, or moisture-detecting device used to alert caregivers when a person leaves a bed/chair) while in the wheelchair and bed. During a review of Resident 1's Care Plan for non-compliant, Resident turns off pad alarm, dated 7/8/2025, the Care Plan indicated to educate resident not to turn off pad alarm. There were no newly updated interventions on the care plan. During a review of Resident 1's Care Plan for Actual Fall, dated 8/23/2025, the Care Plan indicated interventions that Resident 1 would continue the use of pad alarm in bed. During a review of Resident 1's Care Plan titled Falls, dated 8/27/2025, and revied 1/27/2025, the Care Plan interventions indicated that Resident 1 was on the falling star program, had a self release soft belt (a patient safety device designed to prevent falls and unassisted exits from beds or</p> <p>(continued on next page)</p>

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 055288	If continuation sheet Page 1 of 4

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