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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055461	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
California Post Acute	909 S Lake Street Los Angeles, CA 90006

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.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 43851

Based on observation, interview, and record review, the facility failed to provide safe and accident-free environment for one of three sampled residents (Resident 1), who had visual impairment (blindness, difficulty seeing), a left above the knee amputation (AKA - surgical removal of the portion of the leg above the knee), and had history of fall with injury, by failing to:

- Follow the Physician's Order dated 4/15/2024 for Resident 1 to receive visual hourly safety checks for fall prevention.

-Review and update the At Risk for Falls Care Plan after a fall and change in condition on 4/15/2024, including implementation of individualized care and maximizing the resident's safety.

-Assist Resident 1 with mobility and repositioning around 7:30 PM on 12/19/2024, when the roommate (Resident 2) informed Licensed Vocational Nurse 1 that Resident 1 was on the edge of the bed and was going to fall.

As a result, Resident 1 had another fall off her bed on 12/19/2024, was screaming, crying, and the facility staff called 911 (emergency phone number for immediate medical assistance via ambulance). Resident 1 was transferred to General Acute Care Hospital (GACH) 1 where she moaned in pain, sustained a 5-centimeter (cm) laceration (a cut or tear in the skin that is caused by an injury) to her forehead and on 12/20/2024 was admitted to the intensive care unit for acute stroke.

Findings:

A review of Resident 1's Admission Record, indicated the facility originally admitted the resident on 12/22/2021 with diagnoses including a left above the knee amputation (AKA, surgical removal of the portion of the leg above the knee), schizophrenia (a serious mental disorder in which people interpret reality abnormally, may result in delusions and behavior that impairs daily functioning, may have grandiose delusions [strong beliefs of things that are untrue]), and visual impairment (blindness in one eye).

(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	A review of Resident 1's At Risk for Falls care plan initiated 8/19/2022, related to diagnoses of visual impairment and impulsive behavior (acting without thinking of the consequences), lack of awareness, left AKA, muscle weakness, and right heel wound/pain indicated the goal was for Resident 1 to minimize the risk for falls. The care plan interventions indicated to maintain the call light within reach, to remind the resident to use the call light, and to remove hazards from the resident's environment. The care plan indicated the interventions were initiated on 8/19/2022 and had not been updated since 8/19/2022. A review of Resident 1's Actual Fall care plan dated 4/11/2024, indicated the resident fell from the wheelchair while in the resident's room. The care plan was revised on 4/15/2024 which indicated Resident 1 rolled out of bed in the covers and fell on to the floor to the right side of the bed. The care plan indicated interventions for visual hourly safety checks and to continue interventions on the at-risk plan. A review of the Physician's Order dated 4/15/2024 indicated to visually and hourly check Resident 1 for fall monitoring. A review of the Minimum Data Set (MDS, a resident assessment tool) dated 11/22/2024 indicated Resident 1 had mildly impaired cognitive skills (problems or difficulty with memory, thinking, and following instructions, but it did not usually interfere with daily tasks). The MDS indicated Resident 1's functional abilities (dependent on help, for personal hygiene, putting on / taking off footwear, lying to sitting on the bed, bed to chair transfer, and ability for Resident 1 to ambulate at least 10 feet once standing) were not assessed. A review of Resident 1's MDS dated [DATE], indicated the resident had modified independence of cognitive skills for daily decision making (some difficulty in new situations only). The MDS indicated Resident 1 was dependent on help (helper did all of the effort) for personal hygiene, putting on / taking off footwear, lying to sitting on the bed, and bed to chair transfer. The MDS indicated the ability for Resident 1 to ambulate at least 10 feet once standing was not attempted and Resident 1 did not perform this activity. The MDS indicated Resident 1 was always incontinent (having no or little control) of urine and bowel and had one fall with injury (skin tears, abrasions, lacerations, superficial bruises, hematomas, and sprains; or any fall-related injury that causes the resident to complain of pain) since admission / entry, reentry, or the prior assessment. According to a review of Resident 1's Fall Risk assessment dated [DATE], the resident was at a high risk for potential falls with a score of 14. The assessment indicated Resident 1 had intermittent confusion, no falls in the past three months, was chair bound, had poor vision with or without glasses, required the use of assistive devices (i.e. cane, w/c, walker, furniture), had no noted blood pressure drop between lying and standing, had a loss of limb, and was taking hypoglycemics (medication to lower blood sugar levels), narcotics (medication used to treat pain), and psychotropics (medication that affects behavior, mood, thoughts, or perception). A review of the At Risk for Fall Care plan indicated there were no updates or revisions to include Resident 1's current status of high risk for falls with intermittent confusion. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 1's Change of Condition documentation dated 12/19/2024 at 8:08 PM, indicated the resident had a fall. The documentation indicated at 7:40 PM, Resident 1 fell out of her bed and fell on to the floor. The documentation indicated Resident 1 was found to have a gash (a long deep slash, cut, or wound) on their forehead and was bleeding from area. The documentation indicated 911 was called and the paramedics decided to transfer Resident 1 to General Acute Care Hospital (GACH) 1. The documentation further indicated Resident 1's physician was notified. A review of Resident 1's Medication Administration Record (MAR) dated 12/1 - 12/31/2024 indicated to perform visual hourly safety checks for fall precaution. The MAR indicated to document in MAR Y=Yes that the visual check was completed checking on the resident every hour. The MAR indicated the documentation of 2 referred to Drug Refused. The MAR documentation on 12/8 - 12/11/2024 indicated LVN 1 documented 2, drug refused, from midnight to 7 AM for a total of 32 times. The MAR dated 12/19/2024 from 5 PM to 11 PM indicated LVN 1 documented 2. Further review of the December MAR indicated 2 was documented a total of 71 times by LVN 1. A review of Resident 1's Health Status Note documented by Licensed Vocational Nurse (LVN) 1 dated 12/19/2024 at 8:30 PM, indicated LVN 1 went on a break at 7:30 PM and returned at 7:50 PM. The health status note indicated that according to LVN 2, Resident 1 was heard falling at 7:40 PM. LVN 2 went straight to the room and found Resident 1 on the floor with a gash on the forehead, and 911 was called. The note indicated Resident 2 had reported to LVN 1 that Resident 1 was at risk for falling at 6 PM. According to a review of Resident 1's Emergency Documentation (ED) from GACH 1 dated 12/19/2024, the resident was found on the floor from falling out of her bed striking her forehead on the floor and sustaining a laceration. The ED indicated Resident 1 was moaning in pain and had a 5-centimeter horizontal shallow laceration to the forehead. A review of Resident 1's GACH 1 History and Physical (H&P) dated 12/20/2024 indicated the resident had a magnetic resonance imaging (MRI, a noninvasive medical imaging test that used radio waves and strong magnetic fields to create detailed pictures of the inside of the body) scan done on 12/20/2024 for a head injury. The MRI indicated Resident 1 had a small region of acute infarct (a medical emergency that occurs when an organ or body part has a sudden interruption of blood supply, resulting in cell death and tissue damage due to and lack of oxygen, in the context of stroke) along the left corona radiata (a bundle of nerve fibers that carries information between the brain stem and cerebral cortex, or the outer layer of the brain). The H&P indicated Resident 1 was initially admitted to the intensive care unit, was later downgraded to telemetry, and was administered aspirin and statin (a class of medications that reduce the risk of stroke and heart attack) for her acute stroke with a neurology consult. During a concurrent observation and interview on 1/6/2025 at 11:10 AM, in Resident 1's room, the resident was observed lying in bed with an adaptable call light within reach. Resident 1 was observed with the bed low and floor mats to the left and right side of the bed. Resident 1 was observed wearing a yellow wristband that indicated fall risk to their right wrist. Resident 1 stated they did not remember falling or hitting their head in the facility. Resident 1 stated they did not remember anything about falling. A review of Resident 2's Admission Record indicated the facility admitted the resident on 3/20/2024 with diagnoses including muscle weakness, anxiety disorder, and depression. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 2's MDS dated [DATE], indicated the resident was cognitively intact (the ability to think, understand, and reason). During an interview on 1/6/2025 at 12:38 PM, in Resident 2's room, Resident 2 stated she knew Resident 1 and she was roommates with Resident 1 since being admitted to the facility 3/2024. Resident 2 stated she remembered when Resident 1 fell on [DATE] around 8 PM. Resident 2 stated before Resident 1 fell she saw the resident close to the edge of her bed. Resident 2 stated she called LVN 1 and told LVN 1 Resident 1 was about to fall. Resident 2 stated LVN 1 told her, Don't worry. Resident 1 was not going to fall. Resident 2 stated LVN 1 stood at the door and told her not to worry and walked away. Resident 2 stated, LVN 1 did not come into the room at all. Resident 2 stated shortly after notifying LVN 1, Resident 1 fell and landed close to Resident 2's bed. Resident 2 stated after Resident 1 fell , the resident was crying and screaming. Resident 2 stated LVN 1 came into the room after the paramedics came. Resident 2 stated Resident 1, Needed a lot of help doing things, she only had one leg, and she had fallen from the wheelchair before. During a telephone interview on 1/6/2025 at 2:37 PM, Certified Nursing Assistant (CNA) 1 stated he was Resident 1's CNA the night the resident fell . CNA 1 stated Resident 1 was always confused and shouted a lot at night. CNA 1 stated Resident 1 was always moving left and right and needed special pillows on the bed. During an interview on 1/6/2024 at 3:31 PM, LVN 2 stated she was working the 3 PM to 11 PM shift on 12/19/2024. LVN 2 stated she was at the nursing station doing documentation when she heard a noise and Resident 2 yelling for help. LVN 2 stated she went to Resident 1 and 2's room and saw Resident 1 on the floor. LVN 2 stated she saw Resident 1 had blood on her head. LVN 2 stated she asked Resident 1 what had happened, and the resident told her she fell , hit her head, and was in pain but could not provide their pain level. LVN 2 stated she called 911. LVN 2 stated Resident 1 hit the right side of her head and had a smear of blood on their face. LVN 2 further stated LVN 1 was assigned to take care of Resident 1 that night. On 1/7/2024 at 8:57 AM, during a telephone interview, LVN 1 stated on 12/19/2024 he was working the 3 PM to 11 PM shift and was taking care of Resident 1. LVN 1 stated he did not see Resident 1 fall. LVN 1 stated he went on break from 7:30 PM to 8 PM that night. LVN 1 stated he came back early from break because he was called and informed Resident 1 had fallen. LVN 1 stated when he got back to the facility Resident 1 was already in the ambulance. LVN 1 stated Resident 1 had some behaviors that were concerning such as leaning on the side of the bed, crying a lot, and behaviors that make you think the resident might have an accident. LVN 1 stated at baseline Resident 1 was confused and did not know much of what was going on. LVN 1 stated Resident 1 was at risk of falling and he could not remember if Resident 1 had floor mats the night the resident fell on [DATE]. (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 1/7/2025 at 9:32 AM, Resident 1's care plans, MAR dated 12/1 - 12/31/2024, and electronic health care record (EHR) were reviewed with Registered Nurse (RN) 1. RN 1 stated Resident 1 was unpredictable and had periods of confusion but could make their needs known. RN 1 stated Resident 1 was dependent on staff and required total care. RN 1 reviewed Resident 1's EHR and stated prior to the resident's fall on 12/19/2024, the resident fell previously on 4/15/2024. RN 1 stated Resident 1's at risk for falls care plan was not updated after the resident fell on [DATE]. RN 1 stated Resident 1's at risk for falls care plan was last updated on 8/19/2022. RN 1 stated after a resident had a fall, staff refer to the at-risk for falls care plan and update the care plan with additional interventions. RN 1 stated after a resident had a fall, an actual fall care plan should also be created. RN 1 stated care plans were updated with a change of condition, quarterly, and as needed. On the same interview, RN 1 reviewed Resident 1's December MAR. RN 1 stated and confirmed that on 12/19/2024 from 5 PM to 11 PM, 2 was documented for visual hourly safety checks for fall prevention. RN 1 stated 2 indicated Drug Refused. RN 1 stated the documentation on the MAR was incorrect. RN 1 stated, I don't know how you can refuse a visual check; I can't deny what my eyes are seeing. RN 1 stated a visual check means seeing if Resident 1 was good, the resident may refuse a drug, but a visual check was not a drug. RN 1 stated you can visually see where Resident 1 was by just looking or passing by a room. RN 1 stated the documentation on Resident 1's MAR indicated that a visual check was not done. RN 1 stated if the visual check was done the documentation would indicate a Y which it did not. During a concurrent telephone interview and record review on 1/7/2025 at 10:03 AM, Resident 1's MAR dated 12/1- 12/31/2024 was reviewed with LVN 1. LVN 1 stated that on 12/19/2024 from 5 PM to 11 PM, he documented a 2 for visual hourly safety checks for fall prevention. LVN 1 stated the 2 indicated Drug Refused. LVN 1 stated the documentation on the MAR was incorrect and he made a mistake. LVN 1 stated that night he was informed by Resident 2 that Resident 1 was on the edge of the bed and might fall. LVN 1 stated he did not enter the room because he could see that Resident 1 was centered in the bed. LVN 1 stated he did not reposition Resident 1 when he was notified of Resident 2's concern because the resident was centered in the bed. During an interview on 1/7/2025 at 10:45 AM, Resident 1's Physician's Orders were reviewed with RN 1. RN 1 stated Resident 1 had floor mats to prevent falls placed after the fall on 12/19/2024 after she returned to the facility from GACH 1. RN 1 stated Resident 1 did not have any physician's orders for floor mats prior to the resident's fall on 12/19/2024. RN 1 stated there were no care plan interventions for floor mats on Resident 1's at risk for falls or actual fall care plans. RN 1 further stated Resident 1's laceration could have been prevented if the resident had floor mats in place when they fell on [DATE]. During a concurrent interview and record review on 1/7/2025 at 11:31 AM, Resident 1's care plans, MAR dated 12/1 - 12/31/2024, and EHR were reviewed with the DON. The DON stated Resident 1 had a previous fall on 4/15/2024. The DON reviewed Resident 1's at risk for fall care plan, the left AKA care plan, and the Self Care Deficit care plan and stated the care plans had not been updated since 2022. The DON stated when a resident has a fall, the at risk for falls care plan should be updated to include additional and new interventions to help prevent further falls. The DON stated appropriate care plans should be updated with any change in condition and quarterly with specific and person-centered interventions that are based on the resident's assessments. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During the same concurrent interview and record review of Resident 1's MAR, and the DON stated that on 12/19/2024 from 5 PM to 11 PM, a 2 was documented for visual hourly safety checks for fall prevention. The DON stated the 2 indicated Drug Refused. The DON stated the documentation on the MAR was incorrect and indicated a visual check was not done. The DON stated if the visual check was done the documentation would indicate Y for yes. The DON stated Resident 1 had floor mats placed to the sides of her bed when she returned to the facility after their fall on 12/19/2024. The DON stated floor mats could have helped prevent Resident 1 from sustaining a laceration when she fell on [DATE]. The DON further stated an updated at risk for falls care plan and hourly visual checks would have prevented Resident 1 from falling off their bed. A review of the facility's policy and procedure titled, Fall Risk Assessment, revised 1/2024, indicated the nursing staff, in conjunction with the attending physician, consultant pharmacist, therapy staff, and others, will seek to identify and document resident risk factors for falls and establish a resident-centered falls prevention plan based on relevant assessment information. The attending physician and nursing staff will evaluate the resident's vital signs, assess the resident for medical conditions (such as those that cause dizziness or vertigo) or sensory impairments (such as decreased vision and peripheral neuropathy) that may predispose falls. Assessment data shall be used to identify underlying medical conditions that may increase the risk of injury from falls (such as osteoporosis). The staff will seek to identify environmental factors that may contribute to falling, such as lighting and room layout. The staff and attending physician will collaborate to identify and address modifiable fall risk factors and interventions to try to minimize the consequences of risk factors that are not modifiable. A review of the facility's policy and procedure titled, Care Plans, Comprehensive Person-Centered, revised 5/2024, indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident. The interdisciplinary Team must review and update the care plan: when there has been a significant change in the resident's condition; when the desired outcome is not met; when the resident has been readmitted to the facility from a hospital stay; and at least quarterly, in conjunction with the required quarterly MDS assessment. A review of the facility's policy and procedure titled, Assessing Falls and Their Causes, revised 5/2024, indicated the purposes of this procedure was to provide guidelines for assessing a resident after a fall and to assist staff in identifying causes of the fall. Review the resident's care plan to assess any special needs of the resident. Falling may be related to underlying clinical or medical conditions, overall functional decline, medication side effects, and/or environmental risk factors. Residents must be assessed upon admission and regularly afterward for potential risk of falls. Relevant risk factors must be addressed promptly. When a resident falls, the following information should be recorded in the resident's medical record. Appropriate interventions taken to prevent future falls.