

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055525	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/31/2024
NAME OF PROVIDER OR SUPPLIER  Crenshaw Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE  1900 S Longwood Ave Los Angeles, CA 90016	

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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44294</b></p> <p>Based on interview and record review, the facility failed to report to the California Department of Public Health (CDPH), within 24 hours, for one of three sampled residents, Resident 3, who sustained a total of three bruises (result of a direct blow or an impact, such as a fall or after trauma, such as a blow to the body) of unknown source from 6/2024 to 12/2024.</p> <p>This deficient practice resulted in the delay of investigation by the CDPH.</p> <p>Findings:</p> <p>During a review of Resident 3 ' s Admission Record, the Admission Record indicated Resident 3 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including schizophrenia (serious mental illness that affects how a person thinks, feels, and behaves) and major depressive disorder (mood disorder that causes a persistent low mood and loss of interest in activities).</p> <p>During a review of Resident 3 ' s Minimum Data Set ([MDS], a standardized assessment and care screening tool), dated 2/2/2024, the MDS indicated Resident 3 had impaired cognitive impairment. The MDS indicated Resident 3 required set-up assistance with eating, toileting, and personal hygiene. The MDS indicated Resident 3 required supervision with oral hygiene, shower/ bathing, and putting on/taking off footwear.</p> <p>1). During a review of Resident 3 ' s Change of Condition (COC)/ Interact Assessment Form (Situation, Background, Assessment, and Recommendation [SBAR] a structured way to communicate to the care team about a resident ' s change in condition), dated 6/18/2024 at 1:29 p.m., the SBAR indicated Resident 3 was noted with swollen tibia and fibula (the two long bones located in the lower leg).</p> <p>During a review of Resident 3 ' s progress notes dated 6/18/2024 and 6/19/2024, the notes did not indicate the swollen tibia, fibula was reported to CDPH.</p> <p>2). During a review of Resident 3 ' s SBAR dated 11/5/2024 at 6:28 p.m., the SBAR indicated Resident 3 had swollen left wrist. The SBAR indicated Resident 3 did not know what happened and how the swelling happened.</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
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 3 ' s progress notes dated 11/5/2024 and 11/6/2024, the notes did not indicate swollen left wrist was reported to CDPH.</p> <p>3). During an interview on 12/24/2024 at 9:58 a.m., Certified Nurse Assistant (CNA 1) stated Resident 3 was on one on one (1:1) care (when a CNA only takes care of one resident) and was monitored 24 hours a day, 7 days a week because Resident 3 would get out of bed without asking for assistance and had a very poor balance, poor self-awareness and was at risk for falls and injuries.</p> <p>During a concurrent interview and record review on 12/24/2024 at 11:31 a.m. with Treatment Nurse (TN), the SBAR dated 12/24/2024 at 2:07 p.m. was reviewed. The TN stated even though Resident 3 had been on 1:1 monitoring, the facility did not know how Resident 3 sustained the left lower extremities' skin discolorations and other injuries like swelling and bruises on different parts of her body on the 6/18/2024, 11/5/2024 and 12/24/2024 incidents. The TN stated it was suspicious for a resident to just wake up with a bruise or swelling without a reason on how it happened.</p> <p>During a review of Resident 3 ' s progress notes dated 12/24/2024 and 12/25/2024, the notes did not indicate the left lower extremities' skin discolorations were reported to the CDPH.</p> <p>During an interview on 12/31/2024 at 2:40 p.m., the Administrator (Admin) stated it was suspicious the staff was monitoring Resident 3, 24-hours a day, 7 days a week and does not know how any of the bruising and swelling occurred on 6/18/2024, 11/5/2024 and 12/24/2024. The Admin stated, the facility should have investigated and reported the bruises and swelling to the CDPH within two hours per their policy.</p> <p>During a review of the facility ' s policy and procedures (P&amp;P) titled, Abuse, Neglect, Exploitation or Misappropriation- Reporting and Investigating, dated 3/2023, the P&amp;P indicated, if injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to the state licensing/ certification agency responsible for surveying/ licensing the facility according to state law. The P&amp;P indicated immediately was defined as within two hours if the allegation resulted in serious bodily injury and 24 hours if the allegation did not result in serious bodily injury.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44294</b></p> <p>Based on interview and record review, the facility failed to investigate swelling and bruises (an injury appearing as an area of discolored skin on the body, caused by a blow or impact rupturing underlying blood vessels) of unknown source, on 6/18/2024, 11/5/2024 and 12/24/2024, for one of three sampled residents, Resident 3.</p> <p>This failure resulted in Resident 3 ' s continued sustaining injuries requiring interventions.</p> <p>This failure placed the resident at risk for severe injuries, resulting in hospitalization and death.</p> <p>Findings:</p> <p>During a review of Resident 3 ' s Admission Record, the Admission Record indicated Resident 3 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including schizophrenia (serious mental illness that affects how a person thinks, feels, and behaves) and major depressive disorder (mood disorder that causes a persistent low mood and loss of interest in activities).</p> <p>During a review of Resident 3 ' s Minimum Data Set ([MDS], a standardized assessment and care screening tool), dated 2/2/2024, the MDS indicated Resident 3 had impaired cognitive impairment. The MDS indicated Resident 3 required set-up assistance with eating, toileting and personal hygiene. The MDS indicated Resident 3 required supervision with oral hygiene, shower/ bathing, and putting on/taking off footwear.</p> <p>1). During a review of Resident 3 ' s Change of Condition (COC)/ Interact Assessment Form (Situation, Background, Assessment, and Recommendation [SBAR] a structured way to communicate to the care team about a resident ' s change in condition), dated 6/18/2024 at 1:29 p.m., the SBAR indicated Resident 3 was noted with swollen tibia and fibula (two long bones in the leg).</p> <p>During a review of Resident 3 ' s progress notes dated 6/18/2024 and 6/19/2024, the notes did not indicate an investigation was conducted regarding the swollen tibia, fibula.</p> <p>2). During a review of Resident 3 ' s SBAR dated 11/5/2024 at 6:28 p.m., the SBAR indicated Resident 3 had swollen left wrist. The SBAR indicated Resident 3 did not know what happened and how it happened.</p> <p>During a review of Resident 3 ' s progress notes dated 11/5/2024 and 11/6/2024, the notes did not indicate an investigation was conducted regarding the swollen left wrist.</p> <p>3). During an interview on 12/24/2024 at 9:58 a.m., Certified Nurse Assistant (CNA 1) stated Resident 3 was on one on one (1:1) care (when a CNA only takes care of one resident) and was monitored 24 hours a day, 7 days a week because Resident 3 would get out of bed without asking for assistance and had a very poor balance, poor self-awareness and was at risk for falls and injuries.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 3 ' s progress notes dated 12/24/2024 and 12/25/2024, the progress notes did not indicate documentation and investigation was conducted regarding the left lower extremities skin discolorations.</p> <p>During a concurrent interview and record review on 12/24/2024 at 11:31 a.m. with Treatment Nurse (TN), the SBAR dated 12/24/2024 at 2:07 p.m. was reviewed. The TN stated even though Resident 3 had been on 1:1 monitoring, the facility did not know how Resident 3 sustained the lower extremities skin discolorations and injuries like bruises on different parts of her body on the 6/18/2024, 11/5/2024 and 12/24/2024 incidents. The TN stated it was suspicious for a resident to just wake up with a bruise or swelling without a reason. The TN stated for residents to have an injury (residents ' swelling and skin discolorations) without reasons, were suspicious and should have been investigated.</p> <p>During an interview on 12/31/2024 at 2:40 p.m., the Administrator (Admin) stated it was suspicious that the staff was monitoring Resident 3, 24 hours a day, 7 days a week and does not know how any of the bruising and swelling occurred on 6/18/2024, 11/5/2024 and 12/24/2024. The Admin stated, the facility should have investigated the bruises and swelling immediately.</p> <p>During a review of the facility ' s P&amp;P titled Abuse, Neglect, Exploitation or Misappropriation- Reporting and Investigating, dated 3/2023, the P&amp;P indicated all reports of abuse including injuries of unknown source should be thoroughly investigated by facility management and are reported to local, state, and federal agencies (as required by current regulations). The P&amp;P indicated findings of all investigations are documented and reported and provide the 5-day follow-up investigation report.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44294</b></p> <p>Based on interview, and record review, the facility failed to develop an individualized plan of care for the safety of a resident that required to be within sight at all times of day and night for one of three sampled resident (Residents 3).</p> <p>This deficient practice had the potential for recurrent injuries or falls for Resident 3.</p> <p>Findings:</p> <p>During a review of Resident 3 ' s Admission Record, the Admission Record indicated Resident 3 was admitted on [DATE] with diagnoses including schizophrenia (a mental illness that is characterized by disturbances in thought) and major depressive disorder (mood disorder that causes a persistent feeling of sadness and loss of interest).</p> <p>During a review of Resident 3 ' s care plan, titled At Risk for Falls/Injury, dated 2/14/2024, the goal of care plan was to keep Resident 3 free from falls and injury. Interventions indicated facility would visibly observe resident frequently. The care plan did not indicate what frequency Resident 1 should be monitored or observed.</p> <p>During a review of Resident 3 ' s Minimum Data Set ([MDS], a resident assessment tool), dated 10/30/24, the MDS indicated Resident 3 sometimes understood others and sometimes be understood by others. The MDS indicated Resident 3 required supervision or touching assistance (staff provided verbal cues and/or touching/steadying assistance as resident completed activity) for Activities of Daily Living (ADLs) such as eating, upper body dressing, bed mobility, chair/bed transfers and walking 10 feet. The MDS indicated Resident 3 required partial/moderate assistance (staff did less than half the effort) personal hygiene, lower body dressing and toilet transfers.</p> <p>During a review of Resident 3 ' s SBAR ([Situation, Background, Assessment, Recommendation], a communication tool used by healthcare workers when there is a change of condition among the residents) dated 3/22/2024, indicated Resident 3 had a fall. The SBAR indicated Resident 3 had unsteady gait and was walking without shoes. The SBAR indicated Resident 3 abruptly turned, lost her balance, and accidentally hit the left side of her forehead on the corner of the bed.</p> <p>During an interview on 12/31/2024 at 12:06 p.m., Certified Nurse Assistant (CNA 1) stated Resident 3 was on one on one ([1:1] one staff delegated to supervise single resident) care and was monitored 24 hours a day, 7 days a week because Resident 3 would get out of bed without asking for assistance and had very poor balance. CNA 1 stated Resident 3 also had poor self-awareness and was at risk for falls and injuries.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 12/15/2025 at 9:55 a.m. with the Director of Nursing (DON), the DON stated care plans were tools to provide care to residents and used to provide guidance to achieve goals by placing interventions to meet those goals and maintain resident safety and wellbeing of residents. The DON stated, Resident 3 ' s care plan did not address the problems of the resident not having shoes, abrupt behavior, and poor balance. The DON stated adding interventions such as non-skid socks, re-directing, a psychologic consult and 1:1 supervision or constant supervision to assist to ambulate would be good effective interventions to prevent future falls and injuries. The DON also stated Resident 3 was on a 1:1 since 4/24/2024 because of wondering and abrupt behavior and should have been included in the resident ' s care plan, however, was not done.</p> <p>During a review of the facility ' s Policy and Procedure (P&amp;P) titled, Care Plans, Comprehensive Person-Centered, dated 3/2022, the P&amp;P indicated a comprehensive, person-centered care plan that included measurable objectives and timetables to meet the resident's physical, mental and psychosocial well-being. The P&amp;P indicated resident ' s care plans reflected recognized standards of practice for problem areas and conditions and include services provided for or arranged by the facility.</p>		

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<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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 44294</p> <p>Based on interview and record review, the facility failed to:</p> <ol style="list-style-type: none"> <li>1). Provide an environment free of accident hazards as possible and provided one of three residents ' (Resident 3), adequate supervision and assistance to prevent accidents.</li> <li>2). Conduct accurate fall risk assessment to one of 3 residents, Resident 3, who had history of fall.</li> <li>3). Implement its policy and procedure (P&amp;P) titled Safety and Supervision of Residents, which indicated safety risks and environmental hazards are identified on an ongoing basis and the Quality Assurance and Performance Improvement (QAPI) review safety and incident/accident data; and a facility-wide commitment to safety at all levels of the organization.</li> </ol> <p>These failures resulted in Resident 3 experienced multiple incidents of bruising (an injury appearing as an area of discolored skin on the body, caused by a blow or impact rupturing underlying blood vessels). Resident 3 sustained swollen tibia (shinbone), fibula (calf bone) on 6/18/2024. Resident 3 sustained swollen left wrist on 11/5/2024. Resident 3 sustained bluish discoloration and swelling on left eye on 11/17/2024. Resident 3 sustained swelling and pain on left wrist on 12/15/2024.</p> <p>These failures had the potential to result in Resident 3 ' s severe injuries, hospitalization , or death.</p> <p>Findings:</p> <p>During a review of Resident 3 ' s Admission Record, the Admission Record indicated Resident 3 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including schizophrenia (serious mental illness that affects how a person thinks, feels, and behaves) and major depressive disorder (mood disorder that causes a persistent low mood and loss of interest in activities).</p> <p>During a review of Resident 3 ' s Minimum Data Set ([MDS], a standardized assessment and care screening tool), dated 2/2/2024, the MDS indicated Resident 3 had impaired cognitive impairment. The MDS indicated Resident 3 required set-up assistance with eating, toileting, and personal hygiene. The MDS indicated Resident 3 required supervision with oral hygiene, shower/ bathing, and putting on/taking off footwear.</p> <p>During a review of Resident 3 ' s care plan, titled At Risk for Falls/Injury, dated 2/14/2024, the goal of care plan was to keep Resident 3 free from falls and injury daily. The interventions indicated facility would visibly observe resident frequently (frequency not specified), provide safety instruction to resident regarding safety ambulation, transfers, and ADLs when appropriate.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>1). During a review of Resident 3 ' s Change of Condition (COC)/ Interact Assessment Form (Situation, Background, Assessment, and Recommendation [SBAR] a structured way to communicate to the care team about a resident ' s change in condition), dated 3/22/2024 at 6:04 a.m., the SBAR indicated Resident 3 who had unsteady gait was stopped from entering the hallway due to housekeeping was beginning to mop the hallway floors. The SBAR indicated Resident 3 was escorted by the Charge Nurse back to the room to get a wheelchair. The SBAR indicated Resident 3 was not wearing shoes. The SBAR indicated Resident 3 reached the foot of her bed and abruptly turned away from Charge Nurse, and went in between beds A and B, while the charge nurse was taking Resident 3 ' s wheelchair located between beds B and C. The SBAR indicated Resident 3 lost her balance and accidentally hit her left side of forehead on the corner of bed A. The SBAR indicated Resident 3 ' s head was bleeding and had a laceration (cut) measured 0.7 centimeters (cm- a unit of measurement) x 0.1 cm. The SBAR indicated Resident 3 received wound treatment on the head. The SBAR indicated Resident 3 was sent to a general acute care hospital via 911 (emergency services) for further evaluation and treatment.</p> <p>During a review of Resident 3 ' s care plan titled, Recent fracture of the left wrist, dated 3/22/2024, the interventions indicated to handle resident gently during care and assist with transfers and ambulation as needed.</p> <p>2). During a review of Resident 3 ' s Fall Risk assessment dated [DATE] at 9:43 p.m., the fall risk assessment indicated Resident 3 was a low fall risk of falling. The fall risk assessment did not indicate Resident 3 ' s history of fall on 3/22/2024.</p> <p>During an interview on 12/31/2024 at 11:09 a.m., Licensed Vocational Nurse (LVN 3) stated Registered Nurse (RN) did the fall assessment dated [DATE]. LVN 3 stated the fall risk assessment dated [DATE] should have included the fall on 3/22/2024. LVN 3 stated the result would have been high fall risk.</p> <p>During an interview on 1/15/2025 at 9:55 a.m., the Director of Nursing (DON)stated Resident 3 fell within 3 months and the box for history of falls and the third box which indicated current fall or/with history in the last 6 or 12 months, should have been clicked. The DON stated the result of Resident 3 ' s fall risk assessment of low risk was incorrect. The DON stated the care plan for low fall risk residents will change if the resident was a high fall risk. The DON stated high fall risk residents would require more interventions for supervision and safety. The DON stated Resident 3 had a one on one ([1:1] when a Certified Nurse Assistant [CNA] only takes care of one resident) sitter, however, the sitter did not know how all the incidents occurred.</p> <p>3). During a review of Resident 3 ' s SBAR dated 6/18/2024 at 1:29 p.m., the SBAR indicated Resident 3 was noted with swollen tibia, fibula, down to the talus (bones that form the ankle joint). The SBAR indicated Resident 3 complained of 8/10 pain ([a numeric pain scale] 1-3 mild pain; 4-6 moderate pain; 7-10 severe pain) in the tibia fibula area. The SBAR indicated Resident 3 was medicated for pain and the physician ordered x-ray (process of taking pictures of tissues and structures inside the body for diagnosis and treatment) on the left lower leg.</p> <p>During a review of Resident 3 ' s care plan, titled Edema/Swelling Right Lower Extremity, dated 6/18/2024, the interventions indicated resident would avoid sharp angulation (sudden, sharp bend or turn) of hip joints, handle affected extremities gently, notify the physician for further changes.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>4). During a review of Resident 3 ' s SBAR dated 11/5/2024, the SBAR indicated Resident 3 had swollen left wrist. The SBAR indicated Resident 3 did not know what happened and how the swelling happened. The SBAR indicated Resident 3 had 2/10 pain level. The SBAR indicated Resident 3 was given pain medication to address the pain. The SBAR indicated Resident 3 ' s physician was notified and ordered x-ray of left wrist.</p> <p>During a review of Resident 3 ' s care plan, titled Left Wrist Pain, Swelling and Limited Mobility, dated 11/05/2024, the interventions indicated staff would assist Resident 3 with ADLs and mobility as needed.</p> <p>5). During a review of Resident 3 ' s SBAR dated, 11/17/2024 at 7:30 a.m., the SBAR indicated Resident 3 ' s 1:1 sitter reported that Resident 3 was noted with swelling and bluish discoloration above the left eye. The SBAR indicated Resident 3 stated, I bumped my head against the door of the bathroom when I was going to use it.</p> <p>During a review of Resident 3 ' s care plan, titled Alteration in Skin/Integrity actual presence, dated 11/17/2024, the interventions indicated to encourage resident to be out of bed daily as tolerated, handle client, and provide behavior management techniques.</p> <p>6). During a review of Resident 3 ' s SBAR dated 12/24/2024 at 2:07 p.m., the SBAR indicated the Charge Nurse was called to Resident 3 ' s shower room by a CNA. The SBAR indicated Resident 3 was observed with skin ecchymosis (discoloration) on the left lower extremity. The SBAR indicated Resident 3 denied pain or discomfort.</p> <p>During a review of Resident 3 ' s care plan, titled Alteration in Skin/Integrity actual presence, dated 12/24/2024, the interventions indicated to provide siderail cushions, keep resident hydrated, keep skin moisturized, maintain floor mats on the side of beds, monitor skin integrity and reposition every two hours.</p> <p>During an interview on 12/24/2024 at 9:58 a.m., CNA 1 stated Resident 3 was on one on one (1:1) care (when a CNA only takes care of one resident) and was monitored 24 hours a day, 7 days a week because Resident 3 would get out of bed without asking for assistance and had very poor balance. CNA 1 stated Resident 3 had poor self-awareness and was at risk for falls and injuries.</p> <p>During an interview on 1/8/2024 at 12:27 p.m., the MDS nurse stated frequent monitoring in the care plan dated 2/14/2024, usually indicates every two hours or whenever staff is doing rounds. The MDS nurse stated a good intervention for Resident 3 would be to reorient patient to reality and the care plan did not include this.</p> <p>During a concurrent interview and record review on 1/15/2025 at 9:55 a.m. with the DON, the SBARs dated 6/18/2024, 11/5/2024 and 12/24/2024 were reviewed. The DON stated the facility should have provided Resident 3 with constant supervision to assist in ambulation or in moving from area to area in the facility to prevent all the incidents indicated in the SBARs. The DON stated the SBARs dated 6/18/2024, 11/5/2024 and 12/24/2024, the facility did not know what happened to the resident and they had no way of knowing what the issues were or caused the injuries and could not address the specific problems that caused the bruises and swelling. The DON stated if the original care plan for fall had addressed the poor balance, abrupt behavior and not wearing shoes, maybe the injuries could have been prevented.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Crenshaw Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE  1900 S Longwood Ave Los Angeles, CA 90016	
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>During a review of the facility ' s undated policy and procedure (P&amp;P) titled Initial Fall Risk Assessment, the P&amp;P indicated each resident will be given a score, if the score was at least 3 of 5, the resident will be considered moderate to high risk of fall and a plan of care will be established immediately for implementation of interventions to attempt prevention of a fall. The P&amp;P indicated the interdisciplinary team (IDT) will review the plan of care quarterly and as needed for update of the resident ' s current needs. The P&amp;P indicated recommended interventions as needed:</p> <p>soft belt</p> <p>lap buddy</p> <p>nightlight</p> <p>use of cane</p> <p>walker</p> <p>bedside commode</p> <p>side rails</p> <p>lower bed</p> <p>bean bag chair</p> <p>floor mats</p> <p>During a review of the facility ' s P&amp;P titled Safety and Supervision of Residents, dated 2017, the P&amp;P indicated the facility would strive to make the environment as free from accident hazards as possible. The P&amp;P indicated resident safety and supervision and assistance to prevent accidents are facility-wide priorities. The P&amp;P indicated safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting processes; QAPI reviews of safety and incident/accident data; and a facility-wide commitment to safety at all levels of the organization. The P&amp;P indicated when accident hazards are identified, the QAPI/safety committee shall evaluate and analyze the cause(s) of the hazards and develop strategies to mitigate or remove the hazards to the extent possible. The P&amp;P indicated the employees shall be trained on potential accident hazards and demonstrate competency on how to identify and report accident hazards and try to prevent avoidable accidents. The P&amp;P indicated the interdisciplinary care team shall analyze information obtained from assessments and observations to identify any specific accident hazards or risks for individual residents. The P&amp;P indicated the care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices. The P&amp;P indicated implementing interventions to reduce accident risks and hazards shall include the following:</p> <p>a. Communicating specific interventions to all relevant staff.</p> <p>b. Assigning responsibility for carrying out interventions.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Crenshaw Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE  1900 S Longwood Ave Los Angeles, CA 90016	
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>c. Providing training, as necessary.</p> <p>d. Ensuring that interventions are implemented; and</p> <p>e. Documenting interventions.</p> <p>The P&amp;P indicated monitoring the effectiveness of interventions shall include the following:</p> <p>a. Ensuring that interventions are implemented correctly and consistently.</p> <p>b. Evaluating the effectiveness of interventions.</p> <p>c. Modifying or replacing interventions as needed; and</p> <p>d. Evaluating the effectiveness of new or revised interventions.</p>		