STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055527	A. Building B. Wing	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Palos Post-Acute Care Center	1430 West 6th Street San Pedro, CA 90732

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44443 Based on interview and record review, the facility failed to develop an individualized care plan and conduct an interdisciplinary (group of professionals from different disciplines) team conference, involving the family member 1 (FM 1), to address one out of nine sampled resident's (Resident 1) refusal of examination and treatment by the podiatrist (foot specialist) and optometrist (health professional that involves examining eyes). This deficient practice resulted in a delay of needed services and had the potential to contribute to further medical problems and contribute to a negative physical wellbeing. Findings: During a review of Resident 1's Admission Record, dated 5/23/2024, the Admission Record indicated Resident 1 was originally admitted on [DATE] and readmitted on [DATE] with a diagnosis including dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities) with agitation, bipolar disorder (a serious mental illness that causes extreme mood swings that include emotional highs [mania] and lows [depression], and difficulty in walking. During a review of Resident 1's Minimum Data Set (MDS), a standardized assessment and care planning tool, dated 4/30/2024, the MDS indicated, Resident 1 had severe cognitive (thinking) impairment. Resident 1 also had impairment to the lower extremities to both sides, uses a wheelchair for a mobility device, and required substantial, maximum assistance with lower body dressing and with putting on and taking off footwear. During a review of Resident 1's care plan for cognitive (thinking) deficit, initiated 7/6/2022, the care plan indicated, Resident 1 was observed with impaired cognition as evidence by having impaired recall ability, confusion related to Alzheimer's (disease process) dementia and age- related factors. One of the care plan interventions indicated, to involve resident/ family in decision making. During a review of Resident 1's care plan for vision impairment, date initiated 1/26/2022, the care plan indicated, as one of the interventions to involve family member in plan of care. During a review of Resident 1's Order Summary Report (physician orders), dated 8/28/2023, the Order Summary Report indicated, Resident 1 had an active physician order for consults for podiatry (study of the foot) consult as needed and for optometry as needed. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/23/2024, at 2:50 p.m., with Family Member (FM1), FM 1 stated, No one had mentioned Resident 1 had refused his examinations with the podiatrist or optometrist. During an interview on 5/24/2024, at 9:50 am, with the charge nurse (CN), the CN stated he was not aware that Resident 1 refused the podiatrist appointments on 1/13/2024, 3/16/2024, or on 5/16/2024. CN stated the social worker arranges the doctor visits and the chart was not checked to see if Resident 1 had been seen by the podiatrist and the chart should have been checked. The CN stated It was the responsibility of the nurses to check the podiatrist's notes. The responsible party should have been made aware of Resident 1's refusal to be examined by the podiatrist and maybe could have convinced Resident 1 to have his feet checked so Resident 1 doesn't develop any serious foot problems. During a concurrent interview and record review on 5/24/2024, at 10 a.m., with the Registered Nurse Supervisor (RNS), Resident 1's care plans and progress notes were reviewed, and review indicated Resident 1 did not have a care plan for refusals of podiatry and optometry services. Resident 1 Records indicated family was not notified of resident refusals of podiatry and optometry services. The RNS stated, there was not a care plan indicating Resident 1's refusal to be examined by the podiatrist or Resident 1's refusal for eyeglasses. During an interview on 5/24/2024, at 10:36 a.m., with the Registered Nurse Supervisor (RNS), RNS stated, the family should have been notified of resident refusal for podiatry and optometrist services to see if the family could have spoken with Resident 1 and persuaded Resident 1 to be examined by the specialists so Resident 1 doesn't develop problems. During a concurrent interview and record review on 5/24/2024, at 3:29 p.m., with the Director of Nursing (DON), the policy for Refusal was reviewed. The DON stated there should have been an Interdisciplinary Team (IDT) meeting to make IDT members and family aware so the family can encourage the patient to receive treatment and discuss interventions with the family and a care plan should have been developed. The DON stated when a resident has dementia and was refusing to be seen by the doctor, our process was that the family was notified that the resident was refusing to be seen, re- schedule the appointment, and invite the family member to be present. For the second time, the family should be informed, and the care plan should be started that the resident was refusing treatment from the doctor. If the resident continues to refuse treatment without the family knowing, Resident 1 could get an infection in the foot, pain, and could also cause other foot problems or decrease Resident 1 mobility. During a review of the facility policy and procedure (P&P), titled, Requesting, Refusing and/or Discontinuing Care or Treatment, dated 2/2021, the P&P indicated, If a resident/ representative requests, discontinues or refuses care or treatment, an appropriated member of the interdisciplinary team (IDT) will meet with the resident/representative to: determine why he or she was requesting, refusing, or discontinuing care or treatment, try to address his or her concerns and discuss alternative options, and discuss potential outcomes or consequences (positive and negative) of the decision. Detailed information relating to the request, refusal, or discontinuation of treatment are documented in the resident's medical record. During a review of the facility P&P, titled, Change in a Resident's Condition or Status, dated 2/2021, the P&P indicated our facility promptly notifies the resident, his/ her attending physician, and the resident representative of changes in the resident's medical/ mental condition and or status. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, dated 3/2022, the P&P indicated, assessments of residents were ongoing and care plans were revised as information about the residents and the resident's conditions change. The Interdisciplinary team (IDT) reviews and updates the care plan when the desired outcome was not met.

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F 0689 Level of Harm - Minimal harm or potential for 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** 44443 Based on observation, interview, and record review the facility failed to place floor mats (mats used to reduce fall?related trauma if a patient gets up from bed, loses balance, and falls to the floor) on both sides of one out of nine sampled resident's (Resident 1), bed as ordered by the physician and as indicated in the care plan. This deficient practice had the potential to result in severe injury if Resident 1 fell on to the floor from the bed. Findings: During a review of Resident 1's Admission Record, dated 5/23/2024, the Admission Record indicated Resident 1 was originally admitted on [DATE] and readmitted on [DATE] with a diagnosis including dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities) with agitation, bipolar disorder (a serious mental illness that causes extreme mood swings that include emotional highs [mania] and lows [depression], and difficulty in walking. During a review of Resident 1's Minimum Data Set (MDS), a standardized assessment and care planning tool, dated 4/30/2024, the MDS indicated, Resident 1 had severe cognitive (thinking) impairment. Resident 1 also had impairment to the lower extremities to both sides, uses a wheelchair for a mobility device, and required substantial, maximum assistance with lower body dressing and with putting on and taking off footwear. During a review of Resident 1's care plan titled Risk for falls related to activities of daily living decline, balance problem, and cognitive deficit initiated 5/5/2023, the care plan intervention indicated, to place bilateral landing pads/floor mats at bedside. During a review of Resident 1's Morse Fall Scale (a tool used to assess a patient's likelihood of falling), dated 5/17/2024, the Morse Fall Scale indicated, Resident 1 had a history of falls and a fall risk score of 75 which indicated Resident 1 was a high risk for falls (reference range of 45 or higher was high risk for falls). During a concurrent record review and interview on 5/24/2024 at 9:45 a.m., with the Charge Nurse (CN), Resident 1's physician orders were reviewed. The order indicated Resident 1 had an active physician order on 9/30/2022 for floor mat placement on both sides of bed. The CN stated there should be floor mats on both sides of Resident 1's bed because he had a history of falls. CN stated floor mats can prevent injury if the fell by the bed. During a concurrent observation and interview on 5/24/2024, at 9:50 p.m., with the CN, in Resident 1's room, Resident 1's bed was observed without any floor mats on either side of bed. The CN stated she was unsure why Resident 1 did not have any floor mats by the bed and the CN will place floor mats by Resident 1's bed immediately. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/24/2024, at 3:29 p.m., with the Director of Nursing (DON), the DON stated, that the nurses should follow the physician orders. The DON stated Resident 1 had an active physician order for floor mat placement on both sides of the bed for the safety of Resident 1, so he does not injure himself badly and hit a hard surface in case the resident falls out of bed. During a review of the Position Description Charge Nurse, (undated), the position description indicated, performs safely and competently those functions delegated by the physician to nursing through written and verbal physician orders. During a review of the facility policy and procedure (P&P) titled Falls and Fall Risk Managing, dated 3/2018, the P&P indicated based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and try to minimize complications from falling. The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls. In conjunction with the attending physician, staff will identify and implement relevant interventions (e.g., hip padding or treatment of osteoporosis [disease the weakens bones], as applicable) to try to minimize serious consequences of falling.