STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055704	A. Building B. Wing	07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Angels Nursing Health Center	415 S Union Avenue Los Angeles, CA 90017

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 interview and record review, the facility failed to ensure one of three sampled residents (Resident 1), who had a history of falls and was assessed as high risk for falls, received the care and services necessary to prevent accidents and falls as evidenced by failing to provide the resident with assistance and supervision when ambulating (walking) to the bathroom. As a result, on 7/5/2024 (three days after admission), Resident 1 was found on the floor bleeding, and with a four-centimeter laceration (deep cut or tear in the skin or flesh) on the occipital posterior area of the head (back of the head). Resident 1 was transferred to General Acute Care Hospital (GACH) 2 where Resident 1 was diagnosed with subdural hematomas (pools of blood between the brain and its outermost covering caused by a head injury strong enough to burst blood vessels). Findings: A review of Resident 1's General Acute Care Hospital (GACH) 1 History and Physical (H&P) dated 6/3/2024 at 11:34 PM, indicated the resident was brought in by ambulance from their home to GACH 1 after having a fall. The H&P indicated Resident 1 fell while attempting to get out of the bed. The H&P indicated Resident 1 also fell when attempting to use the restroom in the Emergency Department (ED) at GACH 1. A review of Resident 1's Admission Record indicated the resident was admitted on [DATE] from GACH 1 with diagnoses including subarachnoid hemorrhage (bleeding in the space between the brain and surrounding membrane), hemiplegia (paralysis of one side of the body) and hemiparesis (one-sided muscle weakness) following cerebral infarction (also known as a stroke; refers to damage to tissues in the brain due to a loss of oxygen to the area), abnormalities of gait and mobility (when the pattern in which you walk and move is not normal), lack of coordination (impaired balance), repeated falls, and history of falls. A review of Resident 1's Fall Risk assessment dated [DATE] at 9:50 AM, indicated the resident was a high risk for falls with a score of 80 (a score of 45 or more indicated a resident was a high risk for falling). The Fall Risk Assessment indicated Resident 1 had fallen before, had more than one diagnosis, used crutches, a cane, or a walker as an ambulatory (walking) aid; had a weak gait (stooped [having the head and shoulders bent forward] but able to lift head without losing balance, steps were short, resident may shuffle [to walk by pulling your feet slowly along the ground rather than lifting them]); and forgets limits or overestimated. (continued on next page)

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 related to a cerebral vascular accident (CVA, also known as a stroke; refers to damage to tissues in the brain due to a loss of oxygen to the area), lack of safety awareness, poor safety awareness, weakness, and a recent fall incident at home was initiated on 7/2/2024. The care plan indicated a goal to reduce the risk of falls and/or injury for Resident 1 through appropriate interventions. The care plan interventions included to assist Resident 1 with all ambulation or transfers as needed. A review of Resident 1's Physical Therapy (PT) Evaluation and Plan of Treatment dated 7/3/2024, indicated the resident was referred to PT due to exacerbation (increase in the worsening of a disease or symptoms) of decrease in functional mobility (a person's ability to move independently and safely), decrease in strength, decrease coordination, reduced dynamic balance (the ability to remain standing and stable while performing movements or actions), reduced static balance (the ability to hold the body in a specific position and posture) and increased need for assistance from others. The Evaluation and Plan of Treatment indicated Resident 1 felt unsteady when standing and walking. The Evaluation and Plan of Treatment indicated Resident 1 worried about falling. A review of Resident 1's Minimum Data Set (MDS, a standardized assessment and care screening tool) dated 7/5/2024, indicated the resident had moderately impaired cognition (reduced ability to think, understand, and reason) and previously used a walker. The MDS indicated Resident 1 required partial/moderate assistance with toileting hygiene, toilet transfers, walking 10 feet, and walking 50 feet with two turns. The MDS indicated Resident 1 was frequently incontinent (having no voluntary control over urination or defecation) of urine and bowel. The MDS further indicated Resident 1 had a fall in the last month prior to admission. A review of Resident 1's Situation, Background, Assessment, and Recommendation (SBAR, a technique that provides a framework for communication between members of the health care team about a patient's condition) Form and Progress Note dated 7/5/2024 at 10:37 PM indicated the resident had an unwitnessed fall. The note indicated at 8:35 PM, Resident 1 had a fall incident in the resident's bathroom and did not use the call light for assistance. The note indicated Resident 1 was found lying on the floor, on their back with blood coming out from the resident's head. The note indicated a pressure dressing was applied and the resident was transferred back to their bed assisted by four nurses. The SBAR note indicated at 8:50 PM, 911 was called for medical assistance, at 8:55 PM the paramedics arrived and per the paramedics' assessments Resident 1 was stable enough to be transferred to the hospital via regular ambulance. The SBAR note indicated Resident 1 had a four-centimeter laceration on the occipital posterior area of the head, was in stable condition, awake, alert, and could make their needs known. The note indicated Resident 1's physician was notified and gave orders to transfer the resident to the General Acute Care Hospital (GACH) 2 for evaluation of the resident's head/trauma fall. The note indicated Resident 1 left the facility at 10:05 PM. A review of the Physician's Order dated 7/5/2024, indicated to transfer Resident 1 to GACH 2 for evaluation of head trauma/fall and head laceration. A review of Resident 1's GACH 2 Face Sheet Report indicated the resident was admitted to the GACH on 7/5/2024 at 10:16 PM. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 1's GACH 2 Patient Results, indicated the resident had a Computed Tomography (CT - diagnostic imaging procedure that uses a computer linked x-ray machine to create detailed images of the inside of the body) of the head on 7/5/2024 at 11:15 PM, with an acute on chronic subdural hematomas (refers to a second episode of sudden bleeding that occurs in same area where bleeding in the brain had already existed) which measured 7 millimeters (mm) on the right and 4 mm on the left. The CT results further indicated Resident 1 had a moderate left parietal scalp hematoma (a collection of blood that collects in the skin and muscle on the upper back of the head, not affecting the brain). A review of Resident 1's Emergency Department (ED) Note from GACH 2 dated 7/6/2024 at 1:04 AM, indicated the resident presented to the ED after a fall two hours prior to arrival. The note indicated Resident 1 stated he did not hit his head or lose consciousness (to no longer be awake and aware of what is happening around you). The note indicated Resident 1 stated he had a headache that was mild. According to a review of Resident 1's Patient Results from GACH 2, the resident had a second CT of the head on 7/6/2024 at 5:18 AM, which indicated Resident 1 had stapling of their left parietal scalp laceration (deep cut of the upper back of the head). A review of Resident 1's Post Fall Interdisciplinary Team (IDT) note dated 7/8/2024, indicated on 7/5/2024 at around 8:35 PM, the resident had a fall incident outside their bathroom. Resident 1 was found lying on the floor, on his back with blood coming out from the head. The Post Fall IDT note indicated Resident 1 can ambulate with supervision using the front wheel walker (FWW). Per nursing, the call light was not on at the time of incident, it was assumed that the resident did not use the call light or ask for assistance to go to the bathroom. The resident was continent of bowel and bladder and used a urinal when in bed. The resident goes to the toilet for bowel movements with assistance of the nursing aide. The IDT documentation further indicated Resident 1's periods of confusion may have contributed to the resident's poor safety judgment by not asking for assistance or using the call light to go to the bathroom. During a telephone interview on 7/16/2024 at 12:54 PM, Certified Nursing Assistant (CNA) 1 stated they were assigned to take care of Resident 1 on 7/5/2024, and did not see Resident 1 fall. CNA 1 stated after being called to Resident 1's room, they saw Resident 1 on the floor, bleeding from the back of their head. CNA 1 stated there was a lot of blood. CNA 1 stated Resident 1 normally used a walker when ambulating and required one-person assistance to the bathroom. During a telephone interview on 7/16/2024 at 1:45 PM, CNA 2 stated they were working on 7/5/2024 during the 3 PM - 11 PM shift and was watching the facility's front door that night. CNA 2 stated she saw Resident 1 walking to the bathroom with a walker but the resident did not use the call light to ask for assistance to the bathroom. CNA 2 stated they did not assist Resident 1 to the bathroom because the resident was walking fine. CNA 2 stated they then saw Resident 1 fall, so they called for help for the resident. During an interview on 7/16/2024 at 2:32 PM, Physical Therapist (PT) 1 stated, they had been seeing the resident after they were admitted to the facility. PT 1 stated Resident 1 required minimal to moderate assistance with bed mobility and transferring. PT 1 stated Resident 1 could walk approximately 10-20 feet. PT 1 stated Resident 1 had unsteady gait and needed to use a walker. PT 1 stated Resident 1 was not safe to ambulate independently. PT 1 stated Resident 1 needed assistance with close supervision and always needed supervision when walking. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 7/16/2024 at 3 PM, Registered Nurse Supervisor (RNS) 1 stated at about 8:35 PM on 7/5/2024 Resident 1 fell . RNS 1 stated when she entered the room, she found Resident 1 on the floor with their head towards the door of the bathroom. When the resident was asked what happened, the resident stated they fell but did not know why. RNS 1 stated they saw blood coming from Resident 1's head, as there was a laceration to the occipital area. RNS 1 stated Resident 1 did not use the call light and usually always called for assistance. RNS 1 stated Resident 1 should have assistance when going to the bathroom. RNS 1 stated any staff who sees a resident ambulating should provide assistance for safety reasons to ensure the resident did not fall. RNS 1 stated if Resident 1 had assistance to the bathroom that night the resident probably would not have fallen. During an interview on 7/16/2024 at 3:30 PM, the Director of Nursing (DON) stated Resident 1 always used the call light but was not sure what happened that night on 7/5/2024. The DON stated he had not seen Resident 1 walk or go to the bathroom in the past, but stated from what he gathered from the nurses was that the Resident 1 normally utilized a walker and needed assistance and supervision when ambulating. Furthermore, the DON stated that according to the Fall Risk Assessment, Resident 1 was at high risk for falls. The DON stated Resident 1's care plan indicated that the staff were to provide Resident 1 with assistance when ambulating as needed. The DON stated that if Resident 1 was provided with supervision and assistance when ambulating the resident might not have fallen. A review of the facility's policy and procedure titled, Fall Management Program, dated 2/9/2024, indicated the purpose was to prevent resident falls and minimize complications associated with falls through the development of a Fall Management Program. It was the policy of this facility to provide the highest quality of care in the safest environment for the residents residing in the facility. The facility developed a Fall Management Program that strives to prevent resident falls through meaningful assessments, interventions, education, and reevaluation. The licensed nurse will assess each resident for their risk of falling upon admission, quarterly, and with a significant change in condition. Based on the information gathered from the history and assessment of the resident, the Nursing Staff, and Interdisciplinary Team (IDT), with input from the Attending Physician, will identify and implement interventions to reduce the risk of falls. The following are suggested measures that can be used in the prevention of falls. This list is not all-inclusive. Assist patient with toileting as appropriate. Encourage use of assistive devices (i.e. walker/wheeled walker and cane) as appropriate.