STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055760	A. Building B. Wing	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alhambra Healthcare & Wellness Centre, LP	415 South Garfield Alhambra, CA 91801

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 - 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. 47362 Based on observation, interview, and record review, the facility failed to prevent fall () for one (1) of three (3) sampled residents (Resident 1), assessed as high risk for falls when Resident 1 was not provided assistance when getting up from the bed to go to the bathroom and failing to initiate a fall care plan (a document created for a resident receiving healthcare, personal care, or other forms of support) , as indicated on the facility policy and procedure. This deficient practice resulted to Resident 1 ' s fall on 5/19/2024 and transfer to General Acute Care Hospital (GACH 1). Findings: A review of Resident 1 ' s Admission Record indicated the facility admitted Resident 1 on 5/9/2024 with diagnoses which included muscle weakness, history of falling, and abnormality of gait and stability. A review of Resident 1 ' s Fall Risk Evaluation, dated 5/9/2024 indicated Resident 1 ' s score was 11 which indicated high risk of fall. Resident 1 ' s risk factors included were history of falls in the past 3 months, change of condition in the last 14 days, and balance problem while walking. A review of Resident 1 ' s History and Physical (H&P),dated 5/10/2024, indicated Resident 1 had the capacity to understand make decisions. It indicated Resident 1 ' s diagnosis of subdural hematoma (SDH, a clot of blood that develops between the surface of the brain and the dura mater [brain ' s tough outer covering], usually due to stretching and tearing of veins on the brain ' s surface. These veins rupture when a head injury suddenly jolts or shakes the brain) and was status post craniotomy (an operation in which a small hole is made in the skull or a piece of bone from the skull is removed to show part of the brain). (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 - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 1 ' s Minimum Data Set (MDS, standardized care and screening tool), dated 5/16/2024, indicated Resident 1 ' s cognitive (processes of thinking and reasoning) skills for daily decision making was intact. Resident 1 required substantial maximal assistance (helper does more than half the effort, helper lift or hold trunk or limb) with toileting, shower, and lower body dressing. Resident 1 required partial / moderate assistance (helper does less than half the effort. Helper lift, holds, support trunk or limbs) with sit to stand (ability to come to standing position from sitting in a chair, wheelchair, or on the side of the bed), toilet transfer (ability to get off a toilet commode), and walking 10 feet (once standing ability to walk at least 10 feet in the room, corridor, or similar space). A review of Resident 1 ' s Physical Therapy Treatment Notes, dated 5/17/2024, indicated Resident 1 required partial/moderate assistance with ambulation for 10, 50, and 150 feet. A review of Resident 1 ' s Occupational Therapy Treatment Notes, dated 5/18/2024, indicated Resident 1 required partial/moderate assistance with transfers. A review of Resident 1 ' s Post Fall Evaluation, dated 5/19/2024, timed at 4:15 AM, indicated an unwitnessed fall, which occurred in Resident 1 ' s room. It indicated Resident 1 tripped on the side table while attempting to go to the bathroom, which resulted to bleeding in Resident 1 ' s surgical wound on the left side of the head and left eyebrow. Resident 1 was sent to GACH via 911 (phone number to contact emergency services). During a concurrent record review of Resident 1 ' s medical record and interview with the PT Director on 5/19/2024 at 1:44 PM, PT stated Resident 1 needs assistance to go to the bathroom because of balance problems. PT stated when residents have completed their PT, PT needs to communicate with the nurses on how to assist the resident. During a concurrent record review of Resident 1 ' s medical record and interview with the Director of Nursing (DON) on 5/29/2024 at 2:15 PM, the DON stated Resident 1 was assessed as high risk for fall. The DON stated Resident 1 did not and should have had a fall care plan initiated to prevent fall. The DON also stated Resident 1 should have been assisted with getting out of bed and for toileting as indicated on the MDS assessment. During a concurrent review of Resident 1 ' s GACH record, dated 5/19/2024 and timed at 7:03 AM and interview with the Medical Record Designee(MR) on 5/29/2024 at 11:30 AM, MR stated Resident 1 ' s GACH records indicated Resident 1 had a traumatic hematoma (a collection of blood outside of blood vessels) of the left eyebrow, head injury. During a review of facility ' s policy and procedure (P&P) titled, Comprehensive Person-Centered Care Planning revised date 12/2018, indicated it is the policy of this facility to provide person centered, comprehensive, and interdisciplinary care that reflects best practice standards for meeting health, safety, psychosocial, behavioral and environmental needs of residents in order to obtain or maintain the highest physical, mental and psychosocial wellbeing. During a review of facility ' s P&P titled, Fall Management Program revised date 3/2021, indicated To provide resident safe environment that minimized complications associated with falls. As part of the admission assessment, the license nurse will complete a fall risk evaluation. If a fall risk factor is identified, document interventions on the resident ' s care plan.