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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055918	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa Del Sol Post Acute	16910 Woodruff Ave. Bellflower, CA 90706

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** 47092 Based on observation, interview, and record review, the facility failed to ensure a resident, who was assessed at risk for falls, and who had a history of getting out of bed unassisted, did not fall and sustain a head injury for one out of five sampled residents (Resident 4). The facility failed to: 1. Ensure the nursing staff followed interventions, per Resident's 4's Care Plan titled, Risk for Falls dated 7/1/2024, to reduce Resident 4's risk for falls by increasing the frequency of monitoring rounds. 2. Ensure the nursing staff, who provided care to Resident 4, were made aware of what the time frame was for frequent monitoring for Resident 4 and other residents assessed at risk for falls and who had a history of getting out of bed unassisted. These deficient practices resulted in Resident 4 getting up from his bed unassisted without staff knowledge, to go to the bathroom, where he was found on the floor with a head injury. These deficient practices had the potential for Resident 1 to continue getting up unassisted, without staff knowledge, and possibly leading to more serious injuries including death. Findings: During a review of Resident 4's Admission Record (Face Sheet), the Face Sheet indicated Resident 4 was admitted to the facility on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities), difficulty walking, lack of coordination, and muscle weakness. During a review of Resident 4's Minimum Data Set ([MDS] a federally mandated resident assessment tool) dated 10/9/2024, the MDS indicated Resident 4's cognition (ability to think and reason) was severely impaired. The MDS indicated Resident 4 required maximal assistance (helper does more than half the effort) for toileting, hygiene and showering, and moderate assistance (helper does less than half the effort) for dressing, personal hygiene, and walking. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 4's Fall Risk assessment dated [DATE], the Fall Risk Assessment indicated Resident 4 was at risk for falls due to intermittent (occurring at irregular intervals, not continuous) confusion, requiring assistance with elimination (using the toilet), balance, gait (how a person walks) problems, currently taking more than three medications, and disease predisposition (a condition where a person has an increased chance of developing a disease due to genetic or environmental factors). During a review of Resident 4's Care Plan titled, Risk for Falls dated 7/1/2024, the Care Plan indicated Resident 4 was at risk for falls. The Care Plan's goal indicated to reduce Resident 4's risk for falls with interventions that included meeting Resident 4's needs and to follow the facility's Fall Protocol (policy), which indicated to increase the frequency of rounds. During a review of Resident 4's Nurses Progress Notes dated 10/29/2024 at 2:40 p.m., the Nurses Progress Notes indicated Resident 4 was found in his bathroom on the floor, next to the sink, with bleeding on the back of his head, a laceration measuring 1.1 x 1.4 centimeters ([cm] a unit of measurement) and swelling. The Nurses Progress Notes indicated Resident 4 stated he slipped and hit his head on the sink. During a review of Resident 4's Care Plan titled, Unwitnessed Fall dated 10/29/2024, the Care Plan indicated Resident 4 had an unwitnessed fall on 10/29/2024. The Care Plan indicated the goal was for Resident 4 to have no unavoidable fall incidents. The care plan interventions included frequent visual checks every two hours. During a concurrent observation and interview on 10/30/2024 at 9:30 a.m., Resident 4 was observed lying in bed, with a hematoma (a collection of blood outside of a blood vessel caused by a broken blood vessel) on the back of his head that was approximately 2.5 x 2.5 cm in length/width, and it was raised approximately 1.0 cm. Resident 4's hematoma had a light blue and yellow discoloration and in the middle of it were three wound closure strips (tape strips used to close small wounds) with a small amount of blood. Resident 4 stated he hit his head and was unable to recall any details surrounding his fall and subsequent head injury. During an interview on 10/30/2024 at 9:35 a.m., Resident 5 stated Resident 4 fell yesterday (10/29/2024) because nursing staff took a long time to come in and help him (Resident 4) to the restroom. During an interview on 10/30/2024 at 10:45 a.m., Licensed Vocational Nurse 1 (LVN 1), stated Resident 4 had a known behavior of trying to get out of his wheelchair without assistance due to his forgetfulness and he needed to be instructed periodically not to stand up without assistance. During an interview on 10/31/2024 at 10:19 a.m., Certified Nursing Assistant 1 (CNA 1), stated the day Resident 4 fell (10/29/2024) she was making her final rounds around 2:45 p.m. and was informed by the Housekeeper (HS 1), that Resident 4 was on the floor in the bathroom. CNA 1 stated she went to the bathroom and saw Resident 4 sitting on the bathroom floor next to the sink. CNA 1 stated she last saw Resident 4 at 2 p.m., in bed in his room, prior to his fall at 2:45 p.m. CNA 1 stated she usually checked on Resident 4 every one to two hours during her shift when she was assigned to him. CNA 1 stated Resident 4 was very demanding and had a history of trying to get out of bed without assistance. CNA 1 stated they (the nursing staff) do not document when they monitor Resident 4. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Villa Del Sol Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 16910 Woodruff Ave. Bellflower, CA 90706	

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/31/2024 at 10:55 a.m., LVN 2 stated residents, who were at risk for falls, required frequent visual checks at least once every 2 hours. During an interview on 10/31/2024 at 11:09 a.m., Registered Nurse 1 (RN 1) stated all residents should be checked at least once every 2 hours but more frequently if they were confused. RN 1 stated she had not been instructed regarding what the time frame was for frequent visual checks, but she believed it would be reasonable to check on a confused resident, who had a behavior of trying to get out of bed, every 15 to 30 minutes, or to assign someone to monitor them one to one. During an interview on 10/31/2024 at 11:53 a.m., the Director of Nursing (DON), stated frequent visual checks meant once every 2 hours for all residents, including residents who were confused or who were at risk for falls. The DON stated she was not aware that Resident 4 had a history of trying to get out of bed without assistance prior to his fall on 10/29/2024, but even if he had a history of trying to get out of bed unassisted, monitoring him every two hours was reasonable. The DON stated they do not put a time frame for frequent monitoring of residents in the care plan because it would not be realistic for nurses to monitor residents on a schedule unless the resident had a sitter (a patient companion who was responsible for sitting with and monitoring the welfare of patients who cannot be left alone). The DON stated she was not aware that their policy Fall Prevention Program indicated interventions must include increased frequency of rounds for residents at risk for falls. The DON stated that an increased frequency of rounds would mean more than once every 2 hours. During an interview on 10/31/2024 at 1:48 p.m., CNA 1 stated she did not inform anyone that Resident 4 had a history of trying to get out of bed without assistance because she assumed everyone already knew. During an interview on 10/31/2024 at 2:23 p.m., the DON stated the facility does not document when they visually check on a resident because if the nurses could not check on a resident timely, the nurses would be out of compliance with Federal and State regulations. During a review of facility's policy and procedure (P&P) titled Fall Prevention Program dated 12/2023, the P&P indicated under At Risk Protocols to provide additional interventions as directed by the resident's assessment, including but not limited to increased frequency of rounds.