

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055952	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/09/2024
NAME OF PROVIDER OR SUPPLIER Torrance Care Center West, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 4333 Torrance Blvd Torrance, CA 90503	

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>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44958</p> <p>Based on interview and record review, the facility failed to ensure a resident who was assessed as a high risk for falls and required assistance from staff during transfers, was provided with safe and appropriate transfer assistance to avoid a fall for one of three sampled residents (Resident 1). The facility failed to:</p> <ol style="list-style-type: none"> 1. Ensure Certified Nurse Assistant (CNA) 1 utilized a gait belt ([transfer belt] a device placed on a resident who has mobility issues to aid in safe movement for the resident) upon transferring Resident 1. 2. Ensure Resident 1 ' s Care Plan included specific interventions indicating the requirement for two-person assistance when transferring Resident 1, in compliance with the facility ' s procedure Transfer from a Bed to a Wheelchair. <p>These deficient practices resulted in Resident 1 falling to the ground on 8/30/2024 which had the potential to cause Resident 1 serious physical and psychosocial harm.</p> <p>Findings:</p> <p>During a review of Resident 1 ' s Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE] with a diagnoses including mood disorder (mental condition where there are long periods of sadness, elation or depression), neuralgia (nerve pain which feels like a burning, sharp or stabbing sensation), neuritis (inflammation of the nerves), and chronic pain syndrome (pain that lasts longer than three months) .</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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1 ' s Minimum Data Set ([MDS]) a standardized assessment and care screening tool), dated 7/22/2024, the MDS indicated Resident 1 ' s cognitive skills (thinking process) for daily decision-making were intact and had the ability to understand and be understood by others. The MDS indicated Resident 1 had functional limitations in range of motion on one side which affected her upper and lower extremities. The MDS indicated Resident 1 required substantial/maximum assistance (helper does more than half the effort) during sit to stand (ability to come to a standing position from sitting in a chair, wheelchair, or on site of the bed). The MDS indicated Resident 1 required partial/moderate assistance (helper lifts, holds, or supports trunk or limbs but provides less than half the effort) during bed to chair transfers (ability to transfer to and from a bed to a wheelchair). The MDS indicated Resident 1 presented with hemiplegia (a condition which causes weakness on one side of the body) or hemiparesis (inability to move on one side of the body).</p> <p>During a review of Resident 1 ' s Fall Risk Assessment (assessment tool indicating a resident ' s likelihood of falling), dated 7/26/2024, the Fall Risk Assessment indicated Resident 1 ' s fall risk score was 13 (a score of 10 and above indicates a resident is a high fall risk).</p> <p>During a review of Resident 1 ' s Clinical Record (Care Plan section), dated 7/22/2024, the Care Plan indicated Resident 1 was admitted with left above the knee amputation ([AKA] a surgical procedure removing the leg above the knee) related to trauma, had impaired physical mobility, and was at risk for pain, ineffective pain management, and fall. The Care Plan indicated the following goals and re-evaluation date of 10/24/2024 included:</p> <ol style="list-style-type: none"> Resident 1 will show/verbalize no pain for 90 days. Resident 1 will be able to participate in Activities of Daily Living ([ADL] grooming, dressing, hygiene) every day for 90 days. Resident 1 will verbalize understanding of the individual, situation, treatment regimen and safety measures every day for 90 days. <p>The Care Plan interventions indicated, to assess for pain, and to provide medications and interventions as needed.</p> <p>During a continued review of Resident 1 ' s Clinical Record (Care Plan section), dated 7/26/2024, the Care Plan indicated Resident 1 was at risk for falls and injuries related to incontinence, unsteady gait, chronic and acute condition which makes resident unstable.</p> <p>The Care plan goals indicated the facility will minimize the risk for falls and will decrease significant injury as a result from a fall in the next 3 months with a re-evaluation date of 10/24/2024. The Care Plan indicated the following approaches (interventions) included assess, anticipate, and intervene for factors causing prior falls (e.g. mobility problem, standing, and transferring). The Care plan approaches further indicated to evaluate current fall prevention interventions and use appropriate device as needed.</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>During a review of Resident 1 ' s Change of Condition (COC) dated 8/30/2024, the COC indicated on 8/30/2024, CNA 1 was transferring Resident 1 from the bed to wheelchair and was unable to hold Resident 1 ' s body weight so CNA 1 lowered Resident 1 to the floor. The COC indicated Resident 1 complained of right foot pain rated 3 out of 10 based on the numeric pain scale (11-point numeric scale, ranging from 0 indicating no pain to 10 indicating worse pain imaginable).</p> <p>During an interview on 9/9/2024 at 12:07 p.m., Certified Nurse Assistant (CNA) 1 stated Resident 1 required assistance from staff during transfers from the bed to the wheelchair and bed and vice versa. CNA 1 stated, some CNAs will transfer Resident 1 alone and some CNAs will ask for a second person to help during assistance. CNA 1 stated, it is up to the person transferring Resident 1 on what they feel they can physically handle. CNA 1 stated most petite CNAs will ask for a second person but not always. CNA 1 stated staff do not use a gait belt during transfers with Resident 1.</p> <p>During an interview on 9/9/2024 at 1p.m., CNA 2 stated on 8/30/2024 at approximately 9:30 a.m., she heard someone call for help in Resident 1 ' s room. CNA 2 stated when she walked into the room, she saw Resident 1 kneeled on her right knee while CNA 3 was holding Resident 1 by the pants. CNA 2 stated Resident 1 can require one or two-persons to assist depending on the strength of the CNA.</p> <p>During a record review of the facility ' s Investigative Interview dated 8/30/2024, the Investigative Interview indicated the on 8/30/2024, CNA 3 was asked by Resident 1 to assist in transferring her from her bed to her wheelchair. CNA 3 attempted to request assistance from another staff member to help with transfer but none were available. Resident 1 then instructed CNA 3 to hold Resident 3 by the back of the pants and place her in the wheelchair while Resident 1 used the side table and wheelchair to transfer herself to the wheelchair. Upon transfer, CNA 3 indicated she was unable to hold Resident 1 ' s body weight during the transfer so decided to lower Resident 1 to the floor and call for help.</p> <p>During an interview on 9/9/2024 at 2 p.m., the Director of Staff (DSD) stated it is her role to train CNAs to transfer residents safely. The DSD stated Resident 1 ' s Care Plan did not indicate the need for one or two-person assistance for transfer. The DSD stated, the Care Plan should have reflected two-persons assistance to ensure the safety of Resident 1 and the staff. The DSD stated, Resident 1 had a left AKA and could only transfer on the right leg. The DSD stated per procedure, Resident 1 should have been transferred with two staff members.</p> <p>During a concurrent interview and record review on 9/9/2024 at 2:10 p.m. with the DSD, the facility ' s undated procedure titled, Transfer from a Bed to a Wheelchair was reviewed. The procedure indicated transferring patients from a bed to a wheelchair requires the understanding the patient ' s needs, one- person assist may be performed if the patient can bear weight on both lower extremities and predictably take small steps, if these criteria are not met, a two-person transfer, or mechanical lift may be necessary to transfer the patient safely. The procedure further indicated, if transferring a patient from a bed to the wheelchair, sit the patient on the side of the bed with the legs off the bed and the feet squarely on the floor and if necessary, attach a gait belt or walking belt around the patient ' s waist. The DSD stated the CNA 3 did not follow the proper procedure when she transferred Resident 1 from the bed to the wheelchair. The DSD stated, there should have been two- persons assisting in Resident 1 ' s transfer and CNA 3 should have used a gait belt to ensure safely and not Resident 1 ' s pants.</p> <p>(continued on next page)</p>		

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