STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055960	A. Building B. Wing	06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Crescenta Healthcare Center	3050 Montrose Ave LA Crescenta, CA 91214

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 44018 Based on interview and record review the facility failed to report immediately, but not later than 2 hours, all alleged violations involving abuse, including injuries of unknown source to the California Department of Public Health for one of three sampled residents (Resident 1) with increased bruising on the left flank area and new fractures of the ribs on 6/1/24. This deficient practice had the potential for Resident 1 and other residents in the facility to be subject from possible abuse in the facility. Findings: A review of Resident 1 ' s Admission Record indicated the facility admitted the resident on 3/25/24 with diagnoses that included fracture (broken bone) of sacrum (injuries that involve sacral lateral to the foramina (based of the skull), fracture of first and fifth lumbar vertebra (lower back), and thrombocytopenia (a condition in which you have low blood platelet count). A review of Resident 1 ' s the Minimum Data Set (MDS, a standardized assessment and care-screening tool), dated 3/31/24, indicated Resident 1 ' s cognitive skill (mental action or process of acquiring knowledge and understanding for daily decision-making) was moderately impaired. The MDS indicated Resident 1 required substantial/maximal assistance (helper does more than half the effort) with toileting hygiene, shower/bathe self, and personal hygiene. A review of Resident 1 ' s Interdisciplinary Team (IDT, a group of health care professional with various areas of expertise who work together toward the goals of their residents) notes, dated 4/1/24, indicated Resident 1 was at risk for fall, skin and pressure ulcer (skin injury due to prolonged unrelieved pressure on the bony part of the body). The notes indicated to informed IDT team of current skin condition and the preventative measures in place. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Registered Nurse 4 (RN) on 6/4/24 at 3:50 PM, RN 4 stated Resident 1 had a blood disorder and increased risk of bleeding and bruising. RN 4 stated it was important to inform IDT team of Resident 1 ' s current skin condition and if there were any new bruising and thoroughly indicate body marking such as scars, incision, bruise, discolorations, abrasion, or questionable markings. RN 1 stated that facility staff should indicate location, size, color, and drainage and indicate in the Observation Detail List Report (ODLR-a daily nursing assessment note). RN 1 stated this is to avoid unnecessary treatment and avoid resident possibly being abuse by other residents or staff. A review of Resident 1 ' s ODLR, dated 5/26/24 documented by Registered Nurse 1 (RN), under skin condition section indicated Resident 1 did not have skin discoloration nor bruises. A review of Resident 1 ' s ODLR, dated 5/27/24 documented by Licensed Vocational Nurse 2 (LVN), under skin condition section indicated Resident 1 did not have skin discoloration nor bruises. During an interview with Director of Nursing (DON) on 6/4/24 at 3:23 PM, the DON stated that there was no documented evidence that an ODLR was completed for Resident 1 on 5/28/24. A review of Resident 1 ' s ODLR, dated 5/29/24, documented by LVN 2, indicated Resident 1 ' s skin was warm and dry, and the right buttock skin had a scratch. The ODLR note did not indicate if Resident 1 had bruises or not or described the appearance or size of the scratches. A review of Resident 1 ' s ODLR, dated 5/30/24 documented by LVN 2, under the Skin Condition Section indicated Resident 1 did not have skin discoloration issues or bruises. A review of Resident 1 ' s SBAR General Report (a communication tool that can help teams share information about the condition of a patient or team member or about another issue that the team needs to address), dated 6/1/24, documented by LVN 2, indicated on 6/1/24 at 1:30 PM, Certified Nursing Assistant (CNA) 3 noted discoloration on the resident ' s left lower back while changing the resident ' s undergarment. The SBAR indicated that during an observation on 6/1/24 timed at 3:30 PM, LVN 2 noted Resident 1 ' s skin discoloration was spreading and becoming darker. The SBAR report did not indicate the specific appearance of the skin discoloration such as size and color. A review of Resident 1 ' s Radiology (looking at the image of inside the body using specialized machine) Report result, dated 6/1/24, timed at 3:51 PM, indicated Resident 1 sustained a left 3-9 rib fractures. The Radiology Report further indicated Age indeterminant 4-7 rib fractures. A review of the General Acute Care Hospital (GACH) History and Physicals (H&P) dated 6/2/24 timed at 3:30 PM, indicated Resident 1 arrived at the GACH ED due to concerns of an injury that could have possibly occurred at the facility. The GACH H&P indicated the resident Woke up this morning with left flank pain and significant bruising was noted. [Resident 1] was unable to tell what happened, states that she woke up with this type of injury. The GACH H&P indicated the resident denied any recent falls, any traumatic event that is aware of .and states she did feel some type of pain while she was sleeping overnight, but unable to provide any further details . No family at bedside at this time. The GACH H&P indicated After discussion with the ED doctor who had spoken with Family (FM) 1, there was concerns of possible abuse incident in the [facility]. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 1 ' s Radiology Report result from the GACH, dated 6/2/24 timed at 6:44 AM, indicated Resident 1 had a displaced fracture (pieces of the bone moved so much that a gap formed around the fracture when the bone broke) of the left fourth through seventh rib. During a telephone interview on 6/5/24 at 8:38 AM, Family (FM) 1 stated she visited Resident 1 daily. FM 1 stated she observed a bruise on Resident 1 ' s left lower back while CNA 3 was cleaning the resident on 6/1/24 at 1:30 PM. FM 1 stated, when she asked how Resident 1 sustained the bruises, CNA 3 and LVN 2 stated, they did not know how Resident 1 sustained the bruises on her back. FM 1 stated she became concerned and asked to speak to Registered Nurse Supervisor (RN) 4 (on 6/1/24) who informed her that Resident 1 ' s physician would be notified. FM 1 stated she was concerned that Resident 1 was being abused or neglected. FM 1 stated, RN 4 assured her that facility would investigate about the bruises. FM 1 stated RN 4 and the facility did not provide her the results of the alleged abuse or neglect investigation and the facility informed her that they were not aware when Resident 1 sustained the bruise on her left lower back. During an interview with CNA 3 on 6/5/24 at 1:26 PM, CNA 3 stated while changing Resident 1 ' s undergarment on 6/1/24, she observed the bruises on Resident 1 ' s left lower back. CNA 3 stated the bruises were obvious, and it was purple and red color, but she did not know the exact size. CNA 3 stated she then notified LVN 2 because she did not see the bruise from Resident 1 on 5/31/24 (previous day) during care. During an interview with LVN 2 on 6/5/24 at 1:32 PM, LVN 2 stated she did not receive a report from the previous shift (11 PM - 7AM) on 6/1/24, about Resident 1 ' s bruises. When asked how LVN 2 assessed or monitored Resident 1 ' s skin, LVN 2 stated usually if there was a change in skin condition, the CNA would notify the treatment nurse. LVN 2 stated she only received report from CNA 3 and confirmed the bruises on Resident 1 ' s left back was spreading and getting darker purple color. LVN 2 stated she did not document the progression of Resident 1 ' s bruise in the SBAR. LVN 2 stated she reported the incident to RN 4. LVN 2 stated that the facility policy is to report to administrator or DON immediately if staff suspects any abuse allegations. LVN 2 stated reporting the resident ' s bruising to RN 4. During an interview with RN 4 on 6/5/24 at 4:16 PM, RN 4 stated that on 6/1/24, she notified Resident 1 ' s attending physician of Resident 1 ' s bruising and obtained the orders for chest x-ray (radiology test of the chest) and laboratory test. While waiting for lab test, Resident 1 ' s bruises was spreading. RN 4 stated she immediately informed the attending physician and obtained an order to transfer Resident 1 to the GACH. RN 4 stated she reported the incident to the Administrator ([ADM] abuse coordinator). RN 4 stated she did not call FM 1 for an update of the investigation. RN 4 stated because the investigation was still in progress during that time. During an interview and record review on 6/5/24 at 4:34 PM, the ADM stated Resident 1 had a displaced left fourth through seventh rib fracture according to the GACH (General Acute Care Hospital) ' s chest x-ray obtained on 6/2/24 at 6:44 AM. The ADM stated Resident 1 ' s left rib fracture and the bruise on her left back were new. The ADM stated she did not initiate abuse investigation right away and did not report to CDPH within two hours as stated in the facility ' s Abuse and Neglect Clinical Protocol, because Resident 1 had a diagnosis of thrombocytopenia and a history of multiple fractures due to a history of falls. The ADM further stated that failure to initiate abuse investigation and report the incident to appropriate agencies placed the resident at risk for potential elder abuse and a delay in receiving treatment. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a fax transmittal report dated 6/3/24 from the facility indicated a date/time stamp of 6/3/24 timed at 11:08 AM (2 days after CNA 3 and LVN 2 observed the left flank discoloration and reported to RN 4 on 6/1/24 timed at 1:30 PM), reporting Resident 1 ' s left flank discoloration found on 6/1/24. During a review of the facility ' s policy and procedure, titled Abuse and Neglect Clinical Protocol, dated 5/28/19, indicated that if an incident or suspected incident of resident abuse, mistreatment, neglect, or injury of unknown source is reported, the Administrator will conduct the investigation or assign the investigation to an appropriate individual when not available. The administrator will keep the resident and his/her representative informed of the progress of the investigation, and an alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but not later than: two hours if the alleged violation involves abuse or has resulted in serious bodily injury; or twenty-four hours if the alleged violation does not involve abuse and has not resulted in serious bodily injury.