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	12/10/2024

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47882 Based on observation, interview and record review, the facility failed to ensure a personal safety alarm (PSA: any physical or electronic device that monitors resident movement and alerts the staff when movement is detected) was placed on one of two sampled residents (Resident 1) bed, who was assessed as a high risk for fall, in accordance to the facility ' s policy and procedure (P&P) titled, Personal Safety Alarm. This deficient practice had the potential for a delayed response from facility staff when Resident 1 attempted to get out of bed unassisted, potentially resulting in falls. Findings: During areview of Resident 1 ' s Face Sheet, the Face Sheet indicated that Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included Alzheimer ' s disease (a brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks), history of pelvis fracture, history of falling, and osteoporosis (a bone disease that weakens bones, making them more likely to break). During areview of Minimum Data Set (MDS - a resident assessment tool), dated 9/4/2024, the MDS indicated Resident 1 ' s cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 1 was dependent (helper does all the effort) eating, bathing, dressing and personal hygiene, and required substantial/maximal assist (helper does more than half the effort) with walking 150 feet. During areview of Resident 1 ' s facility document titled Fall Risk Data Collection dated 9/4/2024, , the Fall Risk Data Collection indicated Resident 1 score was 14, indicating Resident 1 was considered ahigh risk for fall resident. During areview of Resident 1 ' s facility document titled, Observation Detail List Report for Situation, Background, Action, Response (SBAR) - Fall dated 10/21/2024, the SBAR indicated Resident 1 was found in Resident 1 ' s room sitting on the floor. During areview of Resident 1 ' s facility document titled Fall Risk Data Collection dated 10/21/2024, the Fall Risk Data Collection indicated Resident 1 ' s score was 18, indicating Resident 1 was considered ahigh risk for fall resident. (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 - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1 ' s facility document titled Observation Detail List Report SBAR - Fall dated 11/27/2024, the SBAR indicated Resident 1 was found in Resident 1 ' s room on the floor in a sitting position on top of the bed bolster (narrow cushion stuffed with firm materials like memory foam). During areview of Resident 1 ' s facility document titled Fall Risk Data Collection dated 11/27/2024, the Fall Risk Data Collection indicated Resident 1 ' s score was 18, indicating Resident 1 was considered ahigh risk for fall resident. During a review of Resident 1 ' s facility document titled Physician Order Report (POR) for December 2024, the POR indicated an order for personal safety alarm while in bed to remind resident to call for assistance during mobility and transfers due to dementia (the loss of cognitive functioning - thinking, remembering, and reasoning) and restlessness. The order indicated to check for proper placement and functioning every shift (Shift 1: 7 AM- 3 PM; Shift 2: 3 PM-11 PM; Shift 3: 11 PM- 7 AM). During areview of Resident 1 ' s Care Plan (CP) titled, Falls and high risk for falls that may result to physical harm due to history of fall, balance problems and behavior of getting out of bed and wheelchair unassisted, revised on 12/2/2024 , the CP indicatedinterventions that included the use PSA while in bed to remind Resident 1 to call for assistance during mobility and transfer due to dementia and restlessness. During an observation on 12/10/2024 at 8:35 AM in Resident 1 ' s room, Resident 1 was in bed without the PSA observed on the bed. During a concurrent observation and interview on 12/10/2024 at 10:30 AM with certified nurse assistant (CNA) 1 and Physical Therapist (PT), in Resident 1 ' s room, CNA 1, PT and Licensed Vocational Nurse (LVN) 1 could not locate Resident 1 ' s PSA. CNA 1 stated, he did not know where Resident 1 ' s PSA was, and that Resident 1 required the PSA for safety and for fall prevention. PT stated, Resident 1 was assessed as a high risk for fall resident, therefore Resident 1 should have her PSA present. PT stated since Resident 1 ' s PSA could not be located, there was a potential for Resident 1 to get injured due to poor safety awareness, especially since Resident 1 sustained a recent fall on 11/27/24. During an interview on 12/10/2024 at 11:10 AM with LVN 1, LVN 1 stated Resident 1 ' s PSA was not placed on Resident 1 ' s bed and should have been placed on the bed for safety and to aid in the prevention of falls. During an interview on 12/10/2024 at 11:15 AM with Registered Nurse (RN) 1, RN 1 stated, Resident 1 should always have the PSA while in bed since Resident 1 was assessed as a fall risk. During an interview on 12/10/2024 at 3:10 AM with the Director of Nurses (DON), DON stated the use of Resident 1 ' s PSA was important to aid in notifying facility staff when Resident 1 was attempting to get up from bed. The DON stated the PSA an intervention utilized to aid in the prevention of fall by triggering an alarm, that alerts staff when Resident 1 attempted to get up from the bed unassisted. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility ' s policy and procedure (P&P) titled, Personal Safety Alarm,(Undated), the P&P indicated; a) the facility staff understands the facility ' s responsibility, as well as their own, to ensure the safest environment possible for the resident. The policy indicated that licensed nurse will monitor for the personal safety alarm proper placement every shift, and that the administrator will monitor for compliance of routine rounds and testing of the personal alarm system. During areview of the facility ' s policy and procedure (P&P) titled, Fall Management, dated 3/19/2024, the P&P indicated; a)staff will identify interventions related to resident ' s specific risks and causes to try to reduce the risk of resident falling and try to minimize complications from falling, b) Fall will defined as Fall-Found on the Floor, c) a fall prevention plan will be implemented, and the staff with the input of the attending physician will implement a resident centered fall prevention to reduce specific risk factor(s) of falls for each resident at risk or with history of falls.