| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055989 | A. Building<br>B. Wing | 12/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Heritage Manor | 610 North Garfield Avenue<br>Monterey Park, CA 91754 |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>48661<br><br>Based on interview and record review the facility failed to report an injury of unknown source, immediately, but not later than two (2) hours after the allegation was made at 8:30 AM and reported the allegation to the Department of Public Health (DPH) at 1:23 PM (five [5] hours after the allegation), when Resident 2 was found having ecchymosis (a bruise) to both arms and a skin tear to the left forearm, for one (1) of five (5) sampled residents (Resident 2), in accordance with the facility's policy and procedure [P&P] titled Abuse, Neglect, and Exploitation.<br><br>This deficient practice had the potential to result in placing the resident at risk for undetected elder neglect or abuse.<br><br>Findings:<br><br>During a review of Resident 2 ' s Admission Record indicated the facility admitted the resident on 10/8/2024 with diagnoses including dementia (a progressive state of decline in mental abilities), anemia (a condition where the body did not have enough healthy red blood cells), and lack of coordination.<br><br>During a review of Resident 2 ' s History and Physical (H&P) dated 10/10/2024, indicated the resident did not have capacity to understand and make decisions.<br><br>During a review of Resident 2 ' s Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 10/15/2024, indicated the resident had severe cognitive impairment (problems with a person ' s ability to think, learn, remember, use judgement, and make decisions). The MDS indicated the resident was dependent (Helper did all of the effort and the resident did none of the effort to complete the activity; or the assistance of two or more helpers was required for the resident to complete the activity) from facility staff with eating, hygiene, dressing, and transfers.<br><br>During a review of Resident 2 ' s Social Services Progress Note dated 11/21/2024 at 12:40 PM, indicated the Social Services Director (SSD) interviewed the resident regarding an abuse allegation. The SSD stated initially the resident stated someone had grabbed and hit her but later revised her story and said no one had hit her. The SSD stated the resident seemed confused and disoriented throughout the conversation. The Progress note indicated the SSD assured the resident that she was in a safe environment and the facility staff was always available to support her with any needs.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a review of the Facility ' s Faxed Confirmation Report dated 11/21/2024 at 1:23 PM, indicated the facility reported an abuse allegation for Resident 2 to DPH at 1:23 PM (five hours after the allegation).<br><br>During a review of Resident 2 ' s Situation, Background, Assessment, and Recommendation (SBAR) dated 11/21/2024 at 1:30 PM, indicated the resident had ecchymosis to both arms and a skin tear to the left forearm. The SBAR indicated the resident did not have pain and the residents Family Member (FM) and physician were notified with no new orders.<br><br>During a review of Resident 2 ' s Physician ' s Order dated 11/21/2024 at 2:13 PM, indicated left outer forearm the part of the upper limb between the elbow and the wrist) proximal (nearer to the center of the body) with ecchymosis open: apply stay-strip (a thin, adhesive bandage used to close small cuts or wounds by holding the edges of the skin together) and betadine (an antiseptic medication that treats minor wounds and prevents infections), leave open to air, every day shift.<br><br>During a review of Resident 2 ' s Physician ' s Order dated 11/21/2024 at 2:20 PM, indicated left outer forearm with multiple ecchymosis: apply A&D (a multipurpose skin protectant and moisturizer that could help treat and prevent a variety of skin conditions), leave open to air, every day shift.<br><br>During a review of Resident 2 ' s Physician ' s Order dated 11/21/2024 at 2:24 PM, indicated left dorsum (the upper surface of a body part) hand with ecchymosis: apply A&D, leave open to air, every day shift.<br><br>During a review of Resident 2 ' s Physician ' s Order dated 11/21/2024 at 2:27 PM, indicated right inner forearm with ecchymosis: apply A&D, leave open to air, every day shift.<br><br>During a review of Resident 2 ' s Physician ' s Order dated 11/21/2024 at 2:28 PM, indicated right dorsum hand with ecchymosis: apply A&D, leave open to air, every day shift.<br><br>During a review of Resident 2 ' s Psychiatry Progress Note dated 11/21/2024, indicated the resident denied any incident of abuse and was confused and anxious. The Progress Note indicated the resident ' s abuse allegation was not reliable and the resident did not have the capacity of making decisions for herself. The Progress Note indicated the physician increased medication dosing and ordered a urinalysis (UA, a simple, noninvasive test that examines a urine sample to check for a variety of health conditions) and a urine culture and sensitivity (CS, a lab procedure that checks for bacteria or other germs in a urine sample and determines which antibiotics were effective against them) test.<br><br>During a review of Resident 2 ' s Suspected Abuse/Neglect Care Plan initiated 11/21/2024, indicated a goal for the resident to be treated with respect, dignity, and reside in the facility free of mistreatment. The Care Plan indicated interventions included observing the resident for signs of fear and insecurity during delivery of care, psychiatrist consult for emotional support, and assure resident that she was in a safe and secure environment with caring professionals.<br><br>During a review of Resident 2 ' s Skin Integrity Care Plan initiated 11/21/2024, indicated a goal for the resident to maintain/develop clean and intact skin, be free from injury ecchymosis, and have no complications related to multiple ecchymosis. The Care Plan interventions included applying A&D, assess/record/monitor wound healing on a weekly basis and as needed, and identify/document potential causative factors and eliminate/resolve where possible.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 12/3/2024 at 11:11 AM, Certified Nursing Assistant (CNA) 4 stated on 11/21/2024 at 8:30 AM during morning care for Resident 2, CNA 4 saw blackish things on the resident ' s arm. CNA 4 stated the blackish thing did not look like a bruise and was roughly 10 centimeters (cm, a metric unit used to measure length). CNA 4 stated he did not report the finding to the charge nurse because the resident was not in pain but later, the resident ' s FM reported the discoloration to the manager.<br><br>During an interview on 12/3/2024 at 12:38 PM, Licensed Vocational Nurse (LVN) 2 stated on 11/21/2024 around lunch time she was asked to check Resident 2 ' s skin. LVN 2 stated the resident ' s left forearm had an opening and went to get the treatment cart. LVN 2 stated she cleaned the site with betadine (an antiseptic medication used to treat minor skin infections and wounds) and put sterile strips (thin, adhesive strips used to close small cuts) because there was a skin tear. LVN 2 stated on admission the resident had discoloration on the skin but that afternoon, the skin was open.<br><br>During an interview on 12/3/2024 at 3:19 PM, the Director of Staff Development (DSD) stated CNAs were in-serviced to report any changes right away to the charge nurse or supervisor when a resident had a change of condition (COC) like discoloration on the skin. The DSD stated the CNAs should report the COC when they notice the change immediately. The DSD stated CNA 4 should have reported the finding right away to the charge nurse or supervisor.<br><br>During a concurrent interview and record review with the Registered Nurse (RN) on 12/3/2024 at 3:34 PM of the facility ' s policy and procedure (P&P) Abuse, Neglect, and Exploitation, dated 12/19/2022, indicated Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies within specified timeframes: immediately, but not later than two (2) hours after the allegation was made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. The RN stated when staff see a COC the expectation was to report the COC to the nurse so the facility could address the situation right away. The RN stated CNA 4 should have reported the finding to the charge nurse. The RN stated when the finding was not reported, the problem would not be solved, and the resident would not be protected or safe. The RN stated CNA 4 did not follow the facility ' s P&P because he did not report the finding immediately.<br><br>During a review of the facility ' s policy and procedure (P&P) titled, Compliance with Reporting Allegations of Abuse/Neglect/Exploitation, dated 12/19/2022, indicated All allegations of abuse/neglect/exploitation or mistreatment, including injuries of unknown sources and misappropriation of resident property were reported immediately to the Administrator of the facility and to other appropriate agencies in accordance with current state and federal regulations within prescribed timeframes. The P&P indicated, New employees had to be educated by the department manager on alleged violations and reporting requirements during initial orientation. Annual education and training was provided to all existing employees.<br><br>During a review of the facility ' s policy and procedure (P&P) titled, Incidents and Accidents, dated 12/19/2022, indicated, The purpose of incident reporting could include assuring that appropriate and immediate interventions were implemented and corrective actions were taken to prevent recurrences and improve the management of resident care. The P&P indicated, Incidents that rise to the level of abuse, misappropriation, or neglect, would be managed and reported according to the facility ' s abuse prevention policy.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a review of the facility ' s P&P titled, Abuse, Neglect, and Exploitation, dated 12/19/2022, indicated, Training for existing staff on activities that constitute abuse, neglect, exploitation, and misappropriate of resident property, reporting procedures, and dementia management and resident abuse prevention. The P&P indicated, Training topics would include reporting process for abuse, neglect, exploitation, and misappropriation of resident property, including injuries of unknown sources. The P&P indicated, The facility would provide ongoing oversight and supervision of staff in order to assure that the policies were implemented as written. |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48661<br><br>Based on interview and record review the facility failed to ensure one (1) of five (5) sampled residents (Resident 1), who was assessed at risk for falls and diagnoses of dementia (a progressive state of decline in mental abilities) and age-related osteoporosis (weak and brittle bones due to lack of calcium and Vitamin D) was free from falls and injury in accordance with the resident ' s care plan by failing to:<br><br>1. Ensure Certified Nursing Assistant (CNA) 1 prevented Resident 1, who was assessed as totally dependent to staff for bathing/showers, from falling in the Shower Room while sitting on the shower chair. On 11/30/2024, Resident 1 fell on her left side when the resident opened the arm rest of her shower chair while CNA 1 bent over to fix the hem (an edge that is folded over and stitched down to prevent threads coming loose) of her [CNA 1] pants.<br><br>2. Ensure CNA 1 notified Registered Nurse (RN) 1 when Resident 1 fell from the shower chair and placed the resident back on the shower chair, after the resident fell on [DATE] timed at 10:30 AM.<br><br>3. Ensure CNA 1 did not move and transfer Resident 1 back to the shower chair, prior to a licensed nurse assessing the resident for injuries in accordance with the facility ' s Policy and Procedure (P&P) on Incidents and Accidents.<br><br>As a result of this deficient practice, on 11/30/2024 at around 11:10 AM, RN 1 heard Resident 1 screaming and yelling from the resident's room and observed Resident 1 with left upper arm swelling (the enlargement of organs, skin, or other body parts), moaning and grimacing in pain, with sad/frightened/frown. The X-ray (electromagnetic [relating to the electrical and magnetic forces produced by an electric current] waves that create pictures of the inside of your body) report taken at the facility indicated the resident had a moderately displaced oblique (having a slanting direction or position/angle) fracture (a broken bone that happens suddenly due to a traumatic injury) of the distal diaphysis (the main or midsection of a long bone) of the left humerus (upper arm bone), consistent with an acute fracture (a broken bone that happens suddenly due to a traumatic injury, like a fall causing immediate pain and noticeable damage to the bone). Resident 1 was transferred to the general acute care hospital (GACH) on 11/30/2024 at 8:11 PM for further treatment. It was determined in the GACH that Resident 1 was not a good candidate for surgery and therefore received non-operative treatment (medical treatment that does not involve surgery) at the GACH that included medication management for pain control. A left humerus fracture splint [a brace that supports and immobilizes the shoulder or arm to help with healing after an injury] was placed to the resident ' s left arm and to continue with non-weight bearing (you are not allowed to put any weight on a specific body part) to the left upper extremity.<br><br>Findings:<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During a review of Resident 1 ' s Admission Record [AR], the AR indicated the facility admitted the resident on 6/22/2021, with diagnoses including history of falling, age-related osteoporosis (weak and brittle bones due to lack of calcium and Vitamin D) without current pathological fracture (a broken bone that occurs when a disease weakens the bone, making the bone more likely to break than normal), and abnormalities in gait (a person ' s manner of walking) and mobility (a change to a person ' s walking pattern).<br><br>During a review of Resident 1 ' s Fall Risk form dated 6/20/2024, the Fall Risk form indicated the resident had intermittent (fluctuating) confusion. The Fall Risk form indicated the resident was assessed at risk for falls.<br><br>During a review of Resident 1 ' s History and Physical (H&P) dated 6/23/2024, the H&P indicated additional diagnosis that included dementia. The H&P indicated Resident 1 was dependent to staff for all activities of daily living [ADL, basic tasks people need to do to take care of themselves that included eating, bathing]. The H&P indicated the resident did not have the capacity to understand and make decisions.<br><br>During a review of Resident 1 ' s Care Plan for Self-Care Deficit: Bathing revised on 6/28/2024, the Care Plan indicated interventions that included facility staff would evaluate the resident ' s ability to perform ADLs.<br><br>During a review of Resident 1 ' s Care Plan for Age-related Osteoporosis revised on 6/28/2024, the care plan indicated the goal for the resident was to remain free of injuries or complications related to Osteoporosis. The Care Plan interventions included to monitor/document for risk of falls to reduce risk of falls.<br><br>During a review of Resident 1 ' s Care Plan for Risk of Falls revised on 6/28/2024, the care plan indicated a goal for the resident to be free of falls and minor injury. The Care Plan interventions included anticipating the resident ' s needs, reminding the resident to call for help when needed, and educating the resident about safety reminders and what to do if a fall occurs.<br><br>During a review of Resident 1 ' s Minimum Data Set (MDS - a federally mandated [a law or court ruling that the federal government imposes on state and local governments to address issues that affect the United States] resident assessment tool) dated 9/19/2024, the MDS indicated the resident had severe cognitive impairment (problems with a person ' s ability to think, learn, remember, use judgement, and make decisions). The MDS indicated Resident 1 ' s speech was unclear and was sometimes able to understand and be understood. During further review of the MDS, the MDS indicated under Self-Care, that assessed the resident ' s safety and quality of performance, Resident 1 was assessed as dependent (helper did all of the effort and the resident did none of the effort to complete the activity; or the assistance of two or more helpers was required for the resident to complete the activity) to facility staff with showering/bathing. The MDS indicated shower transfers (the ability to get in and out of a tub/shower) was not applicable (not attempted and the resident did not perform this activity prior to the current illness).<br><br>During a review of Resident 1 ' s Care Plan for an Actual Fall that happened to the resident, dated 11/20/2024, the care plan indicated Resident had an actual fall on 11/20/2024 [10 days prior to Resident 1 ' s fall in the shower room on 11/30/2024]. The Fall care plan goal for Resident 1 was to provide a safe environment that minimizes complications associated with falls.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During a review of another Fall Risk evaluation form for Resident 1, dated 11/20/2024, the Fall Risk form indicated Resident 1 continued to be at risk for falls.<br><br>During a review of Resident 1 ' s Situation, Background, Assessment, and Recommendation (SBAR) dated 11/30/2024 timed at 2:11 PM, the SBAR indicated the resident had a left upper arm swelling and was moaning and grimacing when moving the left upper arm. The SBAR indicated the resident had pain with non-verbal signs of occasional moan or groan (make a deep inarticulate [not able to express yourself clearly or effectively] sound in response to pain), low-level of speech with a negative or disapproving quality, and sad/frightened/frown. The SBAR indicated the resident ' s family (FM) was at the bedside during the assessment and the physician was notified with an order for a STAT (is derived from the Latin word statim, which means instantly or immediately) left shoulder upper arm X-ray.<br><br>During a review of Resident 1 ' s Physician ' s Order dated 11/30/2024, the Physician ' s Order indicated left upper arm X-ray STAT due to pain and swelling.<br><br>During a review of Resident 1 ' s Final X-ray Report taken at the facility on 11/30/2024, the X-ray Report indicated the exam was for the left humerus due to swelling, mass/lump (a noticeable bump or swelling on the body) of unspecified site. The X-ray report indicated the resident had a moderately displaced oblique fracture of the distal diaphysis of the left humerus, consistent with an acute fracture. The X-ray Report indicated clinical follow-up was recommended.<br><br>During a review of Resident 1 ' s Physician ' s Order dated 11/30/2024, the Physician ' s Order indicated to administer Acetaminophen (a pain reliever) oral tablet 325 milligrams (mg, a unit of measurement of weight), two (2) tablets by mouth every four (4) hours as needed (PRN) for mild pain (one [1] to three [3]/10) for 30 days.<br><br>During a review of Resident 1 ' s Medication Administration Record (MAR) dated 11/30/2024 at 2:17 PM, the MAR indicated the resident received two 325 mg Acetaminophen tablets by mouth for mild pain.<br><br>During a review of Resident 1 ' s Nurses Progress Note dated 11/30/2024 timed at 8 PM, the Note indicated the resident was in bed complaining of pain and swelling on the left upper arm and an x-ray done at 4 PM, that showed a left upper arm fracture. The Nurses Progress Note indicated the family requested the resident be transferred to the GACH. The Nurses Progress Note indicated the facility staff gave report to the GACH at 5 PM, the ambulance arrived at the facility on 11/30/2024 at 7:50 PM, and the resident was sent to the GACH at 8:11 PM.<br><br>During a review of Resident 1 ' s GACH emergency room (ER) Triage (the preliminary assessment of patients or casualties in order to determine the urgency of their need for treatment and the nature of treatment required) Notes dated 11/30/2024 timed at 8:54 PM, the ER Triage Notes indicated the resident had left upper arm swelling, tenderness, and the resident was in a left arm sling (a device that supports and immobilizes an injured body part) upon arrival to the GACH ER.<br><br>During a review of Resident 1 ' s GACH Left Humerus Computed Tomography (CT - a medical imaging technique that uses X-rays and a computer to create detailed pictures of the inside of the body) Radiology Report dated 11/30/2024, the CT Radiology Report indicated there was a complete displaced fracture involving the distal humeral diaphysis. The CT report indicated there was posterior displacement of the distal humeral diaphyseal (relating to the diaphysis of a bone) fragment.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During a review of Resident 1 ' s GACH Left Humerus X-ray Radiology Report resulted on 12/1/2024, the X-ray Radiology Report indicated there was a complete oblique displaced fracture of the distal humeral diaphysis and a posterior displacement of the distal humeral fragment.<br><br>During a review of Resident 1 ' s GACH Orthopedic (the branch of medicine dealing with the correction of deformities of bones or muscles Consult) H&P dated 12/1/2024, the GACH H&P indicated the resident ' s affected side revealed intact thin skin, swelling and edema (a condition that occurred when fluid builds up in the body ' s tissue and caused swelling), significant ecchymosis (a bruise), and tenderness (pain or discomfort) along the left upper extremity. The GACH H&P indicated Resident 1 ' s left humerus x-ray was a spiral fracture (a type of fracture characterized by a complete break in a bone that occurs when a twisting force causes the bone to split into at least two pieces) of the distal humerus. The GACH H&P indicated the original plan was to perform an open reduction internal fixation (ORIF, to realign broken bone pieces and secure them) of the humerus but decided against surgery due to comorbidities (condition of having two or more disease at the same time). The GACH H&P indicated Resident 1 would receive non-operative treatment that included medication management for pain control application, a left humerus fracture splint (a brace that supports and immobilizes the shoulder or arm to help with healing after an injury) was placed to the resident ' s left arm and to continue daily with non-weight bearing to the left upper extremity.<br><br>During an interview on 12/3/2024 at 2:47 PM, RN 1 stated on 11/30/2024, CNA 1 was providing care to Resident 1 inside the resident ' s room around 11 AM, and she heard the resident screaming and yelling. RN 1 stated at around 11:10 AM, when she entered Resident 1 ' s room, she observed the resident ' s left arm was swollen but the skin was intact and there was no discoloration. RN 1 stated Resident 1 would not move her left arm or let the facility staff touch the left arm. RN 1 stated the attending physician was notified around 12 PM and ordered a STAT x-ray. RN 1 stated CNA 1 did not inform her that Resident 1 had a fall on 11/30/2024.<br><br>During an interview on 12/3/2024 at 3:54 PM, CNA 2 stated Resident 1 required total care (providing a person with all the necessary support and assistance they need to manage their health and daily life, including medical care, personal hygiene, and other needs) and could also use hands to gesture what the resident wants. CNA 2 stated Resident 1 usually sits down in the wheelchair. CNA 2 stated on 11/30/2024 during the 3 PM to 11 PM shift, Resident 1 was sitting in the wheelchair and was not moving her left arm. CNA 2 stated Resident 1 ' s x-ray was performed around dinner time and shortly after the resident was sent to the GACH.<br><br>During an interview on 12/4/2024 at 7:18 PM, the Administrator (ADM) stated CNA 1 contacted the Director of Staff Development (DSD) on 12/3/2024 at 9:18 PM and stated she did not provide accurate information when CNA 1 witnessed Resident 1 falling from the shower chair in the Shower Room and did not tell any staff. The ADM stated that according to CNA 1, on 11/30/2024 at 10:30 AM, CNA 1 took Resident 1 to the Shower Room and as CNA 1 was turning on the shower, Resident 1 opened the safety arm to the shower chair and fell . The ADM stated, CNA 1 took Resident 1 back to the resident ' s room and noticed swelling and informed RN 1 of the swelling. The ADM stated CNA 1 did not inform RN 1 of the fall and what actually happened on 11/30/2024.<br><br>(continued on next page) |

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|---|---|
| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During a telephone interview on 12/4/2024 at 7:39 PM, CNA 1 stated on 11/30/2024 Resident 1 was sitting on the shower chair in the Shower Room. Resident 1 opened the arm rest of the shower chair, while CNA 1 was bending over to tuck the hem of CNA 1 ' s pants into her socks, to avoid her pants from getting wet. CNA 1 stated while she was bending over, Resident 1 opened the arm of the shower chair and fell to the left side with the shower chair to the floor. CNA 1 stated the shower chair arm rest was secured prior to the resident falling but Resident 1 was still able to open the arm rest to the shower chair. CNA 1 stated that when she saw Resident 1 getting up, CNA 1 tried to get to Resident 1 but was not able to catch the resident because by the time she could get to the resident, Resident 1 already touched the ground. CNA 1 stated she had her hand on the resident ' s stomach when she attempted to get to her, to make sure the resident ' s head does not hit the ground.<br><br>During the same telephone interview on 12/4/2024 at 7:39 PM, CNA 1 stated after Resident 1 fell , she attempted to call another CNA to assist her, but nobody came, so CNA 1 picked up Resident 1 by herself, along with the shower chair. CNA 1 stated another CNA [CNA 3] came after Resident 1 was already back up in the shower chair, to ask what happened, but she told CNA 3 that nothing happened and did not mention Resident 1 fell . CNA 1 stated she proceeded to take Resident 1 back to bed. CNA 1 stated when she put Resident 1 back to bed, she noticed the resident ' s left arm was swollen. CNA 1 stated when RN 1 came to the resident ' s room and asked if Resident 1 fell , CNA 1 did not tell RN 1 that the resident fell from the shower chair to the floor. CNA 1 stated she told RN 1 that Resident 1 ' s left arm was already swollen when she came to assist the resident that morning [11/30/2024]. CNA 1 stated she did not tell anyone in the facility what actually happened [Resident 1 falling from the shower chair in the shower room] on 11/30/2024, because she was scared.<br><br>During an interview on 12/5/2024 at 2:17 PM, CNA 3 stated when CNA 1 called for help because the resident ' s arm looked different on 11/30/2024, Resident 1 was already back in the room and observed the resident ' s arm was swollen. CNA 3 told CNA 1 to inform RN 1, and both walked out of the room. CNA 3 stated if a resident would have an incident of fall and the resident was on the floor, it is the facility ' s policy to not move the resident and instead call for help and report to the licensed nurse to assess the resident.<br><br>During an interview on 12/5/2024 at 2:38 PM, Licensed Vocational Nurse (LVN) 1 stated if a resident fell , she would call the RN Supervisor to help assess the resident for any swelling, pain, or injury. LVN 1 stated not moving the resident was important to see the position the resident was in and to avoid further harm to the resident.<br><br>During an interview on 12/5/2024 at 3:17 PM, the DSD stated unlicensed staff like CNAs were expected to ask for help and should not have moved or lifted a resident until help arrived because the licensed nurse would need to do an assessment. The DSD stated the CNAs must wait before moving the resident for safety issues because moving the resident would cause more harm to the resident.<br><br>During an interview on 12/5/2024 at 3:30 PM, RN 2, who was assisting the Director of Nursing at the facility, stated she expects the facility staff to call for assistance and not do anything by themselves, if a resident falls because the facility staff may not be knowledgeable to assess the resident. RN 2 stated CNA 1 should have called for help/assistance from a licensed nurse to be able to assess if Resident 1 was safe to move, after the resident fell on [DATE]. RN 2 stated CNA 1 should have called for help instead of moving Resident 1 back to the shower chair and to bed.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055989 | A. Building<br>B. Wing | 12/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Heritage Manor | 610 North Garfield Avenue<br>Monterey Park, CA 91754 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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|---|---|
| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During an interview on 12/13/2024 at 3:54 PM, the DSD stated since Resident 1 was totally dependent to staff for shower/bathing, CNA 1 should not have taken her eyes off Resident 1 and should not have left Resident 1 in the shower chair while she reached down to tuck her pants in to her socks. The DSD stated CNA 1 informed her during her post-interview with CNA 1 that on 11/30/2024, Resident 1 was being resistant when she placed the resident on the shower chair. The DSD stated CNA 1 should have asked another CNA to assist her on 11/30/2024, since Resident 1 was being resistant so CNA 1 would not have to take her eyes off [Resident 1]. The DSD stated that CNA 1 should have followed the facility ' s policy for Incidents and Accidents that indicated not to move a resident after a fall to prevent further harm because a licensed nurse need to know and assess the resident and notify the physician.<br><br>During a review of the facility ' s P&P titled, Incidents and Accidents, dated 12/19/2022, the P&P indicated the purpose of reporting an incident which is defined as an occurrence or situation that is not consistent with the routine care of a resident or with the routine operation of the organization, assures that appropriate and immediate interventions are implemented, and corrective actions are taken to prevent recurrences. The P&P further indicated, Any injuries would be assessed by the licensed nurse or practitioner and the affected individual would not be moved until safe to do so.<br><br>During a review of the facility ' s P&P titled, Comprehensive Care Plans, dated 12/19/2022, indicated the facility would Develop and implement a comprehensive person-centered care plan for each resident consistent with resident ' s rights that include measurable objectives and timeframes to meet the resident ' s medical, nursing, mental, and psychosocial needs that are identified in the resident ' s comprehensive assessment.<br><br>During a review of the facility ' s P&P titled, Accidents and Supervision, dated 12/19/2022, indicated, Each resident would receive adequate supervision and assistive devices to prevent accidents including identifying hazards and risks, evaluating and analyzing hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary. The P&P indicated, Resident-directed approaches may include implementing specific interventions as part of the plan of care. The P&P indicated, Monitoring and modification processes include ensuring interventions are implemented correctly and consistently, evaluating the effectiveness of interventions, modifying or replacing interventions as needed, and evaluating the effectiveness of new interventions.<br><br>During a review of the facility ' s P&P titled, Fall Prevention Program, dated 12/28/2023, indicated, Each resident would be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. |