STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056008	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Guardian Rehabilitation Hospital	533 S. Fairfax Ave Los Angeles, CA 90036

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49881 Based on interview and record review, the facility failed to ensure one of three sampled residents (Residents 1's) comprehensive assessment accurately reflected the residents' history of fall and functional limitation in range of motion [ROM, full movement potential of a joint (where two bones meet)]. This deficient practice had the potential to result in a negative effect to Resident 1's plan of care that can lead to an injury or fall. Findings: a. A review of the Orthopaedic Surgery H&P notes from the General Acute Care Hospital (GACH) dated 7/15/24 indicated Resident 1 presented with right hip pain on 7/14 after an unwitnessed ground level fall at home. The clinical impression indicated a right hip fracture. A review of Resident 1 ' s Admission Record indicated the facility originally admitted the resident on 7/21/24 with diagnoses including repeated falls and displaced comminuted fracture (bone breaks into three or more pieces) of shaft of right femur and was readmitted on [DATE] with diagnoses including periprosthetic fracture around internal prosthetic right hip joint (a broken bone that occurs around the implants of a total hip replacement). A review of Resident 1 ' s History and Physical (H&P), dated 7/23/24, indicated the resident had a history of fall and had fluctuating capacity to understand and make decisions. A review of Resident 1 ' s Minimum Data Set (MDS - a standardized resident assessment and care screening tool) dated 7/27/24, 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 does all of the effort) with toilet hygiene and showering and required partial/moderate assistance (helper does less than half the effort) with eating, oral and personal hygiene. A review of the fall history section of the MDS indicated Resident 1 was coded as not having a fall in the last month or any fracture related to a fall in the last 6 months prior to admission/entry or reentry. A review of the functional limitation in ROM section of the MDS indicated the resident had no impairment on the lower extremity (hip, knee, ankle, foot). (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 8/21/24 at 10:54 AM with the MDS coordinator, Resident 1 ' s MDS Section J Health Conditions and Section GG Functional Abilities and Goals dated 7/27/24 were reviewed. The MDS Coordinator acknowledged the discrepancy and stated Resident 1 ' s Fall History in Section J and Functional Limitation in ROM in Section GG was inaccurate. The MDS coordinator stated the MDS should have indicated yes for a fall in the last month and a fracture related to a fall in the last 6 months prior to admission. The MDS Coordinator stated the MDS should have indicated impairment on one side of the lower extremity. The MDS coordinator stated it was important to have an accurate assessment of a residents fall history and ROM. During a concurrent interview and record review on 8/22/24 at 10:35 AM with the Director of Nursing (DON), Resident 1 ' s MDS Section J Health Conditions and Section GG Functional Abilities and Goals dated 7/27/24 were reviewed. The DON acknowledged the discrepancy in the Resident 1 ' s fall history and functional limitation of range of motion. The DON stated it was important to have an accurate assessment of the residents fall history and ROM limitation. The DON stated there was a risk for injury or fall with inaccurate assessments. A review of the facility ' s undated job description titled, Resident Assessment/Care Plan Coordinator (MDS) Job Description, indicated the general duties and responsibilities include conducting and coordinating the development and completion of the resident assessment (MDS) in accordance with current rules, regulations, and guidelines that govern the resident assessment.

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(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** 49881 Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 1), who had a history of falls, received supervision per the Interdisciplinary Team (IDT) plan to provide a sitter from 3 PM to 7 AM. Resident 1 was observed in the room without a staff member present. This deficient practice caused an increased risk of another fall with injury for Resident 1. Findings: a. A review of the Orthopaedic Surgery H&P notes from General Acute Care Hospital (GACH) dated 7/15/24 indicated Resident 1 presented with right hip pain on 7/14/24 after an unwitnessed ground level fall at home. The clinical impression indicated a right hip fracture. A review of Resident 1 ' s Admission Record indicated the facility originally admitted the resident on 7/21/24 with diagnoses including repeated falls and displaced comminuted fracture (bone breaks into three or more pieces) of shaft of right femur and was readmitted on [DATE] with diagnoses including periprosthetic fracture around internal prosthetic right hip joint (a broken bone that occurs around the implants of a total hip replacement). A review of Resident 1 ' s Minimum Data Set (MDS - a standardized resident assessment and care screening tool) dated 7/27/24, 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 does all of the effort) with toilet hygiene and showering and required partial/moderate assistance (helper does less than half the effort) with eating, oral and personal hygiene. A review of Resident 1 ' s Fall care plan dated 8/12/24 indicated the resident was a high risk for fall and injury related to unsteady gait, cognitive impairment, and history of falls. The care plan goal was to minimize the risk of fall and fall reoccurrance daily. The care plan interventions indicated to implement fall precautions i.e., provide safe environment. A review of the Interdisciplinary (IDT) Care Plan Conference Summary dated 8/14/24 indicated Resident 1 had a fall in the facility on 8/7/24 and the IDT plan was for Resident 1 to have a sitter a from 3 PM to 7 AM. A review of the facility Staff Assignment form dated 8/21/24, indicated CNA 1 was the sitter for Resident 1 ' s room. During an observation on 8/21/24 at 6:47 AM, CNA 1 was observed exiting Resident 1 ' s room with a trash bag in her hand, as Resident 1 remained in the room without staff. (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 concurrent observation and interview with CNA 1 on 8/21/24 at 6:48 AM, CNA 1 was observed walking back to Resident 1 ' s room and stated that she exited Resident 1 ' s room to remove the trash. CNA 1 stated she did not inform another nurse or staff member that she was leaving Resident 1 ' s room. CNA 1 stated a staff member should be with Resident 1 at all times and that there was a risk Resident 1 could fall when left unsupervised. During an interview on 8/21/24 at 6:52 AM, Licensed Vocational Nurse 1 (LVN 1) stated she was the charge nurse for Resident 1 who was a high fall risk and CNA 1 was assigned to watch Resident 1. LVN 1 stated CNA 1 should not leave Resident 1 unsupervised and should communicate with LVN 1 or another staff member when she needs to leave the room. LVN 1 stated another staff member needed to replace CNA 1 when she was not in Resident 1 ' s room. LVN 1 confirmed CNA 1 did not communicate with her that she was leaving Resident 1 ' s room and she was unaware CNA 1 had stepped out of Resident 1 ' s room. LVN 1 stated it was important that CNA 1 did not leave Resident 1 unsupervised because there was a potential the resident could fall. During an interview on 8/22/24 at 10:40 AM, the Director of Nursing (DON) stated a sitter needed to notify the charge nurse if they were going on break or stepping out of a resident ' s room. The DON stated the sitter should not leave the resident unsupervised and should notify the charge nurse. The DON stated it was important a sitter did not leave a resident unattended because there was a risk of fall or injury. After review of the fall care plan, the DON stated the fall care plan was not updated to include the IDT plan of a sitter from 3 PM to 7 AM. The DON stated it was important to follow the plan of care discussed in the IDT meeting and update the care plan to ensure that staff were aware of the interventions for Resident 1. The DON stated that not updating the care plan had the potential to result in another fall or injury for Resident 1. During an interview on 8/22/24 at 2:13 PM, the Administrator (ADM) stated the facility did not have a sitter policy or a one to one supervision policy. A review of the facility ' s policy and procedure titled, Safety and Supervision of Residents, revised February 2019, indicated the interdisciplinary team (IDT) shall analyze information obtained from assessments and observations to identify any specific accident hazards or risks for each resident. The care team shall target interventions to reduce potential accidents. The policy indicated resident supervision was a core component of the systems approach to safety. The type and frequency of resident supervision was determined by the individual needs and identified hazards in the environment.