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	02/12/2025

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 0744 Level of Harm - Actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42243 Based on observation, interview and record review, the facility failed to ensure one of three sampled residents (Resident 1), who had diagnosis of dementia (condition of a person losing the ability to think, remember and reason) and history of fall, received care and services to prevent fall by failing to: 1. Implement Resident 1's Dementia Care Plan and At Risk for Fall Care Plan to ensure: Licensed Vocational Nurse (LVN) 1 and Certified Nurse Assistant (CNA) 1 explained procedure, remind not to have position change, remind for safety, reassure resident safety, and avoid environmental hazard (using multiple ramps) to Resident 1 before transporting Resident 1 in a wheelchair. 2. Identify and develop an appropriate care plan to addressed how to safely transport Resident 1 using wheelchair when resident have episodes of forgetfulness, confusion and poor safety awareness to maximize resident safety. 3. Ensure Resident 1 who had dementia, episodes of confusion, forgetfulness, poor safety awareness was safe when pushed in a wheelchair up and down the ramp (a slope or incline that connects two different surfaces) and did not have an accident. 4. Ensure to use an alternative safer route of transport for resident with dementia that have poor safety awareness and did not use a route (with multiple ramps) closer to the street parking for staff convenience. These failures resulted in Resident 1, who made a sudden movement while being wheeled in a wheelchair, to fall and sustain a right clavicle (a long bone that connects the shoulder blade and the breastbone, allowing free movement of the arm) fracture (broken bone) and experience severe pain. Resident 1 was transferred to General Acute care Hospital (GACH) for treatment and evaluation. Findings: (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 0744 Level of Harm - Actual harm Residents Affected - Few	During a concurrent observation and interview on 2/12/2025 at 10:15 am with Resident 1 in her room, Resident 1 was observed with blue sling (a device that holds a broken arm or shoulder while it heals) on her right arm and guarding (the body's ways of protecting an injury) her right arm. Resident 1 stated her right shoulder hurts. Resident 1 stated her pain level was four on a scale of 0 to 10 on a numeric pain scale (zero meaning no pain and 10 meaning the worst pain imaginable. A pain level of four meant mild pain). Resident 1 stated her pain level was eight (severe pain) when touched. Resident 1 stated the pain was from the right side of her neck down to her right shoulder. Resident 1 stated she was told (unable to recall who informed her) she got fractured from a fall (did not specify exact location) but does not remember the fall incident. During an interview on 2/12/2025 at 10:38 am., CNA 2 stated on 1/29/2025, LVN 1 was pushing Resident 1 in a wheelchair and asked her (CNA 2) to wheel Resident 1 from the basement to the front of facility to meet Resident 1's Family Member (FM 1) for dental appointment. CNA 2 stated LVN 1 instructed her to take the route that uses multiple ramps closer to the street parking lot to transport Resident 1 but did not provide safety precaution instructions. CNA 2 stated she had taken care of Resident 1 before at least more than ten times. CNA 2 stated Resident 1 usually ambulated (walked) with a walker and did not use a wheelchair on daily basis. CNA 2 stated that day (on 1/29/2025) was the first time she transported Resident 1 in a wheelchair. CNA 2 stated she did not give any instructions to Resident 1 before and during the transport or before approaching the ramp because Resident 1 was calm during transport. CNA 2 stated she did not see a reason to explain the procedure (the transport) to Resident 1, remind the resident to avoid any sudden movements or provide reassurance regarding safety, as the resident was calm prior to transport. During a concurrent observation and interview on 2/12/2025 at 10:58 am, at the facility basement, CNA 2 demonstrated how she transported Resident 1 on 1/29/2025. CNA 2 stated, when she received the resident in the basement from LVN 1, she transported Resident 1 alone using the wheelchair. CNA 2 demonstrated how she maneuvered the resident backward down Ramp 1 (ramp by the basement). CNA 2 stated and demonstrated that she then used her back to push the doubles door open (leading to Ramp 2 in the basement) CNA 2 stated she wheeled Resident 1 facing forward while going up the Ramp 2. During the concurrent observation and interview on 2/12/2025 at 10:58 am, CNA 2 stated Resident 1 all of a sudden appeared nervous, made a sudden movement halfway up the incline of Ramp 2, and caused the wheelchair to tilt to the right side. CNA 2 stated she released the wheelchair and attempted to catch Resident 1 from behind, grabbing the resident by both shoulders, but was unable to support her (Resident 1), resulting in Resident 1 falling. CNA 2 stated Resident 1 landed on her buttocks, with her back and head leaning against the seat of the wheelchair. CNA 2 stated Resident 1's head did not hit the floor. CNA 2 stated the fall was an accident, and she (CNA 2) did not expect Resident 1 would make a sudden movement. CNA 2 stated Resident 1 was not used to being transported in a wheelchair. CNA 2 stated that the accident could have been prevented if she had requested assistance from another staff member to transport Resident 1 who could have assisted her (CNA 2) from ensuring Resident 1 will not make sudden movements and prevent Resident 1 from falling. (continued on next page)

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F 0744 Level of Harm - Actual harm Residents Affected - Few	During a concurrent observation and interview on 2/12/2025 at 11:30 am with Maintenance Supervisor (MS) 1, MS 1 stated on 1/29/2025, he heard someone called for help from Ramp 2. MS 1 stated he saw Resident 1 sitting on the floor while CNA 2 was on the right side of the wheelchair, holding the wheelchair and Resident 1. MS 1 stated he went to the nurses' station to report that Resident 1 fell . MS 1 stated the ramps were usually used for ambulance transport. MS 1 stated there are several ramps, Ramp 1 inside the facility basement, Ramp 2 outside the double doors, followed by two more ramps (Ramp 3 and Ramp 4) after the facility gate. MS 1 stated there was another way to exit the facility that did not need to pass through ramps. MS 1 showed the exit path going to the garage and it was a flat surface. MS 1 stated using the garage is a safer way to transport the resident. During a concurrent observation and interview on 2/12/2025 at 11:58 am, at the basement of the facility, MS 1 measured the steepness of the ramps and stated Ramp 1 at the basement of the facility had a length of 200 inches and rise of 15 inches. Ramp 2 outside the basement double doors had a length of 160 inches and a rise of 10 inches, Ramp 3 had length of 64 inches and rise of 7 inches, and Ramp 4 had a length of 230 inches and rise of 12 inches. MS 1 stated They were steep ramps for wheelchair transport. MS 1 stated the basement ramps (Ramp 1, Ramp 2, and Ramp 4) were steep, and it was a safer route to transport the wheelchair thru the garage. MS 1 stated the ambulance transporters usually used two persons to transport the resident when using the ramps. During an interview on 2/12/2025 at 12:05 pm., CNA 2 stated she did not know why she chose to go through the ramps instead of going through the garage. CNA 2 stated the ramps were closer to where FM 1 parked. During an interview on 2/12/2025 at 12:17 pm with LVN 1, LVN 1 stated Resident 1 has dementia and on high fall risk precaution. LVN 1 stated although Resident 1 had dementia, she (the resident) could follow directions. LVN 1 stated he picked up Resident 1 from Resident 1's room from bed to wheelchair and told Resident 1 she (the resident) was going to her dental appointment. LVN 1 stated he did not assess if Resident 1 was comfortable with the use of wheelchair, did not explain to Resident 1 that she will be using wheelchair, did not instruct Resident 1 not to make sudden position change, and that she would be transported using the ramps. LVN 1 stated at the basement elevator, he approached CNA 2 to bring Resident 1 at the facility entrance to meet FM 1 for a dental appointment. LVN 1 stated he asked CNA 2 to take the path (with multiple ramps) closer to the street parking but did not provide any instructions to CNA 2 to ensure Resident 1 was informed about safe transport procedure. LVN 1 stated they should have explained the procedure to Resident 1 and reassured Resident 1 of safe transport. (continued on next page)

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F 0744 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review on 2/12/2025 at 12:20 pm, Resident 1's Fall Risk Care Plan dated 10/28/2024 was reviewed. LVN 1 stated Resident 1 had dementia and was on high fall risk precautions. Resident 1's care plan for fall indicated Resident 1 had episodes of confusion and forgetfulness, had poor safety awareness and history of falls, had episodes of trying to be independent beyond physical capability and did not use assistive device or call light for assistance, required assistance with mobility and transfers, and have balance problems during transfers. LVN 1 stated the care plan goal was to ensure to minimize risk for falls and minimize injury secondary to falls. LVN 1 stated the staff should have followed the care plan and instructed Resident 1 not to have sudden position changes, provide adequate assistance during transport, and ensure to do frequent reminders regarding safety to prevent accident. LVN 1 stated Resident 1 did not have a care plan to addressed Resident 1 being transported in the wheelchair because Resident 1 was ambulatory and do not use wheelchair. LVN 1 stated the care plan for fall and dementia did not address what to do in the event Resident 1 had episode of confusion or forgetfulness while being transported in a wheelchair because Resident 1 was not using a wheelchair independently and was being assisted by one staff during transport. LVN 1 stated because of the incident (fall) they should add two person assist when transporting Resident 1 in a wheelchair to prevent future accidents. During a concurrent interview and record review on 2/12/2025 at 12:25 pm, Resident 1's Alzheimer's (a brain disorder that gradually destroys memory and thinking skills) and Dementia Care Plan dated 10/28/2024 was reviewed. LVN 1 stated the care plan indicated Resident 1 had episodes of confusion and forgetfulness, at risk for further decline in cognition and decision making. LVN 1 stated the dementia care plan interventions indicated the staff should have explained all procedures prior to assisting with care, gave simple directions one at a time using short words and simple sentences, provided reassurance as needed with frequent verbal reminders as necessary, and monitored and anticipated resident needs. LVN 1 stated they (LVN 1 and CNA 2) should had followed the care plan and explained the procedure to Resident 1 and reassured Resident 1 of safe transport to prevent the accident. During an interview on 2/12/2025 at 1:40 pm, Registered Nurse Supervisor (RN) 1 stated she rushed to the reported location (Ramp 2) and saw Resident 1 on the floor leaning on the wheelchair with CNA 1 at the right side of Resident 1. RN 1 stated Resident 1 was transported back to the room for assessment. RN 1 stated Resident 1 complained of right arm pain. RN 1 stated she assessed Resident 1 and noted the resident had a bruise on the right side of the head and had limited right arm range of motion (the extent or degree of movement that a joint can achieve). RN 1 stated Resident 1 have dementia, have episodes of forgetfulness but she (Resident 1) could follow instructions but just need constant reminders. RN 1 stated LVN 1 and CNA 2 should have reminded Resident 1 not to do a sudden movement during wheelchair transport and assessed environmental factors to ensure the prevention of accidents. During an interview on 2/12/2025 at 3 pm, the Director of Rehabilitation (DOR) stated Resident 1 does not use wheelchair and able to ambulate with a walker for short distances. The DOR stated Resident 1 could have benefited with instructions on using ramps with a wheelchair to reassure Resident 1 of safe transport. The DOR stated the best practice was to use the correct type of wheelchair, have two staff members during transport, and provide the resident with instructions prior to transport (using the ramps). (continued on next page)

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F 0744 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review on 2/12/2025 at 3:55 pm with the Director of Nursing (DON), Resident 1's fall risk care plan dated 10/28/2024 and Resident 1's Alzheimer's and Dementia Care Plan dated 10/28/2024 were reviewed. The DON stated Resident 1 was a high risk for fall, with dementia, and needed safety awareness and constant reminder. The DON stated Resident 1's fall risk care plan included to instruct Resident 1 not to make sudden movements. The DON stated Resident 1's Dementia care plan included explaining all procedures prior to assisting care. The DON stated the staff should have followed Resident 1's care plan to ensure Resident safety and avoid accidents. The DON stated the care plan did not have an intervention to addressed Resident 1 being transported in the wheelchair and what to do in the event Resident 1 had episode of confusion or forgetfulness. The DON stated they will add two person assist when transporting Resident 1 in a wheelchair to ensure resident safety. The DON stated there was an alternative route that staff could use that did not require using ramps. During a review of Resident 1's Admission Record, the Admission Record indicated Resident 1 was admitted on [DATE], with diagnoses including dementia, metabolic encephalopathy (a brain disorder when chemical imbalance in the blood affects the brain function), hypertension (high blood pressure), intervertebral disc degeneration (refers to symptoms of back or neck pain caused by wear-and-tear), unspecified fall, and weakness. During a review of Resident 1's SBAR (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents) Communication Notes, dated 7/25/2024, the SBAR notes indicated Resident 1 had an unwitnessed fall in the room. The SBAR notes indicated Resident 1 was found sitting on the floor inside her room, Resident 1 stated she was trying to pick up something on the floor and tried to get up but unable to and decided to sit on the floor. During a review of Resident 1's At Risk for Falls and Injuries Care Plan dated 10/28/2024, the care plan indicated Resident 1 had episodes of confusion and forgetfulness, had poor safety awareness and history of falls, Resident 1 had episodes of trying to be independent beyond physical capability and did not use assistive device or call light for assistance, required assistance with mobility and transfers and have balance problems during transfers. The care plan goal was to ensure to minimize risk for falls and minimize injury secondary to fall. The interventions indicated to instruct Resident 1 not to have sudden position changes and provide adequate assistance during transfers and ensure to do frequent reminders regarding safety. During a review of Resident 1's Alzheimer's and Dementia Care Plan dated 10/28/2024, the care plan indicated Resident 1 had episodes of confusion and forgetfulness, at risk for further decline in cognition and decision making. The care plan goal indicated Resident 1 will be oriented to time, place and person. The interventions indicated to explain all procedures prior to assisting care and provide reassurance as needed with frequent verbal reminders, give simple directions one at a time using short words and simple sentences, provide reassurance as needed with frequent verbal reminders as necessary, and monitor and anticipate needs. (continued on next page)

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F 0744 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1's Minimum Data Set (MDS, a standardized assessment and caring-screening tool), dated 1/24/2025, the MDS indicated Resident 1's cognitive (the ability to think and process information) skills for daily decisions making was moderately impaired. The MDS indicated Resident 1 could express ideas and wants and able to understand others. The MDS indicated Resident 1 required partial to moderate assistance (helper lifts or holds trunk or limbs and provides less than half the effort) with walking at fifty and one hundred fifty feet distance. The MDS indicated Resident 1 used a walker and did not use wheelchair. During a review of Resident 1's Fall Risk Evaluation dated 1/28/2025, the fall risk evaluation indicated Resident 1 had intermittent confusion, ambulatory, incontinent, balance problem with standing and walking, have gait problems, jerking, unstable when making turns, unsteady gait, shuffling gait, required use of assistive devices, took medications that cause lethargy (a state of feeling tired, sluggish, and lacking energy) or confusion, and had three or more predisposing diseases. The fall risk evaluation indicated Resident 1 scored 18. The fall risk evaluation indicated if a total score of 10 or greater, the resident should be considered a high risk for potential falls, a fall prevention protocol should be initiated immediately, and documented on the resident's care plan. During a review of Resident 1's Licensed Personnel Progress Notes, dated 1/29/2025 at 10:20 am, the progress notes indicated MS 1 called RN 1's attention at the nurses' station to inform Resident 1 was on the floor by the ramp (Ramp 2) outside the building. The progress notes indicated RN 1 immediately went to the site (location of Ramp 2), found Resident 1 sitting on the floor along the ramp, her back and head leaning against the seat of the wheelchair, had no change on level of consciousness, and had no bleeding. The progress notes indicated FM 1 and CNA 2 was at the site of incident (location of Ramp 2) and immediately called for help and assistance from another staff (RN 1). During a review of Resident 1's SBAR Communication Notes, dated 1/29/2025, the SBAR notes indicated Resident 1 had a witnessed fall on 1/29/2025. The SBAR notes indicated, Resident 1 had right lateral side of head purplish discoloration, abrasion on right elbow measuring approximately five centimeter (cm, unit of measurement) in length with minimal bleeding. The SBAR notes indicated the nurses applied ice packs to Resident 1's right side of the head and right shoulder, gave Tylenol (a pain reliever used to treat mild and moderate pain) 1 gram (unit of measurement) as ordered, and cleansed the resident's right elbow abrasion with normal saline and treated with hydrogel (medication for wound healing). The Change of Condition (COC) on the SBAR indicated Resident 1 complained of pain at level eight to nine and unable to move her right arm. The COC indicated the physical therapist came and applied an immobilizer (essential medical devices that are used to restrict the movement of the arm, providing support, stability, and protection during the healing process). The SBAR notes indicated Resident 1's attending physician (MD) was notified and the MD ordered to transfer Resident 1 to GACH for further evaluation. During a review of Resident 1's physician's orders dated 1/29/25, the order indicated to transfer Resident 1 to GACH for further evaluation and treatment. During a review of the GACH Records titled, Emergency Department to Hospital Admission Note (EDN), dated 1/29/2025, the EDN indicated Resident 1 had a closed displaced fracture of the clavicle. The EDN indicated Resident 1 had right shoulder pain, right forearm pain, and sustained hematoma (bruise) to the right forehead after a fall from wheelchair while going up a ramp. The EDN indicated Resident 1 was oriented to self and place and able to follow commands. The EDN provided wound care to Resident 1's right forearm wound. The EDN notes indicated a right arm sling was applied. (continued on next page)

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F 0744 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1's right shoulder Xray (a procedure that uses radiation to create images of inside of the body) report dated 1/29/2025, the report indicated nondisplaced fracture (a broken bone where pieces remained in place and aligned) of distal (away from the center) clavicle. During a review of Resident 1's Medication Administration Record (MAR), for the month of January 2025, the MAR indicated pain rating of 0 = (equals) no pain, 1 to 4= mild pain, 5 to 7=moderate pain, 8 to 10=severe pain. The MAR indicated Resident 1 had pain level of 8 (severe pain) on 1/29/2025 at 10:31 am and received two tablets of acetaminophen (medication to treat pain and reduces fever) 500 milligrams (mg, a unit of measurement) for severe pain. During a review of Resident's History and Physical (H & P) dated 2/4/2025, the H&P indicated Resident 1 had fluctuating capacity to understand and make decisions. During a review of the IDT (Inter Disciplinary Team, a team of professionals from various fields who work together toward the goals of the resident Care Plan Summary notes) notes, dated 2/11/2025, the IDT notes indicated Resident 1 was readmitted on [DATE] from GACH and had right clavicle fracture from a fall at the facility on 1/29/2025. Resident 1's FM 2 wanted Resident 1 to be encouraged to ambulate using assistive device especially during appointment. The IDT notes indicated Resident 1 will use wheelchair with two person assist. The IDT notes indicated the facility will implement preventive measures of siderails, grab bars and visual checks. During a review of facility's policy and procedure (P&P) titled, Dementia Care assessment dated reviewed 1/2017, the P&P indicated people with dementia have significantly impaired intellectual functioning that interferes with normal activities and lose the ability to maintain control, and may experience behavioral problems such as agitation, delusions and hallucinations. The P&P indicated it is the policy of the facility to identify and assess residents with dementia and to provide the highest quality care by providing the necessary care without compromising the resident's rights. The P&P indicated, the IDT will develop a plan of care to maximize the resident's remaining functional level, individual approaches that focus on a resident's individual needs and attempts to understand behavior as a form of communication to reduce behavioral expression of distress. During a review of facility's P&P on Falling Star Program, reviewed 7/2018, the P&P indicated the facility will identify residents who are at high risk for falls and attempt to increase supervision for residents on high fall risk. The P&P indicated if the resident has a fall after being placed on the program, the IDT will develop additional approaches to reduce additional falls. During a review of facility's P&P, titled Fall Risk and Prevention of Injury reviewed 3/2019, the P&P indicated it was the policy of the facility to identify residents that were risk for falls and to implement a plan of care in an attempt to prevent fall. The policy indicated the approaches to prevent falls and or fractures included orienting the resident their room and surroundings as appropriate and to keep the resident's environment free of unnecessary obstacles.