STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056056	A. Building B. Wing	08/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brier Oak on Sunset	5154 Sunset Blvd Los Angeles, CA 90027

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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43878 Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan (is a form that summarizes a person ' s health conditions and current treatments for their care)for one of six sampled residents (Resident 3), who was dependent (helper does all the effort or the assistance of 2 or more helpers is required for the resident to complete the activity) on staff on personal hygiene and diagnosed with muscle weakness (generalized), morbid (severe) obesity (abnormal or excessive fat accumulation that presents a risk to health) and paraplegia (the inability to voluntarily move the lower parts of the body), by failing to: 1. Develop and implement a care plan (is a form that summarizes a person ' s health conditions and current treatments for their care) consistent with Resident 3 ' s Minimum Data Set (MDS - a standardized assessment and care-screening tool), which indicated Resident 3 was dependent on staff on personal hygiene (includes combing hair, shaving, applying make-up, washing/drying face and hands [excludes baths, showers, and oral hygiene]), toileting hygiene (ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement), and rolling left and right (the ability to roll from lying on back to left and right side, and return to lying on back on the bed). 2. Indicate in Resident 3 ' s care plan to change Resident 3 ' s Med Aire Plus 10 Alternating Pressure and Low Air Loss Bariatric Mattress (LALM, a type of medical mattress designed to reduce pressure on the skin, which helps prevent pressure injuries or bed sores [injuries to skin and underlying tissue resulting from prolonged pressure on the skin]) setting from the physician ' s order of 300 pounds (lbs - unit of measurement for weight) to static mode (the mattress provides a firm surface that makes it easier for the patient to transfer or reposition). As a result, Resident 3 fell while Certified Nursing Assistant (CNA 1), was providing nursing care to Resident 3, without assistance from another staff. Resident 3 sustained a laceration (wound in the skin that occurs when skin and underlying tissues are torn or cut) to the left eyebrow and had approximately 1 liter (L - unit of measurement) of blood next to her head and was pronounced dead by the paramedics (healthcare professionals trained to provide a wide range of emergency services) on [DATE] at 10:21 p.m., in the facility. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 4:31 p.m., while onsite at the facility, the State Survey Agency (SSA) called an Immediate Jeopardy (IJ - a situation in which the facility ' s noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident)) in the presence of the Administrator (ADM) and the Director of Nursing (DON) due to the facility ' s failure to ensure Resident 3 was free from accidents under 42 CFR S S483.21 (b) Comprehensive Care Plans. On [DATE] at 3:33 p.m., the ADM and DON submitted an IJ Removal Plan (a detailed plan to address the IJ findings). While onsite at the facility, the SSA verified the IJ situation was no longer present and confirmed the facility ' s implementation of the IJ Removal Plan through observations, interviews, and record reviews, the SSA accepted the IJ Removal Plan and removed the IJ situation in the presence of the ADM and DON [DATE] at 4:15 p.m. The acceptable IJ Removal Plan included the following summarized actions: 1. On [DATE], the Director of Staff Development (DSD), Minimum Date Set (MDS) Nurse, and charge nurses reassessed all the residents ' turning/repositioning level of assistance by reviewing the MDS to assure appropriate provision of activities of daily living (ADL) care. Five residents (names indicated in the list provided by the facility) were identified to require two-person assistance during ADL care. 2. On [DATE], the DON conducted an order listing report of residents that had an order for LALM (in general) and 23 residents (names indicated in the list provided by the facility) were identified. Five residents (names indicated in the list provided by the facility) with LALM were identified to require two-person assist per MDS. 3. On [DATE], the Resource Nurse and the MDS Nurse reviewed the ADL care plans of the residents with LALM that required two-person assist. Three residents (names indicated in the list provided by the facility) were identified to have discrepancy in the ADL care plan regarding level of assistance during care based on the MDS to assure appropriate provision of ADL care. On [DATE], the Resource Nurse and the MDS Nurse revised the care plans for the three residents that were identified with discrepancy of the ADL care plan. 4. On [DATE], the MDS resource and DON reviewed the ADL care plans for all residents to ensure accuracy in conjunction with the MDS. 5. Revisions for all resident ADL care plans were initiated on [DATE] to ensure proper identification and care planning for resident provision of ADL care including the five residents identified (names indicated in the list provided by the facility) to have orders for LALM and requiring two-person assist. 6. On [DATE], the DON and MDS Resource updated the care plan of 23 residents with LALM to indicate static button is available to discontinue alternation therapy (alleviates pressure points, improves blood circulation, and reduces risk of developing pressure injuries) for resident transfers, caregiving, comfort, or preference. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	7. On [DATE], the MDS, Resource Nurse, and MDS Resource staff updated the ADL care plan of the residents identified to require two-person assist based on the provision of care determined through reviewing the MDS. 8. On [DATE], the DON provided an in-service to the MDS RN and Licensed Vocational Nurses (LVNs) on the accuracy of care planning with the emphasis of level of assistance during ADL care. 9. On [DATE], the DON initiated the Special Needs List Form which indicated the level of assistance during ADL care. On [DATE], the DON revised the Special Needs List Form to include a statement that the staff required for ADL care/transfers were minimal requirements, and to ask for additional assistance if needed to ensure patient safety. 10. On [DATE], the DSD initiated a re-education to RNs, LVNs, CNAs, and Rehab Staff emphasizing that the assistance needed on the special needs list are minimum information and emphasized that the staff should ask for additional assistance if needed to ensure patient safety. 11. On [DATE] the DON/Designee initiated an in-service to RNs, LVNs, CNAs and Rehab staff on Med-Aire Plus 10 Alternating Pressure and Low Air Loss Bariatric Mattress Replacement System and other types of LALM the information on the use of static button to discontinue alternation therapy for patient transfers, caregiving, comfort, or preference. 12. On [DATE], the DON/Designee initiated an in-service to RNs, LVNs, CNAs and Rehab staff on other LALM manufacturer's guidelines during patient transfers, caregiving, comfort, or preference. 13. On [DATE], the DSD provided an in-service over the phone to CNA 1 who was assigned to Resident 3 regarding ADL care to a resident with LALM. CNA 1 will be in-serviced in person at the beginning of her next shift. 14. On [DATE], the DON/Designee initiated an in-service to RNs, LVNs, CNAs and rehab staff on the Special Needs List Form which will be located at each nursing station. 15. On [DATE], the DSD provided an in-service over the phone to the assigned Licensed Nurse for Resident 3 addressing the need to set the button to static when ADL is provided. LVN will be in-serviced in person at the beginning of her next shift. 16. On [DATE], the DSD/Designee initiated an in-service to RNs, LVNs, CNAs, and Rehab Staff on providing the correct level of assistance when providing ADL Care. 17. On [DATE], the DON/Designee initiated competencies on providing ADL care for residents on LALM for CNAS, LVNs, RNs and rehab staff. 18. The Director of Nursing and/or Designee will review new admissions daily (Mondays to Fridays). The Director of Nursing and/or Designee will review the ADL care plan based on the information provided from the resident's MDS and the transfer Lift Evaluation assessment. The Director of Nursing and/or Designee will update the Special Needs List Form for accurate provision of ADL care. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	19. The DSD/Designee will do random rounds daily (Mondays to Fridays) to ensure that the staff is adhering to the Special Needs List Form for residents that require two-person assist during ADL care using the ADL Audit Form. 20. The DSD/Designee will do random rounds daily (Monday to Friday) during ADL care to check if static mode is turned on during transfers, caregiving, comfort, or preference of the residents for residents on LALM. 21. The MDS and or Designee will review the accuracy of ADL care plan of residents on LALM for three months. 22. The Director of Nursing and/or Designee will review the ADL Audit Form weekly and address any deficient findings. 23. The Director of Nursing and/or Designee will review the Low Air Loss Static Mode Audit weekly and address any deficient findings. 24. The Director of Nursing/Designee and or Administrator /Designee will be responsible for compliance. Findings will be reported to the Administrator and/or Designee who will then present and discuss the findings during Quality Assessment and Assurance (QAA) meetings for three months for any further recommendations and follow-up or until compliance is achieved. Cross Reference with F689. Findings: A review of Resident 3 ' s Admission Record indicated the facility admitted the resident on [DATE] and readmitted on [DATE] with diagnoses including muscle weakness (generalized), morbid obesity, paraplegia, and cognitive communication deficit (difficulty paying attention to a conversation, staying on topic, remembering information, responding accurately, understanding jokes, or following directions). A review of Resident 3 ' s Care plan, developed on [DATE], for the resident ' s risk for skin breakdown with interventions for LALM for wound skin maintenance and history of pressure injury, indicated staff will monitor proper setting and functioning of the LAL, every shift. A review of Resident 3 ' s Care plan, developed on [DATE] and revised on [DATE], for the resident ' s generalized weakness with decline in overall activities of daily living (ADL) performance skill and physical status with impaired cognition and communication skills included interventions for Resident 3 to provide resident with total assist of one person for bed mobility (how resident moves to and from lying position, turns side or side, and. positions body while in bed or alternate sleep furniture). (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of Resident 3 ' s Order Summary Report, dated [DATE], indicated aspirin (medication to prevent blood clot) oral tablet chewable 81 milligrams (mg - a unit of measurement) 1 tablet via gastrostomy tube (g-tube- a tube inserted through the wall of the abdomen directly into the stomach. It allows air and fluid to leave the stomach and can be used for feeding and nutrition administration) one time a day for cerebrovascular accident (CVA, medical condition that occurs when blood flow to the brain is suddenly cut off) prophylaxis (an attempt to prevent disease). A review of Resident 3 ' s History and Physical, dated [DATE], indicated Resident 3 did not have the capacity to understand and make decisions. A review of Resident 3 ' s Order Summary Report, dated [DATE], indicated low air loss mattress to bed every shift for skin maintenance and history of pressure injury with setting at 300 (pounds), and to check settings and functions every shift. A review of Resident 3 ' s MDS, dated [DATE], indicated Resident 3 was able to understand and be understood. The MDS indicated Resident 3 was dependent assist on staff for eating, oral hygiene, toileting, showering, upper and lower body dressing, rolling left and right, and personal hygiene. The MDS indicated Resident 3 weighed 250 pounds. The MDS indicated Resident 3 had impairment on both sides for upper extremity (shoulder, elbow, wrist, and hand) and lower extremity (hip, knee, ankle, and foot). A review of Resident 3 ' s weight, dated [DATE], indicated Resident 3 weighed 252 lbs. A Review of Resident 3 ' s vital signs (measurements of the body's most basic functions), dated [DATE] at 8:40 p.m., indicated a blood pressure (BP - the force of your blood pushing against the walls of your arteries and the normal BP for adults is a systolic pressure [upper number] of less than 120 and a diastolic pressure [lower number] of less than 80) of ,d+[DATE] millimeters of mercury (mmHg - unit of measurement), and heart rate (the number of times the heart beats within a minute and the normal resting heart rate for adults ranges from 60 to 100 beats per minute or bpm) of 75 bpm. A review of Resident 3 ' s Situational Background Appearance and Review (SBAR - a written communication tool that helps provide essential, concise information, usually during crucial situations) Communication Form, dated [DATE], indicated that around 9:50 p.m., Licensed Vocational Nurse (LVN 1) called Registered Nurse (RN 1) to assess Resident 3 who had a fall. Resident 3 was noted on the floor head turned to the side. The SBAR indicated Resident 3 was conscious and minimally responsive. The SBAR indicated Code blue (emergency code that indicates a patient is experiencing a life-threatening medical emergency) was called, and code status was verified as Do not attempt Resuscitation (DNR- a legal document that means a person has decided not to have cardiopulmonary resuscitation [CPR- giving strong, rapid pushes to the chest to keep blood moving through the body] attempted on them if their heart or breathing stop). Resident 3 was immobilized and 911 (the telephone number to call for emergency services) was called due to possible head injury. The SBAR indicated when the paramedics arrived, Resident 3 lost consciousness completely. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of Resident 3 ' s Los Angeles Fire Department (LAFD- an organization that provides fire prevention and fire suppression services as well as other rescue services) Patient Care Report dated [DATE] at 10:04 p. m. indicated the paramedics were notified at 10:04 p.m. and were on scene at 10:10 p.m. The report indicated at 10:13 p.m. Resident 3 was laying supine (a person lying on their back with their face and torso pointing up) on the ground in the room of the nursing home. The report indicated facility ' s staff stated they heard a thud (a loud, dull sound) and Resident 3 was found on the floor with blood next to her head and 911 was called, approximately 20 minutes after Resident 3 was observed on the floor. The report indicated Resident 3 was laying supine (lying on the back with the face and torso pointing up) on ground naked with approximately 3-inch laceration to left eyebrow and approximately 1 liter of blood next to her head. The report indicated Resident 3 ' s head was approximately 18 inches from the wall, and she was laying in the middle of the room. The report indicated Resident 3 ' s bed was pushed out of way and was elevated approximately 24 to 36 inches (2 to 3 feet) off the ground with all side rails down. The report indicated Resident 3 was pulseless and apneic (a temporary and involuntary stop in breathing) and CPR was started. The report indicated a staff stated Resident 3 was DNR, but the paramedics continued while Resident 3 ' s code status was verified. The report indicated staff took approximately 5 minutes to provide documentation of DNR, CPR was discontinued, and Resident 3 was declared dead at 10:21 p.m. A Review of Resident 3 ' s Skin check, dated [DATE] at 10:37p.m., indicated 1.5-inch skin tear to left upper eyebrow. During an interview on [DATE] at 11:15 a.m., Resident 5, who was Resident 3 ' s roommate and who was present when Resident 3 fell , stated on [DATE] at around 10 p.m., one staff (CNA 1) attempted to change Resident 3 ' s incontinent brief. Resident 5 stated the curtain between both beds was closed but she heard Resident 3 fall off the bed. Resident 5 stated the staff (CNA 1) rolled Resident 3 to change her incontinent brief. Resident 5 stated there was only one staff assisting Resident 3. Resident 5 stated Resident 3 ' s bed only had one upper small siderail and (provide cushioned landing surface and reduce the likelihood of injury) next to Resident 3 ' s bed. Resident 5 stated Resident 3 fell on her face, near Resident 5 ' s bed. During an interview on [DATE] at 12:14 p.m. with CNA 1, CNA 1 stated that around 9:30 p.m., on [DATE] she was about to provide care to Resident 3, and while standing on Resident 3 ' s right side, she elevated the resident ' s bed to the level of her waist high. CNA 1 stated she (CNA 1) was six feet tall, and the bed may have been about three feet off the ground. CNA 1 stated Resident 3 was lying on her back, and she rolled Resident 3 onto her left side, placed Resident 3 ' s hand on the handrail with CNA 1 ' s hands on Resident 3 ' s hip. CNA 1 stated she rolled the draw sheet under Resident 3, opened the incontinence brief tab (undergarment designed to absorb urine and it can be fastened at the hip), took the left hand off Resident 3 and Resident 3 let go of the handrail and fell face down. CNA 1 stated she did not request assistance from another staff before performing care and did not change the pressure on Resident 3 ' s LAL. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 12:32 p.m., LVN 1 stated Resident 3 is bed-bound, alert and oriented to self (able to correctly identify self). LVN 1 stated that on [DATE] around 9:30 to 9:45p.m. she was passing out medications when CNA 1 came out running stating Resident 3 fell on the floor. LVN 1 stated she stopped what she was doing and ran into Resident 3 ' s room. Resident 3 ' s bed was pushed back but the bed was locked. Resident 3 was on the floor with the face down near Resident 5 ' s bed. LVN 1 stated there was no landing mat and Resident 3 was making a noise like she (Resident 3) was trying to breathe. LVN 1 stated she turned Resident 3 and noted Resident 3 with a cut on the left eyebrow with blood. LVN 1 stated Resident 3 ' s bed was too high, possibly three feet off the ground. LVN 1 stated Resident 3 required two staff or 3 staff depending on how small the staff was, for care. During a concurrent interview and record review on [DATE] at 2:47 p.m., with Registered Nurse (RN 2), Resident 3 ' s MDS dated [DATE] and care plan for generalized weakness dated [DATE], were reviewed. RN 2 stated based on the MDS, Resident 3 needed a 2-person assistance when providing care. RN 2 stated the care plan indicated Resident 3 required a one-person assist which was not accurate based on the MDS. RN 2 stated if MDS was not accurate, the plan of care will also not be accurate. RN 2 stated it place the resident at risk of improper care. During an interview on [DATE] at 3:29 p.m., with the DON, the DON stated Resident 3 ' s care plan for generalized weakness did not correlate with the MDS dated [DATE] because the MDS indicated Resident 3 was dependent and/or needed two-person assist. The DON stated Resident 3 would have benefited with a two-person assistance due to Resident 3 ' s diagnosis of left sided weakness. During an interview on [DATE] at 10:08a.m., CNA 1 stated Resident 3 had a LALM, and it was on static mode. CNA 1 stated she was told not to touch the LALM settings because it was set specifically per resident. CNA 1 stated she never called any nurse to change the LALM settings because she was told not to touch it. CNA 1 stated she had never had a nurse change the LALM setting when doing care for Resident 3 since she was hired on [DATE]. During an interview on [DATE] at 10:13 a.m., LVN 1 stated Resident 3 had an LALM which was already set. LVN 1 stated one just needed to keep an eye on it to make sure the setting was correct, the mattress had no holes, and that it was plugged. LVN 1 stated during ADLs, the LALM setting did not need to be changed. During an interview on [DATE] at 10:48 a.m., Treatment Nurse (TN 1) stated Resident 3 had a LALM. TN 1 stated when doing any ADLs care, the LALM setting must be changed into static mode so that it no longer alternates pressure and was firm to do ADLs. TN 1 stated if LALM was not on static mode the LALM would move and inflate on one side and deflate the other. TN 1 stated the LVNs, and RNs were the ones to change the setting from 300 to static mode. During a concurrent interview and record review on [DATE] at 3:14 p.m., Resident 3 ' s LALM 1 was reviewed. The DON stated when a resident was on LALM (in general), the static mode was used when the resident was being cared for. The DON stated for Resident 3, CNA 1 needed to request a LVN or RN to change the setting from 300 lbs to static mode. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 4:22 p.m. with the DON stated care plans need to be resident-centered comprehensive and with goals that were re-assessed based on each resident ' s condition, and it was an interdisciplinary approach (a way of working where staff with different skills and expertise work together towards a common goal). The DON stated a care plan was used to guide the team that provided care for residents. The DON stated the care plan should include the specific manufacturer ' s guidelines on the resident ' s LALM because each manufacture ' s guideline was different. The DON stated if care plans were not resident centered it could staff would not provide the appropriate care to residents. A review of Med Aire Plus 10 ' Alternating Pressure and Low Air Loss Bariatric Mattress Replacement System User Manual, indicated static button is available to discontinue alternation therapy for patient transfer, caregiving, comfort, or preference. Static mode is pressed to set the system to static therapy mode. The system will revert to the previous set alternation mode after 120 minutes. A review of the current facility-provided policy and procedure titled, Safety of Residents, with last revised date of [DATE] indicated to provide a safe environment for resident and facility staff. A review of the current facility-provided policy and procedure titled, Care Planning Interdisciplinary Team, with last revised date of [DATE] indicated Interdisciplinary Team is responsible for the development of an individualized comprehensive care plan for each resident. A comprehensive care plan for each resident is developed within seven (7) days of completion of the comprehensive assessment (MDS).

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** 43878 Based on interview and record review, the facility failed to ensure one of six residents (Resident 3), who was dependent (helper does all the effort or the assistance of 2 or more helpers is required for the resident to complete the activity) on staff on personal hygiene with diagnosis of muscle weakness (generalized), morbid (severe) obesity (abnormal or excessive fat accumulation that presents a risk to health) and paraplegia (the inability to voluntarily move the lower parts of the body), was free from accidents, by failing to: 1. Provide Resident 3 with the needed two-person assistance when Certified Nursing Assistant 1 (CNA 1), with no assistance from another staff, was giving nursing care to Resident 3 on [DATE]. 2. Change the Resident 3 ' s Med Aire Plus 10 Alternating Pressure and Low Air Loss Bariatric Mattress (LALM, a type of medical mattress designed to reduce pressure on the skin, which helps prevent pressure injuries or bed sores [injuries to skin and underlying tissue resulting from prolonged pressure on the skin]) setting from the physician ' s order of 300 pounds (lbs - unit of measurement for weight) to static mode (the mattress provides a firm surface that makes it easier for the patient to transfer or reposition). As a result, Resident 3 fell while Certified Nursing Assistant (CNA 1), was providing nursing care to Resident 3, without assistance from another staff. Resident 3 sustained a laceration to the left eyebrow, had approximately 1 liter (L - unit of measurement) of blood next to Resident 3 ' s head and was pronounced dead by the paramedics (healthcare professionals trained to provide a wide range of emergency services) on [DATE] at 10:21 p.m., in the facility. On [DATE] at 4:31 p.m., while onsite at the facility, the State Survey Agency (SSA) called an Immediate Jeopardy (IJ - a situation in which the facility ' s noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident)) in the presence of the Administrator (ADM) and the Director of Nursing (DON) due to the facility ' s failure to ensure Resident 3 was free from accidents under 42 CFR S S483.25 (d) (1) (2) Accidents. On [DATE] at 3:33 p.m., the ADM and DON submitted an IJ Removal Plan (a detailed plan to address the IJ findings). While onsite at the facility, the SSA verified the IJ situation was no longer present and confirmed the facility ' s implementation of the IJ Removal Plan through observations, interviews, and record reviews, the SSA accepted the IJ Removal Plan and removed the IJ situation in the presence of the ADM and DON [DATE] at 4:15 p.m. The acceptable IJ Removal Plan included the following summarized actions: 1. On [DATE], the Director of Staff Development (DSD), Minimum Date Set (MDS) Nurse, and charge nurses reassessed all the residents ' turning/repositioning level of assistance by reviewing the MDS (a standardized assessment and care screening tool) to assure appropriate provision of activities of daily living (ADL) care. Five residents (names indicated in the list provided by the facility) were identified to require two-person assistance during ADL care. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. On [DATE], the DON conducted an order listing report of residents that had an order for LAL mattress and 23 residents (names indicated in the list provided by the facility) were identified. Five residents (names indicated in the list provided by the facility) with LAL mattress were identified to require two-person assist per MDS. 3.On [DATE], the Resource Nurse and the MDS Nurse reviewed the ADL care plans of the residents with LAL mattress that required two-person assist. Three residents (names indicated in the list provided by the facility) were identified to have discrepancy in the ADL care plan regarding level of assistance during care based on the MDS to assure appropriate provision of ADL care. On [DATE], the Resource Nurse and the MDS Nurse revised the care plans for the three residents that were identified with discrepancy of the ADL care plan. 4. On [DATE], the MDS resource and DON reviewed the ADL care plans for all residents to ensure accuracy in conjunction with the MDS. 5. Revisions for all resident ADL care plans were initiated on [DATE] to ensure proper identification and care planning for resident provision of ADL care including the five residents identified (names indicated in the list provided by the facility) to have orders for LAL mattresses and requiring two-person assist. 6. On [DATE], the DON and MDS Resource updated the care plan of 23 residents with LALM to indicate static button is available to discontinue alternation therapy (alleviates pressure points, improves blood circulation, and reduces risk of developing pressure injuries) for resident transfers, caregiving, comfort, or preference. 7. On [DATE], the MDS, Resource Nurse, and MDS Resource staff updated the ADL care plan of the residents identified to require two-person assist based on the provision of care determined through reviewing the MDS. 8. On [DATE], the DON provided an in-service to the MDS RN and Licensed Vocational Nurses (LVNs) on the accuracy of care planning with the emphasis of level of assistance during ADL care. 9. On [DATE], the DON initiated the Special Needs List Form which indicated the level of assistance during ADL care. On [DATE], the DON revised the Special Needs List Form to include a statement that the staff required for ADL care/transfers were minimal requirements, and to ask for additional assistance if needed to ensure patient safety. 10. On [DATE], the DSD initiated a re-education to RNs, LVNs, CNAs, and Rehab Staff emphasizing that the assistance needed on the special needs list are minimum information and emphasized that the staff should ask for additional assistance if needed to ensure patient safety. 11. On [DATE] the DON/Designee initiated an in-service to RNs, LVNs, CNAs and Rehab staff on Med-Aire Plus 10 Alternating Pressure and Low Air Loss Bariatric Mattress Replacement System and other types of LALM the information on the use of static button to discontinue alternation therapy for patient transfers, caregiving, comfort, or preference. (continued on next page)

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	056056	A. Building B. Wing	08/09/2024

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	12. On [DATE], the DON/Designee initiated an in-service to RNs, LVNs, CNAs and Rehab staff on other LAL mattress manufacturer's guidelines during patient transfers, caregiving, comfort, or preference. 13. On [DATE], the DSD provided an in-service over the phone to CNA 1 who was assigned to Resident 3 regarding ADL care to a resident with LALM. CNA 1 will be in-serviced in person at the beginning of her next shift. 14. On [DATE], the DON/Designee initiated an in-service to RNs, LVNs, CNAs and rehab staff on the Special Needs List Form which will be located at each nursing station. 15. On [DATE], the DSD provided an in-service over the phone to the assigned Licensed Nurse for Resident 3 addressing the need to set the button to static when ADL is provided. LVN will be in-serviced in person at the beginning of her next shift. 16. On [DATE], the DSD/Designee initiated an in-service to RNs, LVNs, CNAs, and Rehab Staff on providing the correct level of assistance when providing ADL Care. 17. On [DATE], the DON/Designee initiated competencies on providing ADL care for residents on LAL for CNAS, LVNs, RNs and rehab staff. 18. The Director of Nursing and/or Designee will review new admissions daily (Mondays to Fridays). The Director of Nursing and/or Designee will review the ADL care plan based on the information provided from the resident's MDS and the transfer Lift Evaluation assessment. The Director of Nursing and/or Designee will update the Special Needs List Form for accurate provision of ADL care. 19. The DSD/Designee will do random rounds daily (Mondays to Fridays) to ensure that the staff is adhering to the Special Needs List Form for residents that require two-person assist during ADL care using the ADL Audit Form. 20.The DSD/Designee will do random rounds daily (Monday to Friday) during ADL care to check if static mode is turned on during transfers, caregiving, comfort, or preference of the residents for residents on LALM. 21. The MDS and or Designee will review the accuracy of ADL care plan of residents on LAL mattress for three months. 22. The Director of Nursing and/or Designee will review the ADL Audit Form weekly and address any deficient findings. 23. The Director of Nursing and/or Designee will review the Low Air Loss Static Mode Audit weekly and address any deficient findings. 24. The Director of Nursing/Designee and or Administrator /Designee will be responsible for compliance. Findings will be reported to the Administrator and/or Designee who will then present and discuss the findings during Quality Assessment and Assurance (QAA) meetings for three months for any further recommendations and follow-up or until compliance is achieved. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Cross Reference with F656. Findings: A review of Resident 3 ' s Admission Record indicated the facility admitted the resident on [DATE] and readmitted on [DATE] with diagnoses including muscle weakness (generalized), morbid (severe) obesity (abnormal or excessive fat accumulation that presents a risk to health), paraplegia (the inability to voluntarily move the lower parts of the body), and cognitive communication deficit (difficulty paying attention to a conversation, staying on topic, remembering information, responding accurately, understanding jokes, or following directions). A review of Resident 3 ' s Care plan, developed on [DATE], for the resident ' s risk for skin breakdown with interventions for LAL mattress for wound skin maintenance and history of pressure injury, indicated staff will monitor proper setting and functioning of the LAL, every shift. A review of Resident 3 ' s Order Summary Report, dated [DATE], indicated aspirin (medication to prevent blood clots) oral tablet chewable 81 milligrams (mg - a unit of measurement) 1 tablet via gastrostomy tube (g-tube a tube inserted through the wall of the abdomen directly into the stomach. It allows air and fluid to leave the stomach and can be used to give drugs and liquids, including liquid food, to the patient) one time a day for CVA prophylaxis (an attempt to prevent disease). A review of Resident 3 ' s Order Summary Report, dated [DATE], indicated bilateral one-half side rails as an enabler (facilitates movement while on bed). A review of Resident 3 ' s History and Physical, dated [DATE], indicated Resident 3 did not have the capacity to understand and make decisions. A review of Resident 3 ' s Order Summary Report, dated [DATE], indicated low air loss mattress to bed every shift for skin maintenance and history of pressure injury with setting at 300 (pounds), and to check settings and functions every shift. A review of Resident 3 ' s MDS, dated [DATE], indicated Resident 3 was able to understand and be understood. The MDS indicated Resident 3 was dependent assist on staff for eating, oral hygiene, toileting, showering, upper and lower body dressing, rolling left and right, and personal hygiene. The MDS indicated Resident 3 weighed 250 pounds. The MDS indicated Resident 3 had impairment on both sides for upper extremity (shoulder, elbow, wrist, and hand) and lower extremity (hip, knee, ankle, and foot). A review of Resident 3 ' s weight, dated [DATE], indicated Resident 3 weighed 252 lbs. A Review of Resident 3 ' s vital signs (measurements of the body's most basic functions), dated [DATE] at 8:40 p.m., indicated a blood pressure (BP - the force of your blood pushing against the walls of your arteries and the normal BP for adults is a systolic pressure [upper number] of less than 120 and a diastolic pressure [lower number] of less than 80) of ,d+[DATE] millimeters of mercury (mmHg - unit of measurement), and heart rate (the number of times the heart beats within a minute and the normal resting heart rate for adults ranges from 60 to 100 beats per minute or bpm) of 75 bpm. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of Resident 3 ' s Situational Background Appearance and Review (SBAR - a written communication tool that helps provide essential, concise information, usually during crucial situations) Communication Form, dated [DATE], indicated that around 9:50 p.m., Licensed Vocational Nurse (LVN 1) called Registered Nurse (RN 1) to assess Resident 3 who had a fall. Resident 3 was noted on the floor head turned to the side. The SBAR indicated Resident 3 was conscious and minimally responsive. The SBAR indicated Code blue (emergency code that indicates a patient is experiencing a life-threatening medical emergency) was called, and code status was verified as Do not attempt Resuscitation (DNR- a legal document that means a person has decided not to have cardiopulmonary resuscitation [CPR- giving strong, rapid pushes to the chest to keep blood moving through the body] attempted on them if their heart or breathing stop). Resident 3 was immobilized and 911 (the telephone number to call for emergency services) was called due to possible head injury. The SBAR indicated when the paramedics arrived, Resident 3 lost consciousness completely. A review of Resident 3 ' s Los Angeles Fire Department (LAFD- an organization that provides fire prevention and fire suppression services as well as other rescue services) Patient Care Report dated [DATE] at 10:04 p. m. indicated the paramedics were notified at 10:04 p.m. and were on scene at 10:10 p.m. The report indicated at 10:13 p.m. Resident 3 was laying supine (a person lying on their back with their face and torso pointing up) on the ground in the room of the nursing home. The report indicated facility ' s staff stated they heard a thud and Resident 3 was found on the floor with blood next to his head and 911 was called, approximately 20 minutes after Resident 3 was observed on the floor. The report indicated Resident 3 was laying supine (lying on the back with the face and torso pointing up) on ground naked with approximately 3-inch laceration to left eyebrow and approximately 1 liter of blood next to his head. The report indicated Resident 3 ' s head was approximately 18 inches from the wall and he was laying in the middle of the room. The report indicated Resident 3 ' s bed was pushed out of way and was elevated approximately 24 to 36 inches (2 to 3 feet) off the ground with all side rails down. The report indicated Resident 3 was pulseless and apneic (a temporary and involuntary stop in breathing) and CPR was started. The report indicated a staff stated Resident 3 was DNR, but the paramedics continued while Resident 3 ' s code status was verified. The report indicated staff took approximately five minutes to provide documentation of DNR, CPR was discontinued, and Resident 3 was declared dead at 10:21 p.m. A Review of Resident 3 ' s Skin check, dated [DATE] at 10:37p.m., indicated 1.5-inch skin tear to left upper eyebrow. During an interview on [DATE] at 11:15 a.m., Resident 5, who was Resident 3 ' s roommate and who was present when Resident 3 fell , stated on [DATE] at around 10 p.m., one staff (CNA 1) attempted to change Resident 3 ' s incontinent brief. Resident 5 stated the curtain between both beds was closed but she heard Resident 3 fall off the bed. Resident 5 stated the staff (CNA 1) rolled Resident 3 to change her incontinent brief. Resident 5 stated there was only one staff assisting Resident 3. Resident 5 stated Resident 3 ' s bed only had one upper small siderail and Resident 3 ' s bed was at the highest level. Resident 5 stated there were no landing mats (provide cushioned landing surface and reduce the likelihood of injury) next to Resident 3 ' s bed. Resident 5 stated Resident 3 fell on her face, near Resident 5 ' s bed. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 12:14 p.m. with CNA 1, CNA 1 stated that around 9:30 p.m., on [DATE] she was about to provide care to Resident 3, and while standing Resident 3 ' s right side, she elevated the resident ' s bed to the level of her waist high. CNA 1 stated she (CNA 1) was six feet tall and the bed may have been about three feet off the ground. CNA 1 stated Resident 3 was lying on her back and she rolled Resident 3 onto her left side, placed Resident 3 ' s hand on the handrail with CNA 1 ' s hands on Resident 3 ' s hip. CNA 1 stated she rolled the draw sheet under Resident 3, opened incontinent brief tab (undergarment designed to absorb urine and it can be fastened at the hip), took left hand off Resident 3 and Resident 3 let go of the handrail and fell face down. CNA 1 stated she did not request assistance from another staff before performing care and did not change the pressure on Resident 3 ' s LAL. CNA 1 stated Resident 3 ' s legs went off the bed causing her to fall to the floor. CNA 1 stated Resident 3 was on the floor, no noise or movement came from Resident 3. CNA 1 stated she ran out of the door and saw Licensed Vocational Nurse 1 (LVN 1) and yelled code blue. CNA 1 stated Resident 3 landed on her face and next to Resident 5 ' s bed. CNA 1 stated LVN 1 came into Resident 3 ' room and CNA 2 came into the room and moved Resident 3 ' s bed towards Resident 5 ' s bed. CNA 1 stated LVNs and RNs came into Resident 3 ' s room to assist and she was told Resident 3 had passed away. During an interview on [DATE] at 12:32 p.m., LVN 1 stated Resident 3 is bed-bound, alert and oriented to self (able to correctly identify self). LVN 1 stated that on [DATE] around 9:30 to 9:45p.m. she was passing out medications when CNA 1 came out running stating Resident 3 fell on the floor. LVN 1 stated she stopped what she was doing and ran into Resident 3 ' s room. Resident 3 ' s bed was pushed back but the bed was locked. Resident 3 was on the floor with the face down near Resident 5 ' s bed. LVN 1 stated there was no landing mat and Resident 3 was making a noise like she (Resident 3) was trying to breathe. LVN 1 stated she turned Resident 3 and noted Resident 3 with a cut on the left eyebrow with blood. LVN 1 stated Resident 3 ' s bed was too high, possibly three feet off the ground. LVN 1 stated Resident 3 was a hospice (a program that provides comprehensive support and care for terminally ill residents and their families) resident. LVN 1 stated no CPR was done and she tried to talk and arouse Resident 3 but nothing worked. LVN 1 stated RN 1 came in and 911 was called, paramedics arrived within 3 minutes and took over. LVN 1 stated Resident 3 required 2 or 3 staff depending on how small the staff was, for care. During an interview on [DATE] at 1:06p.m. with RN 1, RN 1 stated on [DATE] around 9:50 p.m. she was in station 2 and heard a yell from CNA 1 asking for help in Resident 3 ' s room. RN 1 stated he ran to Resident 3 ' s room and observed Resident 3 on the floor face down. RN 1 stated there was blood on the floor and LVN 1 placed pressure on Resident 3 ' s face because Resident 3 had a laceration to the left upper eyebrow. RN 1 stated 911 was called. During a concurrent interview and record review on [DATE] at 2:47 p.m., with Registered Nurse (RN 2), Resident 3 ' s MDS dated [DATE] and care plan for generalized weakness dated [DATE], were reviewed. RN 2 stated based on the MDS, Resident 3 needed 2-person assistance when providing care. RN 2 stated the care plan indicated Resident 3 required a one-person assist which was not accurate based on the MDS. RN 2 stated if MDS was not accurate, the plan of care will also not be accurate. RN 2 stated it placed the resident at risk of improper care. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 3:29 p.m., with the DON, the DON stated Resident 3 ' s care plan for generalized weakness did not correlate with the MDS dated [DATE] because the MDS indicated Resident 3 was dependent and/or needed two-person assist. The DON stated Resident 3 had left side paraplegic (unable to make voluntarily muscle movements). The DON stated Resident 3 would have benefited with a 2-person assistance due to Resident 3 ' s diagnosis of left side weakness. During an interview on [DATE] at 10:08a.m., CNA 1 stated Resident 3 had a LAL mattress, and it was on static mode. CNA 1 stated she was told not to touch the LAL mattress settings because it was set specifically per resident. CNA 1 stated she never called any nurse to change the LAL mattress settings because she was told not to touch it. CNA 1 stated has never had a nurse change the LAL mattress setting when doing care for Resident 3 since she was hired on [DATE]. During an interview on [DATE] at 10:13 a.m., LVN 1 stated Resident 3 had an LALM which was already set. LVN 1 stated one just needed to keep an eye on it to make sure the setting was correct, the mattress had no holes, and that it was plugged. LVN 1 stated during ADLs, the LALM setting did not need to be changed. During an interview on [DATE] at 10:48 a.m., Treatment Nurse 1 (TN 1) stated Resident 3 had a LAL mattress. TN 1 stated that when doing any ADL care, the LAL mattress setting must be changed into static mode so that it no longer alternates pressure and is firm to do ADL. TN 1 stated if LAL is not on static mode the LAL mattress will move and will inflate one side and deflate the other. TN 1 stated the LVNs and RNs were the ones who can change the setting from 300 lbs to static mode. TN 1 stated they would have to manually change it back to 300 lbs if placed on static mode. During a concurrent interview and record review on [DATE] at 3:14 p.m., Resident 3 ' s LALM 1 was reviewed. The DON stated when a resident was on LALM (in general), the static mode was used when the resident was being cared for. The DON stated for Resident 3, CNA 1 needed to request a LVN or RN to change the setting from 300 lbs to static mode. During a concurrent interview and record review on [DATE] at 3:14 p.m., Resident 3 ' s LALM 1 was reviewed. The DON stated when a resident was on LALM (in general), the static mode was used when the resident was being cared for. The DON stated for Resident 3, CNA 1 needed to request a LVN or RN to change the setting from 300 lbs to static mode. A review of Med Aire Plus 10 ' Alternating Pressure and Low Air Loss Bariatric Mattress Replacement System User Manual, indicated static button is available to discontinue alternation therapy for patient transfer, caregiving, comfort, or preference. Static mode is pressed to set the system to static therapy mode. The system will revert to the previous set alternation mode after 120 minutes. A review of the current facility-provided policy and procedure titled, Safety of Residents, with last revised date of [DATE] indicated to provide a safe environment for resident and facility staff.