STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056144	A. Building B. Wing	10/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Huntington Park Nursing Center	6425 Miles Avenue Huntington Park, CA 90255

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 - Minimal harm or potential for actual harm 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** 44294 Based on interview, and record review, the facility failed to ensure a comprehensive, resident-centered care plan was developed for one of three sampled residents (Resident 1), who was admitted high risk for fall. This failure resulted in a total of three falls (2/20/2024, 3/25/2024 and 7/16/2024) within 5 months and had the potential to cause harm and injury to Resident 1. Findings: During a review of Resident 1 ' s Admission Record, the Admission Record indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including history of falls and muscle weakness. During a review of Resident 1 ' s Fall Risk assessment dated [DATE], the fall risk assessmentindicated Resident 1was admitted with history of falls. The fall risk assessment indicated Resident 1 had impaired gait (a person's manner of walking) and overestimates (misjudge) and was forgetful of limitations. The fall risk assessment indicated Resident 1 was a high fall risk. During a review of Resident 1 ' s care plan titled, At risk for falls and injuries related to history of falls, seizure disorder, dated 12/19/2023, the interventions indicated to assess toileting needs, physical (PT) and occupational therapy (OT) for fall/ safety management focusing on transfer, encourage use of call light, evaluate room for immediate safety needs, keep call light within reach and remind resident to use call light for assistance, keep environment clutter free, keep personal belongings within reach keep personal belongings within reach, observe for unsteady gait and balance, provide/reinforce use of non-skid footwear and provide safety cues. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1 ' s Situation, Background, Assessment, and Recommendation ([SBAR] a structured way to communicate to the care team about a resident ' s change in condition) dated 2/20/2024, the SBAR indicated Resident had an unwitnessed fall on 2/20/2024 at approximately 10:18 p.m. The SBAR indicated, Resident 1 stated he was attempting to get the remote control on his roommate ' s table to turn off his television. The SBAR indicated Resident 1 sustained a bump and abrasion on the back of his head. The SBAR indicated Resident 1 was sent to a general acute care hospital (GACH) for evaluation due to the bump on the head and Resident 1 was on blood thinner. The SBAR indicated Interdisciplinary Team ([IDT] group of healthcare professionals, including resident/ resident representative, working together to provide residents with needed care) recommendations to use non-skid footwear, remind to use the call light for assistance and continue with PT and OT for fall and safety management. During a review of GACH ' s Emergency Department (ED) computed tomography ([CT] diagnostic imaging procedure that uses x-rays and a computer to create detailed pictures of the inside of the body) of head/brain dated 2/20/2023, the result was negative of fracture or intracranial hemorrhage (internal bleeding). During a review of Resident 1 ' s Care plan titled At risk for falls and injuries related to history of falls, seizure disorder, [dated 12/19/2023] the interventions were updated on 2/22/2024 indicating to provide and reinforce the use of non-skid footwear. During a review of Resident 1 ' s SBAR dated 3/25/2024, the SBAR indicated Resident 1 had an unwitnessed or suspected fall (second fall) on 3/25/2024 at approximately 9 a.m. at an outside clinic. The SBAR indicated, the clinic receptionist noticed Resident 1 was not in his wheelchair. The SBAR indicated the receptionist stood up and saw Resident 1 was on the floor. The SBAR indicated the receptionist stated Resident 1 stated he was trying to walk. The SBAR indicated IDT recommendation was to provide and escort on all scheduled appointments to ensure safety and PT/ OT to focus on fall/ safety management. During a review of Resident 1 ' s History and Physical (H&P) dated 4/18/2024, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1 ' s Minimum Data Set ([MDS] a federally mandated resident assessment tool) dated 6/19/2024, the MDS indicated Resident could understand and be understood by others. The MDS indicated Resident 1 was dependent and required two or more person ' s assist with activities of daily living (ADLs) such as toileting hygiene, shower. The MDS indicated Resident 1 required partial/moderate assistance for dressing, personal hygiene, roll left and right, chair bed transfer, toilet transfer and walking 10 feet. The MDS indicated Resident 1 required supervision for oral hygiene, sit to lying, lying to sitting on the side of the bed, sit to stand. The MDS indicated Resident 1 was frequently incontinent of bowel and urine. During a review of Resident 1 ' s SBAR dated 7/16/2024, the SBAR indicated Resident 1 had an unwitnessed or suspected fall (third fall) on 7/16/2024 at approximately 12:15 p.m. The SBAR indicated Resident 1 was a self-ambulator. The SBAR indicated Resident did not activate (turn on) the call light. The SBAR indicated Resident 1 was alert and oriented, was found on the floor laying on his left side near the restroom. The SBAR indicated Resident 1 denied pain, had no bruising, able to move all extremities, able to get up with assistance with no facial grimacing. The SBAR indicated Resident 1 had redness on the left elbow and a skin tear on the left scapula (shoulder blade). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1 ' s IDT notes dated 7/16/2024, the IDT notes indicated x-ray (process of taking pictures of tissues and structures inside the body for diagnosis and treatment) of the cervical (back)/lumbosacral (lower back)/thoracic spine (middle back area) & left hip/humerus/femur (hip) was done and had no fractures (broken bone). The SBAR indicated upon facility ' s investigation at the time of incident on 7/16/2024, the floor was clean/dry, lighting adequate, non-skid footwear was in placed, call light was within reach but was not activated, wheelchair was appropriately locked and functioning well, & environment was clutter-free. The SBAR indicated Resident 1 stated he (Resident 1) got up from wheelchair to ambulate to the restroom without assistance & as he reached for the door handle, he lost balance & leaned toward the wall on the left side of his body as support and slid down onto the floor. The SBAR indicated Resident 1 denied hitting his head. During a review of Resident 1 ' s progress notes dated 7/17/2024 at 6:20 p.m., the progress notes indicated Resident 1 was transferred to GACH on 7/17/2024 at 9 p.m. due to a fall. The progress notes indicated Resident 1 had CT scan at GACH with no fracture, no dislocation and no soft tissue swelling. The progress notes indicated Resident 1 returned from GACH on 7/18/2024 at 9:11 a.m. The progress notes indicated Resident 1 was sent back to GACH on 7/19/2024 at 4:10 p.m. due to family ' s request for a Magnetic Resonance Imaging Test ([MRI] a medical imaging technique that uses a magnetic field and computer-generated radio waves to create detailed images of the organs and tissues in the body). The progress notes indicated Resident 1 was admitted to GACH for lumbar back pain. During a concurrent interview and record review on 10/15/2024 at 2:09 p.m., with Licensed Vocational Nurse (LVN 1), LVN 1 stated the care plan for Resident 1 did not indicate monitoring or supervising Resident 1. LVN 1 stated frequent visual check was very important for Resident 1 to ensure safety. During a concurrent record review and interview on 10/21/2024 at 10:37 a.m., with Director of Nursing (DON), the IDT dated 2/20/2024 was reviewed. The DON stated Resident 1 was admitted on [DATE], after a fall with trauma (a serious injury to the body that occurs suddenly due to violence or an accident) and loss of consciousness. The DON stated Resident 1 ' s care plan did not indicate interventions to monitor resident. The DON stated he did not think continuous monitoring could have prevented Resident 1 ' s multiple falls. During a review of the facility ' s policy and procedure (P&P) titled, Fall Prevention and Response, dated 8/2023, the P&P indicated each resident will be assessed for fall risk factors and will receive care and services in accordance with individualized level of risk to minimize the likelihood of falls. The P&P indicated the facility will assess each resident ' s individual fall risk factors and implement comprehensive, resident-centered fall prevention plans for each resident at risk for falls or with a recent history of falls. The P&P indicated the facility should identify and address potential for fall accidents, individual risk factors, need for supervision, care, and assistive devices. The P&P indicated, for residents identified with fall risk factors the facility will provide supervision and physical assistance in accordance with assessed needs. The P&P indicated, for very high-risk residents, the facility may consider implementing a routine rounding schedule during shift.