STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056174	A. Building B. Wing	04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mid-Wilshire Health Care Cntr	676 S. Bonnie Brae Street Los Angeles, CA 90057

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 0689 Level of Harm - 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 44309

Based on interview and record review, the facility failed to ensure one of two sampled residents (Resident 1), who had dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), a history of multiple falls, and was a high risk for falls, received the care and services necessary to prevent accidents and falls by failing to:

1. Implement facility's policy and procedure (P&P) titled Fall Prevention Program, to identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling.

2. Evaluate interventions for effectiveness and implement new interventions to prevent repeated fall incidents after Resident 1 fell on [DATE], 3/20/2024, and 4/17/2024.

3. Monitor the resident for the behavior of trying to get out of bed without assistance as per physician's order dated 11/10/2023.

As a result, Resident 1 had repeated fall incidents and on 4/17/2024 was found on the floor with a laceration (a deep cut or tear in the skin) to the right eyebrow requiring transfer to the General Acute Care Hospital 1 (GACH 1).

Findings:

A review of Resident 1's Admission Record indicated the facility admitted Resident 1 on 9/11/2023, with diagnoses including history of falling, dementia, lack of coordination and Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks).

A review of Resident 1's admission Fall Risk assessment dated [DATE], indicated the resident had a very high risk for potential for falls. The assessment indicated the resident had not had any falls 90 days to the assessment date. The assessment indicated the resident had adequate vision, was confined to bed (unable to get up from bed without assistance), did not use the call light (a device with a button or touch pads a resident uses to set off an alarm that flashes/rings to alert the facility staff the resident needs assistance) or the bathroom call cord reliably (in a way that can be trusted).

(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 0689 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 1's admission Risk for Falls Care Plan initiated on 9/11/2023, indicated Resident 1 had a history of falls prior to admission to the facility and the resident had dementia and Alzheimer's disease. The care plan goal for the resident was to have reduced occurrence of injury from falls for three months. The care plan interventions (specific care and services facility staff need to provide a resident to promote healing and prevent a worsening of a condition) to prevent falls were to monitor the resident`s whereabouts daily, help with transfers and ambulation, provide proper fitting shoes, provide safe and clutter free environment, and to keep the call light and personal items within the resident's reach. A review of Resident 1's History and Physical dated 9/14/2023, indicated the resident did not have the capacity to understand and make decisions due to dementia. A review of Resident 1`s Physician orders dated 11/10/2023, indicated facility staff was to monitor the resident for the behavior of trying to get out of bed without assistance every shift. A review of Resident 1's Situation, background, assessment, and recommendation (SBAR: a form that is a documentation of a complete assessment in response to a change in condition) Communication Form dated 12/7/2023, indicated the charge nurse found Resident 1 on the floor next to the bathroom door. The SBAR form indicated Resident 1 stated she went to the bathroom (on 12/7/2023) to void (urinate) and when she was returning to the bed, lost balance and fell on the floor. A review of Resident 1's Post Fall assessment dated [DATE], indicated Resident 1 was forgetful and confused, had impaired hearing, impaired judgment skills (the ability to make effective decisions), and impaired safety awareness. The post fall assessment indicated Resident 1 exhibited declined (lessening) cognitive skills, and loss of coordination due to Alzheimer's disease and dementia and was not using ambulation aid (walker, wheelchair) or appropriate footwear. A review of Resident 1's Fall Scene Investigation Report dated 12/7/2023, indicated Resident 1 lost her balance and was found on the floor in her room. The investigation report indicated Resident 1 refused help and tried to go to the bed from bathroom after voiding. A review of Resident 1's Interdisciplinary Team Summary and Recommendation (IDT, a team of health care professions, which include the facility's medical director, Director of Nursing [DON], social worker, registered nurse, and other staff as needed who work together to establish plans of care for residents) dated 12/7/2023, indicated the IDT team recommended the following: to instruct the resident not to get out of bed without assistance, monitor the residents behavior of trying to get out of bed without assistance every shift, apply floor mats (a small piece of strong material that covers and protects part of a floor and is designed to absorb impact and reduce the risk of injury) at bedside, place the resident on Falling Star Program (a fall prevention program, that focuses on promoting a safe environment and anticipating the patient's needs to prevent a fall) for three months, and offer toileting program (helping a resident ambulate to the toilet, scheduling regular bathroom trips to avoid accidents, or changing adult diapers). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 1's Risk for Falls Care Plan revised on 12/11/2023, indicated Resident 1 was found on the floor in front of the bathroom on 12/7/2023. The care plan indicated Resident 1 complained of pain to the left hip area. The care plan indicated the X-Ray (digital image of part of the body) results indicated no fracture. The care plan interventions indicated the resident was to be placed on the Falling Star program for three months, staff was to perform visual checks every hour for four (4) weeks, apply floor mats to the bedside, monitor for the behavior of trying to get out of bed, instruct the resident not to try to get out of bed without assistance, use the call light, keep the bed in the lowest position, and to start the resident on toileting program. The care plan intervention indicated Resident 1 refused toileting program on 12/13/2023. A review of Resident 1's Physical Therapy (PT- certain exercises, massages, and treatments that relieve pain and help you move better) Evaluation and Plan of Treatment dated 12/12/2023, indicated the resident was referred to PT due to falling. The evaluation form indicated Resident 1 presented with generalized weakness, incoordination (lack of coordination), and impaired balance resulting in overall decline with functional mobility skills. The evaluation form indicated Resident 1 required extensive assistance with task performance and was at risk for falls and immobility (unable to move). A review of Resident 1's Medication Administration Record (MAR) for the month of January 2024, indicated the resident did not demonstrate the behavior of trying to get out of bed during any shift in January 2024. A review of Resident 1's Occupational Therapy (OT-therapy that focuses on helping people do all the things that they want and need to do in their daily lives) Evaluation and Plan of Treatment dated 2/22/2024, indicated the resident demonstrated decreased safety and dynamic sitting/standing balance which placed the resident at risk for falling. A review of Resident 1's MAR for the month of February 2024, indicated the resident did not demonstrate behavior of trying to get out of bed during any shift in February 2024. A review of Resident 1's Minimum Data Set (MDS- standardized data collection tool used to assess cognitive status [brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions], functional status, and care needs) dated 3/7/2024, indicated the resident had severely impaired cognition. The MDS indicated the resident was dependent on facility staff for showering. The MDS indicated Resident 1 required maximum facility staff assistance with toileting hygiene, personal hygiene, lower body dressing, sit to stand (the ability to come to standing position from sitting in a chair, wheelchair and or on the side of the bed), and chair/bed to chair transfer (the ability to transfer to and from a bed to chair or wheelchair). The MDS indicated Resident 1 required partial/moderate assistance from facility staff with oral hygiene, upper body dressing, toilet transfer (the ability to get on and off a toilet or commode) and sit to lying (the ability to move from sitting on side of the bed to lying flat on the bed). A review of Resident 1's Quarterly Fall Risk assessment dated [DATE], indicated the resident was at a very high risk for potential falls. The fall risk assessment form indicated Resident 1 had 1-2 falls within the last 90 days prior to the assessment date (3/7/2024), displayed behaviors which placed the resident at risk for falls, had impaired safety awareness, had adequate vision, was incontinent (not able to control the flow of urine from the bladder or the escape of stool from the rectum), did not use call light or bathroom call cord reliably, and did not have adequate safety awareness to wait for help. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Mid-Wilshire Health Care Cntr		STREET ADDRESS, CITY, STATE, ZIP CODE 676 S. Bonnie Brae Street Los Angeles, CA 90057	

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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 - Actual harm Residents Affected - Few	A review of Resident 1's Incident Report dated 3/20/2024, indicated Certified Nursing Assistant (CNA-unnamed) reported she heard sounds (on 3/20/2024) coming from Resident 1's room. Upon entering, CNA (unnamed) found Resident 1 on the floor next to her bed. A review of Resident 1's SBAR Communication Forms for 3/20/2024, indicated no SBAR communication form was documented by licensed staff after Resident 1 fell on [DATE]. A review of Resident 1's Fall Morse assessment dated [DATE], indicated the resident had fallen previously, had impaired gait, and overestimated (think they are stronger than they really are) or forgot her limits. The fall assessment did not indicate whether Resident 1 was considered a high risk for fall or not. A review of Resident 1's Post Fall assessment dated [DATE], indicated Resident 1 was forgetful and confused, exhibited loss of coordination due to Alzheimer's disease and dementia, had impaired safety awareness and hearing, and was not using ambulation aid (walker, wheelchair) and appropriate footwear. A review of Resident 1's Fall Scene Investigation Report dated 3/20/2024, indicated Resident 1 lost her balance and strength and was found on the floor in her room. The investigation report further indicated Resident 1 stated she was trying to go to bathroom. A review of Resident 1's IDT Summary and Recommendation dated 3/20/2024, indicated the following recommendations: remind resident to use the call light when assistance needed, instruct the resident not to get out of bed without assistance, monitor behavior of trying to get out of bed without assistance every shift, apply floor mats at bedside, keep the resident`s bed in the lowest position, answer the call light in timely manner, provide frequent visual checks, and to offer toileting program. A review of Resident 1's Actual Fall Care Plan initiated on 3/25/2024, indicated on 3/20/2024 at 7:35 PM, Resident 1 was observed on the floor at the bedside. The care plan indicated the resident stated she lost her balance and fell on the floor while trying to go to the restroom by herself. The care plan indicated a goal for the resident was to minimize episodes of falls or injury within the next 30 days. The care plan interventions were to anticipate and meet the resident`s needs, place the call light within his reach, encourage the resident to use the call light for assistance as needed, educate and remind the resident to request assistance prior to transfer/ambulation, conduct frequent visual checks, keep her bed in a low position, monitor her behavior of trying to get out bed without assistance, and to provide non-skid (designed to prevent sliding), proper fitting socks/shoes as indicated. A review of Resident 1's SBAR Form dated 4/17/2024, indicated the resident had a fall on 4/17/2024 with a laceration to the right eyebrow with moderate bleeding and pain. The SBAR communication form indicated Resident 1`s physician ordered to transfer the resident to GACH 1. A review of Resident 1's Fall Morse assessment dated [DATE], indicated the resident had fallen previously, had weak gait, and overestimated or forgot her limits. The fall assessment did not indicate whether Resident 1 was considered a high risk for fall or not. A review of Resident 1's Post Fall assessment dated [DATE], indicated Resident 1 had diagnoses of dementia and Alzheimer's, and incontinence, was forgetful and confused, exhibited declined cognitive skills and a loss of coordination due to Alzheimer's disease and dementia, had impaired safety awareness, judgment skills and hearing. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 1's IDT Summary and Recommendation dated 4/17/2024, indicated the following recommendation: Rehabilitation services as needed, continue to monitor behavior of trying to get out of bed without assistance, remind the resident to use the call light when assistance needed, visual checks every hour for three months, and to instruct the resident not to get out of bed without assistance. A review of Resident 1's GACH 1 Emergency Department (ED) Summary of Care dated 4/18/2024 at 4:23 AM, indicated the resident was sent to ED for head injury and laceration to right eyebrow which was treated in the ED. A review of Resident 1' MAR for the month of April 2024, indicated the resident did not display the behavior of trying to get out of bed during any shift in April 2024. During a concurrent observation and interview on 4/22/2024 at 9:10AM, inside Resident 1's room, observed Resident 1 laying in her bed. Resident 1 had a dressing over her right eyebrow. The Certified Nursing Assistant 1 (CNA1) present at Resident 1's bedside stated Resident 1 was confused and was trying to get out of bed. During an interview on 4/22/2024 at 9:30AM, Licensed Vocational Nurse 1 (LVN1) stated Resident 1 was forgetful and confused. LVN1 stated Resident 1 was not able to walk independently and required assistance with walking. LVN1 stated She [Resident 1] tried to get up on her own. Today [4/22/2024] she did not get up without assistance and she was calm. She [Resident 1] said, 'I want to go outside, or I want to go see my son or go to the restroom'. She cannot walk on her own. LVN1 stated Resident 1 was at high risk for falling. LVN1 stated [Resident 1] fell ,d+[DATE] times in the facility. We were monitoring her every two hours and sometimes every hour. However, there were times that charge nurses and CNAs were busy and could not check the residents often. LVN1 stated there is no bed alarm (pressure-sensitive alarms go off when a resident gets up) on Resident 1's bed. We did not try to put the alarm. Some residents do not like the alarm. During an interview on 4/22/2024 at 10:05AM, the Registered Nurse Supervisor 1 (RN1) stated Resident 1 was not alert, was confused, and sometimes what the resident said did not make sense. RN1 stated Resident 1 fell on [DATE], suffered an injury to the right forehead, and was sent to ER. RN1 stated She [Resident 1] got out of bed on her own. RN1 stated [Resident 1] tries to get out of bed. Sometimes she sits on the edge of her bed. She does not use the call light. She does not call for help. During a concurrent interview and record review on 4/22/2024 at 10:15 AM with RN1, Resident 1's Fall incidents care plans and SBAR Communication forms for fall incidents were reviewed. RN1 stated RN1 stated Resident 1 was non-compliant (not doing what someone asks you to do) with seeking assistance and did not use the call light. RN1 stated licensed staff did not initiate a care plan with person-centered interventions for Resident 1's non-compliance with calling for help. RN1 stated [Resident 1's] care plan for fall interventions were not revised properly after each fall and it appears that the same interventions are implemented for the resident over and over after each fall. It seems like these interventions are not effective because Resident 1 fell and had an injury on 4/17/2024. Resident 1 needs different care plan interventions for fall to prevent her from falling. We could have placed an alarm on her bed to notify the staff when she tried to get out of her bed. RN1 stated The DON said bed alarm is considered a restraint (controlling the actions or behavior of someone by force). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review of Resident 1's MAR for January, February, and April 2024 on 4/22/2024 at 10:35AM, RN1 reviewed the MARs and stated the licensed staff documented there were no incidents of Resident 1 trying to get out of bed for the months of January, February, and April 2024. RN1 stated the documentations were not accurate because Resident 1 did in fact attempt to get out of bed on numerous occasions. RN1 stated the staff did not document correctly and did not indicate the number of times Resident 1 tried to get out of bed. RN1 stated Resident 1 got out of bed and had a fall on 4/17/2024, However the documentation did not reflect the attempt to get out of bed which led to the fall on 4/17/2024. During an interview on 4/22/2024 at 12:56 PM, the Director of Staff Development (DSD) stated, On 4/17/2024 around 7:30 PM, I was at the nursing station when we heard a scream. We went inside [Resident 1's] room and found her on her floor laying on her right side. We noticed a laceration to [Resident 1`s] right eyebrow which was bleeding. We could not stop the bleeding and perform treatment to her right eyebrow ourselves, so we called the physician and received an order to transfer her to the hospital. The DSD stated Resident 1 was transferred to GACH 1 on 4/17/2024 at 9 PM and returned to the facility on [DATE] at around 6 AM. The DSD stated on 3/20/2024 Resident 1 had another episode of fall. The DSD stated I have seen Korean nurses communicating with [Resident 1]. However, she is unable to retain any information and she has episodes of confusion. I don't know if she would be able to remember educations about using the call light or asking the staff to assist her when she wants to go to the bathroom or get out of bed. During a concurrent interview and record review on 4/22/2024 at 1:15 PM with DSD, Resident 1's fall incidents care plans were reviewed. The DSD stated, [Resident 1`s] fall care plan interventions are the same for all fall incidents. The intervention to instruct the resident to call for assistance is not effective for [Resident 1] because she is forgetful. The DSD stated Resident 1 was non-compliment in using the call light to ask for help. The DSD stated educating Resident 1 to use a call light for help was not an effective intervention because the resident was confused and forgetful. The DSD stated licensed staff did not develop any care plan for Resident 1's non-compliance with asking for assistance. The DSD stated licensed staff were required to develop person centered care plans with resident specific interventions. The DSD stated Resident 1`s fall care plan interventions were not person-centered, and the potential outcome was recurrent falls and injures. The DSD stated bed alarm could be an intervention for [Resident 1]. During an interview on 4/22/2024 at 2 PM, RN2 stated Resident 1 tried to get out of bed and had history of several falls in the facility. RN2 stated Resident who has a behavior of trying to get out of bed, we require CNAs to stay in front of the resident`s room. We asked them to watch the resident frequently. RN2 stated staff were conducting frequent visual checks for Resident 1. However, it seemed like frequent visual monitoring did not work for Resident 1. RN2 stated Resident 1 was unable to remember facility staff instructions to call for assistance. RN2 stated [Resident 1] did not have a bed alarm. Previously, we had an intervention to assign a sitter for high risk for fall residents. It might be an appropriate intervention to prevent [Resident 1] from falling. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review on 4/22/2024 at 2:10 PM, RN2 reviewed Resident 1's fall incidents care plans. RN2 stated licensed staff did not evaluate the effectiveness of the care plan interventions to prevent falls for Resident 1. RN2 stated care plan interventions were not revised and updated effectively for Resident 1 after each fall. RN2 stated licensed nurses were required to revise and update care plan interventions for each resident after each fall. RN2 stated licensed nurses were required to evaluate the effectiveness of care plan interventions and change the interventions if ineffective. RN2 stated the potential outcome of not developing person-centered fall care plan interventions were the risk of recurrent falls and injuries. A review of the facility`s policy and procedure titled Fall Prevention Program, reviewed June 2023, indicated the facility will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. If the resident is at risk for falls, it will be identified on the care plan. All precautions will be implemented to protect the resident according to the fall prevention and reduction program. Care plan interventions should include the treatment prescribed by the physician and interdisciplinary recommendations, if any. A resident's condition and the effectiveness of the plan of care interventions will be evaluated if revisions are necessary to justify for continuing the existing plan based upon the outcome and/or effects of goals and interventions. A review of the facility`s policy and procedures (P&P) titled Fall Prevention Interventions, dated December 2016, indicated residents who were scored high risk on Morse Fall Scale were required to be reassessed after each episode of fall and their current care plan interventions were required to be evaluated for effectiveness and revised if ineffective. The P&P indicated the significant decline in the use of mechanical and chemical restrains to prevent high risk residents' falls had stimulated the proliferation (rapid growth/development) of bed alarm systems which were designed to warn nursing staff if a resident was attempting to leave the bed unassisted. A review of the facility's P&P titled Falling Star Program revised 12/16/2020, indicated identify residents for potential repeated falls with fall risk assessment. Fall risk assessment is initiated upon admission, quarterly, when significant changes occur and when fall incidents occur.