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	06/24/2024

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** 48661 Based on observation, interview and record review, the facility failed to ensure one sampled resident (Resident 1), who had diagnosis of dementia (loss of cognitive functioning - thinking, remembering, and reasoning - to such an extent that the loss interferes with a person's daily life and activities), had history of fall, and was assessed as high risk for falls, received the care and services necessary to prevent accidents and falls by failing to: -Develop a comprehensive care plan for Resident 1's fall prevention, per the facility's policy and procedure (P&P) titled, Person Centered Plan of Care. -Frequently monitor Resident 1 and anticipate resident's needs to ensure the resident's safety to prevent fall accidents. As a result, on 6/8/2024 (two days after admission), Resident 1 was found on the floor, complaining of pain, and was transferred to the General Acute Care Hospital (GACH) where Resident 1 was diagnosed with a left femur fracture (broken thigh bone). The GACH recommended surgery. Findings: A review of Resident 1's Admission Record indicated the facility admitted the resident on 6/6/2024, with diagnoses including a history of falling, dementia, and osteoporosis (bone disease that develops when the structure and strength of the bone weakens). A review of Resident 1's Admission assessment dated [DATE], indicated the resident's Morse Fall Score (method of assessing a patient's likelihood of falling) was 75. A score of 45 or higher indicated Resident 1 was a high risk for falls. A review of the Activities of Daily Living Self Care Performance Deficit Care Plan dated 6/6/2024 indicated the resident had activity intolerance due to disease process of dementia. The care plan goal indicated Resident 1 would improve current level of function and the care plan interventions included the following: -Provide the resident with 1-2 staff for repositioning and turning in bed every two hours and as necessary. (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

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 09/27/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056174	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/24/2024

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F 0689

Level of Harm - Actual harm

Residents Affected - Few

-Provide the resident with total assistance for eating.

-To have a side rails 1/5 up per physician's order for safety during care provision, to assist with bed mobility, reposition every two hours and as necessary to avoid injury.

-Provide the resident with two staff for transferring.

A review of Resident 1's Nursing Progress Note dated 6/7/2024, indicated the resident was alert and oriented with periods of confusion and forgetfulness. The Nursing Progress Note indicated Resident 1 did not have any complaints of pain or discomfort.

According to a review of the medical record, Resident 1 did not have a care plan for falls developed and there was no documentation regarding monitoring Resident 1 for 6/7/2024.

A review of Resident 1's Situation, Background, Assessment, Recommendation (SBAR) Communication Form dated 6/8/2024 at 7:21 AM, indicated Resident 1 was observed sitting on the floor. The SBAR indicated Resident 1 complained of pain but refused pain medicine. The SBAR indicated Resident 1's bed was in the lowest position and a floor mat was placed at bedside. The SBAR indicated the family and physician were notified of the incident.

A review of Resident 1's Pain assessment dated [DATE] at 7:30 AM, indicated Resident 1's pain level was assessed as a three out of 10 for left knee pain, using the zero to 10 pain rating scale (zero equals no pain, and 10 equals the worst possible pain). The Pain Assessment indicated Resident 1's acceptable level of pain was a one.

According to a review of the Nursing Progress Note dated 6/8/2024 at 12:53 PM, Resident 1 had mild left knee pain with facial grimacing but refused pain medication. The Nursing Progress Note indicated Resident 1 was alert with confusion and a floor mat was ordered for safety.

A review of Resident 1's Nursing Progress Note dated 6/8/2024 at 10:33 PM, indicated Resident 1 continued to complain of pain on the left hip but stated the pain was tolerable and refused pain medication.

A review of the Minimum Data Set (MDS - a standardized assessment and care screening tool) dated 6/9/2024, indicated Resident 1 had severe cognitive impairment (problems with a person's ability to think, remember, and make decisions). The MDS indicated Resident 1 required substantial to maximal assistance of facility staff with toileting hygiene, rolling to the left and right side and sit to lying and lying to sitting on the side of the bed. The MDS indicated Resident 1 was dependent on facility staff for transfers and the fall history on admission was unable to be determined.

A review of Resident 1's Laboratory and Radiology Patient Report dated 6/9/2024 at 1:49 AM, indicated Resident 1 had a left subcapital impaction fracture (type of intracapsular fracture in the proximal femur, where the fracture line runs through the junction of the head and neck of the femur) with minimal callus (thickening of or a hard thickened area on skin or bark, and mild displacement (change in position). The Report indicated the joint (part of the body where two or more bones meet to allow movement) showed no dislocation (separation of two bones where they meet at a joint).

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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 SBAR dated 6/9/2024 at 6:55 AM, indicated Resident 1 had a left hip fracture and orders to transfer the resident to the GACH for further diagnosis and treatment was implemented. According to a review of the GACH History & Physical (H&P) dated 6/9/2024, Resident 1 was admitted for left hip pain and was noted to have a left hip fracture. The GACH H&P indicated Resident 1 was confused, disoriented, and complained of left hip pain. A review of Resident 1's GACH Computed Tomography (CT - diagnostic imaging procedure that uses a computer linked x-ray machine to create detailed images of the inside of the body) of the left hip, dated 6/10/2024, indicated Resident 1 had a subcapital fracture of the left femur (thigh bone) without significant displacement. A review of the GACH General Notes dated 6/10/2024, indicated Resident 1's legal guardian did not want the resident to have the recommended surgery. As a result, the surgery was canceled. A review of Resident 1's H&P dated 6/12/2024, indicated Resident 1 was unable to provide accurate history of medical issues and did not have medical decision-making capacity. During an observation on 6/24/2024 at 10:45 AM in Resident 1's room at the facility, Resident 1 was observed lying in bed, call light within reach, a mat to the right and left side of the bed, and the bed was in the lowest position. Resident 1 stated there was pain in the left hip but refused pain medication. During an interview on 6/24/2024 at 11:15 AM, Licensed Vocational Nurse (LVN) 1 stated Resident 1 was a high risk for falls and the facility should have been monitoring Resident 1 for the risk for falls more frequently, because the resident was confused. On 6/24/2024 at 2:19 PM, during a concurrent interview and record review with LVN 1, Resident 1's care plans were reviewed. LVN 1 stated Resident 1 did not have a care plan for a history of falls developed or implemented since admission on 6/6/2024 (over two weeks). LVN 1 stated there should have been a care plan developed and implemented so the facility could anticipate and plan accordingly to accommodate the residents needs to prevent falls. LVN 1 stated because there was a history of falls, that was a repeated issue and should have been assessed further to prevent harm to Resident 1. LVN 1 stated this incident could have been prevented. During a concurrent interview and record review on 6/24/2024 at 2:44 PM with the Director of Nursing (DON), Resident 1's care plans were reviewed. The DON stated because the resident had a history of falls, a care plan should have been developed and implemented upon admission to the facility, to prevent Resident 1 from another fall or injury. The DON stated the fall could have been prevented if a Fall care plan was developed with interventions such as frequent monitoring to prevent injury. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of the facility's policy and procedure (P&P) titled, Person Centered Plan of Care, dated June 2023, indicated the person-centered care plan must describe services that were provided to the resident to attain and maintain the resident's highest practicable physical, mental, and psychosocial well-being that would accommodate resident needs, request, and refusal to treatment. The P&P indicated the person-centered care plan would include interventions to attempt to manage risk factors and be periodically reviewed and revised by the Interdisciplinary Team as changes in the resident's care and treatment occur. The P&P indicated to re-evaluate and modify care plans as necessary to reflect changes in care, service, and treatment, quarterly, and with significant change in status assessment. Care plan evaluation must occur in response to changes in the resident's physical, emotional, functional, psychosocial, or communicative status as they occur. A review of the facility's P&P titled, Post Fall Management Program, dated June 2023, indicated the plan of care for each resident would be accelerated post fall, as indicated, to enhance the standard and medium to high preventative measures and decrease the risk of further falls in a manner that meets the individual needs of the resident. The P&P indicated to consider updating the plan to prevent repeat fall.