STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056244	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grand Park Convalescent Hospital	2312 West 8th 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 0744 Level of Harm - Actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50391 Based on interview and record review, the facility failed to ensure one of four sampled residents (Resident 1), who had diagnosis of dementia (a chronic condition that causes a gradual decline in cognitive abilities, such as thinking, remembering, and reasoning), had a history of falls, and was a high fall risk, was provided with the necessary care needs and services. The facility failed to: -Identify and develop an appropriate care plan for Resident 1's Dementia through an Interdisciplinary Team (IDT) approach, with appropriate interventions including implementation of individualized care and maximizing the resident's safety. -Implement the High Risk for Falls care plan dated 8/8/2024 to provide Resident 1 with a safe environment. -Provide Resident 1 with supervision for bed mobility (ability to move around in bed, such as rolling, scooting, or moving from sitting to lying), per the Activities of Daily Living (ADL) Self-Care Performance Deficit care plan related to Dementia dated 8/8/2024. As a result, on 10/8/2024, Resident 1 had a fall and was found on the floor in her room. On 10/9/2024, Resident 1 presented to the General Acute Care Hospital (GACH) with right leg swollen, minimal movement, and expressed pain. At the GACH, Resident 1 was diagnosed with a displaced right femur (thigh bone) and was placed under general anesthesia (uses drugs or other substances to temporarily induce a loss of feeling or awareness in a patient) for Open Reduction and Internal Fixation (ORIF -a type of surgery used to stabilize and repair broken bones, some form of hardware is used to hold the bone together so it can heal) surgery and required one unit blood transfusion. Findings: A review of Residents 1 admission record (face sheet) indicated the resident was initially admitted to the facility on [DATE] with diagnoses including syncope and collapse (fainting, a sudden loss of consciousness caused by a brief period of low blood pressure and inadequate blood flow to the brain. Collapse, also known as pseudo-syncope, a sudden loss of consciousness caused by other factors, such as a seizure or hypoglycemia [low blood sugar]), dementia, psychosis (a mental disorder, collection of symptoms that affect the mind, where there has been some loss of contact with reality), and abnormalities of gait and mobility. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0744 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 1's History and Physical report completed 1/18/2022, indicated the resident wandered around and had fluctuating capacity to understand and make decisions. A review of the Impaired Cognition care plan evidenced by Dementia and confused thoughts, dated 1/26/2023, indicated the interventions were to provide reality orientation, provide all necessary assistance and anticipate needs. A review of the Interdisciplinary Team (IDT - a coordinated group of experts from several different fields who work together toward a common resident goal) Post Event Note dated 6/24/2024, indicated the reason for the meeting was Resident 1 had a fall event on 6/24/2024 at 9:30 am. The IDT Note indicated the resident had Parkinson's disease (a chronic brain disorder that causes movement problems, shaking, difficulty with balance, stiffness), dementia, psychosis, was alert and oriented x1 with confusion. The IDT note indicated a charge nurse observed Resident 1 on the floor lying on his left side in front of the resident's room. Resident 1 was unable to verbalize what happened. The IDT note indicated Resident 1 had discoloration on the right cheek and left side of jaw and was transferred to the GACH. The root cause analysis indicated Resident 1 had unspecified dementia that interfered with daily functioning. According to a review of the Physician's Order Summary Report dated 6/27/2024, Resident 1 received Depakote (an antipsychotic medication, anticonvulsant) 125 milligrams (mg), two times a day for bipolar disorder (a serious mental illness that causes unusual shifts in mood, ranging from extreme high manic episodes to low depression episodes), psychosis manifested by resistant care, constant pacing. The Physician's Order Summary also indicated Resident 1 had a bed pad alarm to alert staff if resident tried to get up unassisted, as resident was a high risk for fall related to unsteady gait secondary to dementia. A review of the Nurses Notes dated 8/6/2024 indicated Resident 1 had unsteady gait and balance problems while sitting or standing. The Nurses Note under Behavior indicated that Resident 1 wanders and that Resident 1 had no behavior problems noted. This indicated a discrepancy. The Nurses Note indicated Resident 1 had no complaint of pain at this time, to anticipate needs due to history of fall, and to continue to attend rehab activities. The note indicated Resident 1's transfer to and from bed was extensive assist. A review of the Nurses Notes dated 8/7/2024 indicated Resident 1 had unsteady gait and balance problems while sitting or standing. The Note indicated under Behavior, that Resident 1 had no behavior problems noted. The Nurses Note indicated Resident 1 had no complaint of pain at this time, to anticipate needs due to history of fall, and to continue to attend rehab activities. The note indicated Resident 1's transfer to and from bed was extensive assist. A review of Resident 1's ADL Self-Care Performance Deficit care plan dated 8/8/2024, related to Dementia and Impaired Balance indicated the resident would maintain current level of function. The care plan interventions indicated the resident was able, with supervision, for bed mobility and eating. A review of Resident 1's High Risk for Falls care plan dated 8/8/2024, related to confusion, gait balance problems, and unaware of safety needs, indicated the resident would be free of falls. The care plan interventions indicated to anticipate and meet Resident 1's needs, resident needs prompt response to all requests for assistance, and that the resident needed a safe environment. (continued on next page)

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F 0744 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 1's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 8/9/2024, indicated the resident was severely impaired in cognitive skills for daily decision making (trouble concentrating, completing tasks, understanding, following instructions). The MDS indicated the resident required supervision or touching assistance when walking at least 10 feet in a room. According to a review of Resident 1's Fall Risk evaluation dated 8/8/2024, the resident had a history of falling, was disoriented x three times all day, and had a gait / balance problem while standing, walking and making turns. The Fall Risk Screen indicated Resident 1 was a high risk for falls with a score of 15 (a score of 10 or above indicated a resident was a high risk for falling). A review of Resident 1's Situation Background Assessment and Response form (SBAR) dated 10/8/2024 at 4:30 pm, indicated the resident was found on the floor of her room, with no grimacing or signs of discomfort, and no swelling or bruising, and was placed back in her bed. A review of the Physician's Order dated 10/9/2024 at 3:20 pm indicated to transfer Resident 1 to the GACH for further evaluation and treatment of right hip fracture and give a bed hold for 7 days. A review of Resident 1's GACH Emergency Department (ED) note dated 10/9/2024, indicated the resident presented from the skilled facility with right leg swollen, minimal movement, and expressed pain. The ED note indicated an X-ray was conducted of Resident 1's right femur (thigh bone) with the findings of an angulated intertrochanteric fracture (where the bone changes from vertical to a 45 degree angle) of the right femur with lesser trochanter avulsion (a rare injury that occurs when the iliopsoas muscle [a deep muscle group that connects the spine to the lower limbs] contracts forcefully, pulling away the attachment point on the lesser trochanter (a bony projection on the upper thigh bone that serves as an attachment point for the hip flexor muscles). A review of Resident 1's GACH Consultation Note dated 10/11/2024 indicated the history about the fall was unclear, but Resident 1 did have bruises about the body with an assumption of a fall. The consultation note indicated that due to the resident's fracture, surgery was recommended for pain control, early ambulation, and return to functional status. The GACH Operative Note dated 10/11/2024 indicated Resident 1 had right hip long cephalomedullary nail placement (a surgical procedure that treats thigh fractures, involves inserting a nail into the thigh) under general anesthesia. A review of the GACH Discharge Summary dated 10/15/2024 indicated Resident 1 required an Open Reduction and Internal Fixation (ORIF) surgery of the right femur. Resident 1 had acute blood loss related to the surgery and required one unit blood transfusion. During an interview on 10/21/2024, at 2:21 pm, Registered Nurse (RN) 1 stated she reviewed Resident 1's care plans but could not provide the measurable goals or interventions that addressed the resident's diagnosis of dementia. RN 1 was unable to provide documented evidence the licensed nursing staff identified and/or assessed specific details that placed an emphasis on supervision and safety from falls. During an interview on 10/22/2024 10:15 am, when asked if supervision was provided for Resident 1's bed mobility, CNA 1 stated staff usually walked the halls and checked often on the residents. CNA 1 stated the night of Resident 1's incident on 10/8/2024, she did not recall checking the resident's room or hearing an alarm going off, but the resident was discovered on the floor. (continued on next page)

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F 0744 Level of Harm - Actual harm Residents Affected - Few	On 10/22/2024, at 11:18 am, during an interview, the Director of Nursing (DON) stated the language used in care plans should be precise and easy to understand. After review of Resident 1's clinical record, the DON stated, I was not able to find any interventions on supervision for dementia care, of the resident (Resident 1). The DON stated the licensed nursing staff did not develop a care plan with measurable goals and interventions to address the care and services of Resident 1 with a diagnosis of dementia. During a concurrent interview and record review on 10/28/2024 at 10 am with the Assistant Director of Nursing (ADON), Resident 1's care plans were reviewed. The ADON stated and confirmed Resident 1 had dementia but did not have a dementia care plan with individualized interventions with emphasis on supervision. The ADON stated the resident's care plan should have had more clear language used, and individualized interventions that involve supervision for the resident. The ADON stated the resident was found on the floor in her room and could not say for certain if the fall could have been prevented. The ADON stated it was important to have a dementia care plan with goals and interventions to address Resident 1's behavior and ensure the resident was safe. The ADON stated there was a risk that the resident was not receiving care that was specific to her diagnosis of dementia. A review of the facility's revised policy dated January 2024 and titled, Dementia - Clinical Protocol, indicated for a resident with confirmed diagnosis of Dementia, the IDT would identify a resident - centered care plan to maximize remaining function and quality of life. The physician would evaluate residents with new or worsening cognitive impairment and behavior and differentiate dementia from other causes. The IDT would identify and document the resident's condition and level of support needed during care planning and review changing needs as they arise. A review of the facility's P&P titled, Falls and Fall risk, Managing, revised 1/19/2024, indicated fall is defined as unintentionally coming to rest on the ground, floor, or other lower level, but not as a result of an overwhelming external force (e.g. resident pushed another resident). The staff with the input of the physician would implement a resident centered fall prevention plan to reduce the specific factors of fall for each resident at risk or with a history of falls. The policy indicated if falls recur despite initial interventions staff would implement additional or different interventions or indicate why the current approach remains relevant. The staff would monitor each resident's response to interventions intended to reduce falling or the risk of falling. A review of the facility's revised policy titled, Care Planning - Interdisciplinary Team, indicated care planning / IDT was responsible for the development of an individualized comprehensive care plan for each resident.