STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056321	A. Building B. Wing	08/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Olympia Convalescent Hospital	1100 S. Alvarado St Los Angeles, CA 90006

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. (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

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 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide care and services to prevent an avoidable accident from occurring for one of three sampled residents (Resident 1) by failing to: 1. Ensure Restorative Nursing Assistant 1 (RNA 1-nursing aide program that helps residents maintain their function and joint mobility) implemented the Activities of Daily Living (ADL- include eating, dressing, getting into or out of a bed or chair) Care Plan to transfer Resident 1 from a shower chair (is an assistive device designed to help people who have limited mobility or physical strength when bathing) to the bed using a Hoyer lift (a mechanical device used to safely transfer individuals with limited mobility) on 7/26/2025 between 8 am to 9 am. 2. Ensure RNA1 provided two-person physical assistance (help from two person) to transfer Resident 1 from a shower chair to the bed on 7/26/2025 between 8 am to 9 am as indicated in the ADL Care Plan initiated on 6/9/2025. 3. Ensure RNA1 followed the facility policy and procedures (P&P) titled Transfer of Residents reviewed on 1/24/2025, to transfer Resident 1 from the shower chair to the bed on 7/26/2025 between 8 am to 9 am. On 7/26/2025 at 8:50 am, RNA 1 independently (by himself) transferred Resident 1 who was totally dependent (reliant on) on all ADLs including chair to bed transfer, Resident 1's left lower leg was caught inside the metal bed frame. As a result, on 7/26/2025 at 10:20 am, Resident 1 sustained a bluish discoloration (refers to any change in the natural skin tone), skin trauma (a physical injury caused by an external force or violence, or an event that causes significant mental or emotional damage), and slight swelling to left mid shin (front parts of the leg). The facility transferred Resident 1 to a general acute care hospital (GACH) for further evaluation, treatment, and was diagnosed with multiple broken bones of the left leg.Findings: During a record review, Resident 1's admission Record, the admission Record indicated the facility originally admitted the resident on 2/14/2025 and re-admitted on [DATE] with diagnoses that included hemiplegia (partial or total paralysis [extreme form of weakness and nerve dysfunction] and hemiparesis (weakness on one side of the body), reduced mobility (reduced ability to move freely), muscle weakness, lack of coordination (a lack of voluntary control and coordination of muscle movements), aphasia (inability to comprehend or formulate language), and a history of healed traumatic fracture. During a review of Resident 1's Care Plan Report initiated on 6/9/2025 indicated Resident 1 ADL self-care performance deficit related to activity intolerance, hemiplegia, impaired balance Care Plan, it indicated the resident (Resident 1) requires dependent assistance by two staff and Hoyer lift to move from chair to bed/bed to care. During a record review, Resident 1's History and Physical (H&P) dated 6/20/2025, indicated Resident 1 did not have the capacity to understand and make decisions. During a record review, Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 6/7/2025 indicated Resident 1's cognition (The mental ability to make decisions of daily living) was severely impaired. The MDS indicated Resident 1 was totally dependent for all activities of daily living (ADL - eating, oral hygiene, toileting hygiene, shower/bathing, upper and lower body dressing, putting on /taking off footwear, and personal hygiene), rolling left to right, moving from sitting to lying position, and vice versa and chair to bed transfer. The MDS further indicated Resident 1's ability to go up and down a curb and/or up and down one step was not attempted due to safety concerns. During a record review, Resident 1's Pain Assessment record dated 7/26/2025 at 9:05 am., indicated Resident 1 with left shin skin discoloration related to left leg stuck in bed frame, Resident 1 with acute (of sudden onset) aching pain of 3/10, and received Tylenol (medication used primarily to relieve mild to moderate pain) for pain During a record review, Resident 1's Change in Condition (COC- a sudden, clinically important deviation from a patient's baseline in physical, cognitive, behavioral, or functional domains) Evaluation record dated 7/26/2025 at 10:11 am, indicated Resident 1 had skin discoloration (refers to any change in the natural skin tone) on the left shin area with slight swelling and suffered mild pain of three out of 10 (3/10- numerical pain assessment tool where zero is no pain and 10 is severe pain). The COC indicated Resident 1 suffered bruising, swelling over joint or bone. The COC indicated that during transfer from shower chair to bed (Resident 1) became combative and move her legs and the left leg got stuck on the bed frame under the bed and sustained skin discoloration, slight swelling, and mild pain. The COC indicated a medical doctor (MD) was informed and a new order received for a stat (now) x-ray of the left knee, left shin, left fibula (the outer bone of the two bones in the lower part of the leg), and left tibia (the inner bone of the two bones in the lower part of the leg). During a record review, Resident 1's Skin Observation Checks record dated 7/26/2025 at 10:20 am, indicated first observation that Resident 1 had bluish discoloration, skin trauma (a physical injury