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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056377	A. Building B. Wing	03/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Rehabilitation Center on Pico	3233 W. Pico Boulevard Los Angeles, CA 90019

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 assure that services being provided meet professional standards of practice for two of three sampled residents (Resident 1 and Resident 2). For Resident 1, the facility failed to: a. Evaluate and analyze hazards and risks for Resident 1 who is had multiple falls. b. Monitor for the effectiveness and modify interventions for a resident who is a non-compliant. As a result, on 3/13/2024, Resident 1 had a fall from his wheelchair when attempted to transfer himself to his bed and was found on the floor. Resident 1 was transferred to GACH 1 via 911 and sustained a right ankle fracture. For Resident 2, who had severely impaired vision, the facility failed to: c. Complete an accurate Fall Risk Assessment on 9/4/2024. d. Evaluate and implement individualized, resident-centered interventions to reduce the risk of fall for Resident 2. As a result, on 3/16/2024, Resident 2 had a fall from her bed when she turned abruptly (in a sudden and unexpected way) to her left side and was found on the floor. Resident 2 was transferred to GACH 2 via 911 and sustained rib (a curved bone in a person's chest) fractures. Findings: A review of Resident 1's Admission Record (Face Sheet) indicated the facility originally admitted the resident on 11/29/2022, and readmitted on [DATE], with diagnoses including fall, cachexia (loss of body weight and muscle), and muscle weakness. A review of Resident 1's History and Physical dated 12/15/2023, indicated the resident had the capacity to understand and make decisions. (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 Situation-Background-Assessment and Recommendation (SBAR - a written communication tool that helps provide important information) Communication Form dated 1/2/2024, indicated the resident was found sitting on the bathroom floor with a skin tear at his right elbow. The SBAR indicated Resident 1 stated he hit the right side of his head. As a result, a 72- hour neuro-check was initiated. A review of Resident 1's Post Fall Evaluation/Interdisciplinary Team Review (IDT- a group of dedicated healthcare professionals who work together to provide you with the care you need, when you need it) dated 1/2/2024 at 3:57 PM, indicated Resident 1 had unsteady gait and generalized muscle weakness related to the aging process. The IDT Review indicated Resident 1 continued to perform activities beyond his ability and was not compliant with the requirement to call for assistance when using the toilet, despite being educated to do so. A review of Resident 1's Care Plan initiated on 1/2/2024, and resolved on 3/13/2024, indicated that Resident 1 had an actual fall due to poor balance and unsteady gait. The care plan goal for the resident was to resume usual activities minimizing the risk of injury until the next review date. The care plan interventions indicated to check Resident 1's range of motion, encourage the resident to use the bell to call for assistance, keep call lights with reach at all times, monitor/document/report as needed for 72 hours any signs/symptoms of pain, bruises, change in mental status, sleepiness, inability to maintain posture, neuro-checks for 72 hours as ordered, and to start Resident 1 on RNA ambulation (walking with Restorative Nursing Assistant-Assist residents with exercise to improve or maintain mobility and independence) for strength and mobility three times a week. A review of Resident 1's Physician's Progress Notes dated 2/1/2024, indicated the resident was non-compliant with care, did not call for assistance and wants to be independent beyond capacity. The notes indicated Resident 1 had recurrent (happening again) falls, and a diagnosis of osteoporosis (a disease that weakens your bones) which placed him at increased risk for recurrent fracture. A review of Resident 1's Minimum Data Set (MDS - a standardized assessment and care screening tool) dated 3/1/2024, indicated the resident had moderately impaired cognition (decisions poor, cues/supervision required) and required maximum assistance (helper does more than half the effort) with showering. The MDS indicated Resident 1 required partial/moderate assistance (helper does less than half the effort) with toileting hygiene, personal hygiene, dressing upper and lower body, sit to stand (the ability to come to standing position from sitting in a chair, wheelchair and or on the side of the bed), chair/bed to chair transfer (the ability to transfer to and from a bed to chair or wheelchair), and toilet transfer (the ability to get on and off a toilet or commode). A review of Resident 1's SBAR Communication Form dated 3/5/2024, indicated Resident 1 had an assisted fall (when a staff member was with the patient and attempted to minimize the impact of the fall) and was found on the floor with a skin tear at his right elbow and forearm. A review of Resident 1's Fall Risk Evaluation after fall, dated 3/6/2024, indicated a total score of 10. The fall risk evaluation form indicated that if the total score was 10 or greater, the resident should be considered at high risk for potential falls. The form indicated Resident 1 was oriented to person, place, and time, had one to two falls within the last three months, had adequate vision, had balance problem while standing/walking, and had 1-2 predisposing conditions (conditions and activities that can lead to the development of disease). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of the Physical Therapy (PT) Evaluation and Plan of Treatment dated 3/6/2024, indicated Resident 1 was presented to therapy due to repeated falls in the facility with the most recent occurring on 3/5/2024. The PT evaluation form indicated Resident 1 had soreness to the right shoulder and left hip, the X-ray was negative for fracture and had decreased strength and safety awareness. A review of Resident 1's Post Fall Evaluation/IDT Review dated 3/7/2024 at 12:21 PM, indicated the lost his balance while standing up and using urinal and was assisted to the floor by Certified Nursing Assistant (CNA) staff. The IDT Review indicated Resident 1 had episodes of confusion and forgetfulness and required partial to moderate assistance (helper does less than half the effort) with transfers from his bed to his wheelchair and vice versa (with the order changed). The IDT Review indicated the facility would place a floor mat on the left side of the bed to minimize injury in case of a fall. A review of Resident 1's Care Plan initiated on 3/10/2024, indicated the resident had an assisted fall due to loss of balance while using urinal. The care plan goal for the resident was to resume usual activities minimizing the risk of injury until the next review date. The care plan interventions indicated to assess for pain every shift and medicate as needed, check Resident 1's range of motion, encourage the resident to use the bell to call for assistance, keep call lights with reach at all times, monitor/document/report as needed for 72 hours any signs/symptoms of pain, bruises, change in mental status, sleepiness, inability to maintain posture, place a floor mat on left side of the bed to minimize injury in case of fall reoccurrence and to provide skilled PT and Occupational Therapy (OT-therapy that focuses on helping people do all the things that they want and need to do in their daily lives). A review of Resident 1's Physical Therapy Treatment Encounter Notes dated 3/12/2024, indicated the resident reported pain in his left knee, had difficulty standing due to pain and required moderate verbal and tactile (using the sense of touch) cues (signals) to facilitate proper posture and movement during the treatment. A review of Resident 1's Care Plans initiated before 3/13/2024, did not indicate any care plans developed for Resident 1 regarding his non-compliance with care and calling staff for assistance. A review of Resident 1's SBAR Communication Form dated 3/13/2024, indicated the resident fell from his wheelchair, was heard calling for help. The CNA went inside the resident's room and found Resident 1 on the floor mat, on the left side of his bed. The SBAR form further indicated Resident 1's ankle looked dislocated, and he was transferred to GACH 1 for further evaluation. The SBAR form indicated Resident 1 was trying to transfer himself into his bed without staff assistance and he was non-compliant and not using the call light for assistance. A review of Resident 1's Fall Risk Evaluation after fall, dated 3/13/2024, indicated a total score of 11, and that 10 or greater, the resident should be considered at high risk for potential falls. The form indicated Resident 1 was oriented to person, place, and time, had three or more falls within the last three months, had adequate vision, had balance problem while standing/walking, required use of assistive devices and had 1-2 predisposing conditions. A review of Resident 1's Rehabilitation Screening Form dated 3/13/2024, indicated the resident had a history of falls in the past years with the most recent fall on 3/5/2024. The form indicated Resident 1 was currently on skilled therapy. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 1's Post Fall Evaluation/IDT Review dated 3/13/2024 at 4:10 PM, indicated the resident had possible dislocated right ankle, had difficulty walking, osteoporosis, and generalized muscular weakness, and that the fall was due to Resident 1 trying to be independent beyond his ability. The evaluation indicated the resident was non-compliant with calling for staff assistance when help is needed. Per Resident 1's statement, he attempted to transfer himself from his wheelchair to his bed, lost his balance, and he landed on top of the floor mat at the left side of his bed. The IDT Review indicated that 911 was called and Resident 1 was transferred to emergency room (ER) for further evaluation and treatment of the right ankle. A review of Resident 1's ankle X-ray from GACH 1 resulted 3/13/2024, indicated an acute (new) moderately displaced fracture of distal right fibula (bone on the outside of the ankle). A review of Resident 1's GACH 1 Discharge Summary dated 3/16/2024, indicated Resident 1 sustained an ankle fracture that was reduced (push or pull the ends of the fractured bone until they line up) in the ER. The discharge summary indicated Resident 1 and his family refused Open Reduction Internal Fixation surgery (ORIF- a surgical procedure for repairing fractured bone) and requested a non-operative management (not involving surgery). The discharge summary indicated Resident 1 had a long cast, would be discharged back to his Skilled Nursing A review of the Physician's Orders dated 3/16/2024, indicated to place tab alarm in his bed and wheelchair to alert staff when the resident was trying to get up from his bed and wheelchair unassisted. The order further stated to monitor the placement of the alarms and their function during every shift. A review of Resident 1's Admission Summary notes dated 3/17/2024 at 4:34 AM, indicated the resident was readmitted from GACH 1 to the facility on [DATE] at 5:33 PM. During an interview on 3/28/2024 at 12:22 PM, Restorative Nursing Assistant 1 (RNA 1) stated, The resident (Resident 1) was alert but if you told him not to do something, he would do it. Resident 1 was able to walk with assistance. When he fell for the first time this year, we educated him to use the call light for assistance, but he would say that he wanted to go to the toilet by himself. RNA 1 stated, On 3/13/2024, when Resident 1 fell , I was present in the facility. The CNA took him to the toilet, brought him back near his bed, and asked him if he wanted to be transferred to his bed. Resident 1 replied that he did not want to be transferred to his bed. RNA 1 stated, I was sitting on the hallway in front of the resident's room when I heard a scream. I went inside the room and found him (Resident 1) on the floor. RNA 1 stated Resident 1 attempted to transfer himself from his wheelchair to his bed and he fell . During an interview on 3/28/2024 at 12:43 PM, Licensed Vocational Nurse 1 (LVN 1) stated Resident 1 was alert and oriented, but was not compliant with his care, and did not use his call light for assistance, thinking he could do it all. LVN 1 stated Resident 1 required assistance with his transfers, as he had three falls in 2024. LVN 1 stated, On 3/13/2024, I was assigned to Resident 1 and around 2:50 PM, the CNA had just taken him to the restroom. Resident 1 stayed on his wheelchair, and he tried to get into his bed without assistance. LVN 1 stated Resident 1 did not have a pad alarm on his wheelchair. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 3/28/2024 at 1:06 PM, Registered Nurse Supervisor 1 (RN 1) stated, On 3/13/2024, I was present in the facility when Resident 1's fall occurred, as I was passing by the resident's room. I saw that one of the CNAs was inside the bathroom with Resident 1. After I left, the CNA came to me and reported that Resident 1 had fallen. RN 1 stated, The resident fell in less than 5 minutes after I left his room. RN 1 stated Resident 1 did not have a tab alarm on his wheelchair, and if there was a tab alarm it would have alerted the staff to assist him. RN 1 stated that when she went to assess the resident, she observed that Resident 1's right foot appeared to be dislocated. RN 1 stated, When I asked the resident why he did not call for help, he replied I just want to do it myself. During a concurrent interview and record review on 3/28/2024 at 4:15 PM, with the Director of Nursing (DON), Resident 1's care plans were reviewed. The DON stated, Resident 1 was non-compliant and for non-compliant residents, we keep educating them. We provide CNAs they are already familiar with. Resident 1 used to go to the bathroom on his own. The DON stated staff did not initiate a care plan for Resident 1's non-compliance with appropriate interventions. The DON stated there was no documentation that Resident 1's family member was informed about the non-compliance to use the call light for assistance. The DON stated Resident 1's family member was not present at any of the IDT meetings and that the resident was able to use the call light, but only used it whenever he wanted to. The DON stated Resident 1 had dementia. During a telephone interview on 3/28/2024 at 5:40 PM, RN 2 stated when Resident 1 used the call light and if we did not get to him immediately, he would become inpatient and get up on his own. During an interview on 3/29/2024 at 1:42 PM, the Director of Rehab (DOR) stated Resident 1 required assistance with transferring, as he was at high risk for falls. The DOR stated Resident 1 did not have strength in his legs, and he required constant reminders to call for help. In his mind, he thought he could get up on his own. However, his legs did not have the strength for him to get up on his own. The DOR stated Resident 1 did not have a bed alarm or chair alarm and a chair alarm would be a good intervention for Resident 1 which would alarm the staff before he tried to get up on his own. During an interview on 3/29/2024 at 4:08 PM, the DON stated the Falling Star Program (a fall prevention program, that focuses on promoting a safe environment and anticipating the patient's needs to prevent a fall) included residents with falls within the last three months. The DON stated In the falling star program, we monitor residents closely. In addition to low beds, we have safety devises such as tab alarms, rooms close to the nurses' station, and frequent visual monitoring of the residents. The DON stated Resident 1 was part of the falling star program, but he did not have a tab alarm as part of his fall prevention interventions. The DON stated, The resident was alert and oriented. We don't place a tab alarm for residents who are alert and oriented. The DON stated, I included a tab alarm as a person-centered care plan intervention for Resident 1 after his fall on 3/13/2024, when he came back from hospital on 3/16/2024. 2. A review of Resident 2's Admission Record indicated the facility readmitted the resident on 4/29/2022, with diagnoses including end stage renal disease (a medical condition in which a person's kidneys cease functioning on a permanent basis leading), low vision right eye, blindness left eye, glaucoma (a chronic, progressive eye disease caused by damage to the optic nerve, which leads to visual field loss), and dependence on renal dialysis (a procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 2's Care Plan initiated on 4/29/2022, indicated the resident had severely impaired visual function related to glaucoma and blindness. The goal for the resident was to use appropriate visual devices to promote participation in Activities of Daily Living (ADLs- activities related to personal care) and other activities. The care plan interventions included to explain surroundings to the resident, keep belongings within her reach and re-orient placement, always provide safety, provide assistance with needs as needed, call light within reach at all times, identify/record factors affecting visual function and to arrange consultation with eye care practitioner as required. A review of Resident 2's History and Physical dated 11/18/2023, indicated the resident had the capacity to understand and make decisions. A review of the SBAR Communication Form dated 7/21/2023, indicated Resident 2 had an alleged unwitnessed fall. The resident stated she fell on the floor next to her wheelchair while ambulating to the restroom. Resident 2 stated that she bumped into the wheelchair, and she fell on the floor. Resident 2 complained of pain at her right leg. The SBAR form further indicated Resident 2 was assessed for injuries and no bruising, discoloration, bleeding, lacerations (cut), or deformities (not the normal shape) were noted to site. A review of Resident 2's Care Plan initiated on 7/21/2023, and revised on 2/8/2024, indicated an alleged fall in the resident's room, but she got up without staff assistance. The care plan goal was to resume usual activities minimizing the risk of injury until the next review date. The care plan interventions indicated to check Resident 2's range of motion, encourage the resident to use the bell to call for assistance, keep call lights within reach at all times, monitor / document / report as needed for 72 hours any signs/symptoms of pain, bruises, change in mental status, sleepiness, inability to maintain posture, neuro-checks for 72 hours as ordered, and pharmacy consult to evaluate medications. A review of Resident 2's Fall Risk Evaluation after fall, dated 7/21/2023, indicated a total score of three (3). The fall risk evaluation form indicated that if the total score was 10 or greater, the resident should be considered at high risk for potential falls. The form indicated Resident 2 did not have any falls within the last three months, was legally blind, had normal gait/balance, and did not have any predisposing conditions (conditions and activities that can lead to the development of disease) such as arthritis (swelling and tenderness of one or more joints), and osteoporosis. A review of Resident 2's Post Fall Evaluation / IDT Review form dated 7/21/2023, indicated Resident 2 alleged the wheelchair was in her way while ambulating to the restroom. A review of the Rehabilitation Joint Mobility Screening Form dated 7/21/2023 at 2:50 PM, indicated that skilled PT and OT therapy was not recommended for Resident 2. The screening form indicated the recommendation was for RNA/ Functional Maintenance program (clinical programs that can be designed to maintain a resident's functional status). (continued on next page)

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F 0689

Level of Harm - Actual harm

Residents Affected - Few

A review of Resident 2's Fall Risk Evaluation dated 9/4/2023, indicated a total score of 10. The fall risk evaluation form indicated that if the total score is 10 or greater, the resident should be considered at high risk for potential falls. The form indicated Resident 2 did not have any falls within the last three months, required regular assist with elimination (getting grid of waste from body), was legally blind, had balance problem while standing/walking, had decreased muscular coordination and required use of assistive devices (i.e., cane, wheelchair, walker, or furniture) and did not have predisposing conditions such as arthritis, and osteoporosis. The Fall Risk Evaluation note indicated the resident did not have any falls in the last quarter.

A review of Resident 2's History and Physical dated 11/18/2023, indicated the resident had the capacity to understand and make decisions.

A review of the SBAR Communication Form dated 3/16/2024, indicated Resident 2 had a fall because she abruptly turned while in bed, was found sitting on the floor beside her bed and complained of pain to left side of her body, rib, hip, and left lower leg. The form indicated the resident was transferred to the hospital due to pain to the left side of her body.

A review of the Physician's Orders dated 3/16/2024 at 12:33 PM, indicated to transfer Resident 2 to GACH 2 status post fall due to lower back and left side of the body pain via 911.

A review of Resident 2's GACH 2 Computed Tomography (CT- a medical imaging technique used to obtain detailed internal images of the body) of the chest and abdomen report resulted 3/16/2024 at 1:11 PM, indicated the resident had multiple (more than one) fractures of the left 3rd through 9th ribs.

A review of the Physician's Orders dated 3/17/2024, indicated to place bilateral floor mats when Resident 2 was in bed to minimize injury in case of fall reoccurrence.

A review of Resident 2's Fall Risk Evaluation after fall, dated 3/16/2024, indicated a total score of 5 and that if the total score was 10 or greater, the resident should be considered at high risk for potential falls. The form indicated Resident 2 did not have any falls within the last three months, was legally blind, had normal gait/balance and did not have predisposing conditions such as arthritis, and osteoporosis.

A review of Resident 2's Post Fall Evaluation / IDT Review form dated 3/16/2024, indicated the resident had a fall on 3/16/2024, because she abruptly turned to her left side while lying on her bed and ended up on the floor. The IDT review indicated Resident 2 was able to move in and out of bed and ambulate to the toilet on her own and her last fall was on 7/28/2023. The IDT review indicated the resident had history of non-compliance with calling for assistance and wanting to be independent beyond her ability. The IDT review further indicated Resident 2 complained of pain to the left side of her body and was transferred to ER for evaluation. The IDT review further indicated that bilateral (both sides) floor mats were placed at Resident 2`s bedside to minimize the injury in case of fall recurrence.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 2's fall care plan initiated on 3/28/2024, after her fall on 3/16/2024, indicated that the resident is at risk for falls related to incontinence, visual problems, history of fall and she gets up to use the bathroom without calling for assistance. The care plan indicated the risk factors as blindness, lower extremities (legs) weakness, and poor transfer balance. The care plan also indicated that the resident had behavior of trying to be independent beyond her ability and was not calling for assistance. The care plan interventions are to orient resident with surroundings, re-educate regarding calling for assistance when needed, remind to use the call light, re-orient placement of call light, room change to be closer to station two for easy visual monitoring, and placement of tab alarm in bed to alert staff when resident is trying to get up unassisted. During an interview on 3/29/2024 at 11:50 AM, RN 3 stated that on 3/16/2024, she was working in the facility. RN 3 stated, It was noon, when the guy who delivers laundry for the residents, started yelling that Resident 2 was on the floor. We went in the room, and Resident 2 was sitting on the floor next to her bed crying. RN 3 stated LVN 1 asked Resident 2 what happened, she stated she was laying on the left side of the bed and fell on the floor when she abruptly turned. RN 3 stated We offered Resident 2 pain medication and asked her where she was feeling pain. At first, she said her lower back, and later stated left hip, leg, and left upper body. RN 3 stated Resident 2's fall on 3/16/2024, was preventable. If a staff member had told Resident 2 that she was not at the center of her bed, she might not have fallen. RN 3 stated staff are required to be more cautious about how residents are laying down on their beds specially for Resident 2 who was blind. RN 2 further stated that Resident 2 required frequent visual checks by staff for safety. During a concurrent interview and record review, on 3/29/2024 at 12:10 PM, with RN 3, Resident 2's Fall Risk Evaluations were reviewed. RN 3 stated fall risk evaluation dated 3/16/2024, with a total score of 5 indicated Resident 2 did not have any falls within the last three months which was incorrect because Resident 2 fell on [DATE] (the same date). RN 3 stated this fall risk assessment indicated Resident 2 did not have any predisposing conditions, which was not correct because Resident 2 had diagnosis of arthritis. RN 3 further stated the fall risk evaluation dated 9/4/2023, indicated Resident 2 did not have any falls within the last three months which was incorrect because Resident 2 fell on [DATE]. RN 3 stated this fall risk assessment indicated Resident 2 did not have any predisposing conditions, which was incorrect because Resident 2 had diagnoses of arthritis. RN 3 stated when the fall risk assessment was completed inaccurately, the assessment value was also incorrect. RN 3 stated Resident 2 was not considered a high risk for fall based on the incorrect fall risk assessments. Therefore, appropriate interventions were not implemented to prevent her fall. RN 3 stated, High risk for fall residents are placed close to the nursing station. If the resident is able to ambulate, we need to put the tab alarm on their bed or wheelchair, so when they move, the alarm goes off. RN 3 stated Resident 2 did not have a tab alarm for her bed or wheelchair. RN 3 stated prior to Resident 2's fall on 3/16/2024, it was required that a floor mat was placed next to her bed. A floor mat would have potentially reduced the extend of her injuries. During a concurrent interview and record review, on 3/29/2024 at 12:20 PM, with RN 3, Resident 2's care plans were reviewed. RN 3 stated Resident 2's care plan for fall was initiated on 7/21/2023 and revised on 2/8/2024. RN 3 stated Resident 2 did not have the necessary person - centered interventions for a person who was blind in the care plan. RN 3 stated one of the interventions that could be added for Resident 2 was the placement of a commode at her bedside or a tab alarm on her bed and performing frequent visual checks by the staff. RN 3 stated the potential outcome of not developing a person-centered care plan for a high risk for fall resident was fall and injury which was what happened to Resident 2 on 3/16/2024. (continued on next page)

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The Rehabilitation Center on Pico	3233 W. Pico Boulevard Los Angeles, CA 90019

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	During a concurrent interview and record review on 3/29/2024 at 12:41 PM, with LVN 2, Resident 2's fall risk Assessments were reviewed. LVN 2 stated, On 3/16/2024, after Resident 2's fall, I completed the fall risk assessment. I did not enter any falls for the last three months even though Resident 2 had just fallen. Resident 2 had diagnoses of arthritis which was not included in this assessment. LVN 2 stated if a resident was determined to be at high risk for fall, the facility places them in the Falling Star program. LVN 2 stated Resident 2 was high risk for fall because she was blind. However, she was not placed in the falling star program because she did not have any falls prior to this incident. LVN 2 stated there was no floor mats on the floor next to Resident 2's bed. During an interview on 3/29/2024 at 2:19 PM, CNA 1 stated Resident 2 was very stubborn because she was used to always doing stuff on her own. She did not want to ask for help. CNA 1 stated Resident 2 had visual impairments and used to walk without a walker. CNA 1 stated Resident 2 used to go to the bathroom without calling for help. She did not want to be supervised by the staff, and on 3/17/2024, I was assigned to Resident 2. We performed her morning routine. When I came back from lunch, I was told that she fell . CNA 1 stated there was no floor mats at Resident 2's bedside. During an interview on 3/29/2024 at 4:08 PM, the DON stated Resident 2's care plan for fall initiated on 7/21/2023, was not revised quarterly and the licensed staff were required to revise each resident's care plan quarterly or when there was a change of condition to evaluate the effectiveness of the care plan interventions. The DON stated Resident 2 was blind but very independent. The DON stated Resident 2's fall care plan did not indicate person-centered interventions for a blind resident. The DON stated the potential outcome was insufficient care. The DON stated she included floor mat in Resident 2's care plan intervention after her fall on 3/17/2024. The DON stated Resident 2's fall risk assessments dated 7/21/2023, 9/4/2023, and 3/16/2024 were completed incorrectly. A review of the facility's policy and procedure titled, Post Fall Evaluation, revised 3/2023, indicated the purpose of this procedure was to provide guidelines for identifying the cause (s) associated with resident falls. Documentation: the following should be recorded in the resident's medical record, appropriate interventions taken to reduce the potential for future falls. A review of the facility's policy and procedure titled, Fall Management Program, revised 3/2023, indicated the facility strives to provide each resident with adequate supervision and assistance devices to minimize the risks associated with falls; and to provide an environment which remains as free from accident hazards as possible. Avoidable Accident: an accident which occurred because the facility failed to: Identify environmental hazards and/or assess individual resident risk of an accident, including the need for supervision and/or assistive devices; and/or evaluate and analyze the hazards and risk and eliminate them, if possible, or, if not possible, identify and implement measures to reduce the hazards and risks as much as possible; and/or implement interventions, including adequate supervision and assistive devices, consistent with a resident's needs, goals, care plan and current professional standards of practice in order to eliminate the risk, if possible, and if not reduce the risk of an accident; and/or monitor the effectiveness of the interventions and modify the care plan as necessary, in accordance with current professional standards of practice. Residents at risk for falling shall have a care plan that identifies individual risk factors and person-centered interventions, based on the risk factors. The facility nursing staff and/or the interdisciplinary team shall update the resident's plan of care accordingly to reduce the risk for further occurrences of a fall and/or to reduce the risk (s) for significant injury related to falling.