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	04/11/2024

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48661 Based on interview and record review, the facility failed to ensure a comprehensive, person centered care plan for one sampled resident (Resident 1). Resident 1 did not have a resident specific care plan for Fall Risk and the care plan was not revised or updated timely. This deficient practice caused an increased risk in falls for Resident 1, who fell on [DATE] with injury. Findings: A review of Resident 1's Admission Record indicated the facility originally admitted the resident on 10/10/2023, and was readmitted on [DATE], with diagnoses including generalized anxiety disorder (produces fear, worry, and a constant feeling of being overwhelmed), major depressive disorder (a mental health condition that causes a persistently low or depressed mood and a loss of interest in activities that once brought joy), and muscle weakness (decrease in muscle strength). A review of Resident 1's Fall Risk Evaluation dated 10/10/2023, indicated the resident had a history of one to two falls within the past three months, had a balance problem while standing/walking, and was a high risk for falls. A review of Resident 1's History and Physical (H&P), signed and dated by the attending physician on 10/20/2023, indicated Resident 1 had the capacity to understand and make decisions. According to a review of Resident 1's Risk for Fall Care Plan related to confusion, gait/balance problems, incontinence, unaware of safety needs, and muscle weakness initiated 10/11/2023, the interventions were to educate the resident / family / caregivers about safety reminders and what to do if a fall occurs. A review of Resident 1's Physical Therapy (PT) Discharge Summary dated 11/17/2023, indicated to facilitate the resident maintaining current level of performance and to prevent decline in ambulation. The discharge recommendations were for Function Motion Prevention (FMP) / Restorative Nursing Program (RNP) for the resident. A review of Resident 1's Nursing Progress Note dated 1/2/2024, indicated the resident was independent with decision making, was able to be understood, and had clear comprehension. The Nursing Progress Note also indicated Resident 1 did not have a history of falls, which was a discrepancy from the Fall Risk Evaluation dated 10/2023. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 1's quarterly Minimum Data Set (MDS - a standardized resident assessment and care screening tool) dated 1/23/2024, indicated Resident 1 required setup with walking 10 to 150 feet and was independent with eating, oral/toileting/personal hygiene, showering, upper/lower body dressing, putting on/taking off footwear, rolling left and right, sit to lying, lying to sitting, sit to stand, and transfers. A review of Resident 1's Fall Risk assessment dated [DATE], indicated the resident was oriented to person, place, and time, did not have a history of falls within the past three months and his gait/balance was normal. According to a review of Resident 1's Risk for Falls Care Plan initiated 2/20/2024, the goal was to minimize risk of injury from falls. The care plan interventions indicated to educate the resident / family / caregivers about safety reminders and what to do if a fall occurred, and to ensure resident was wearing appropriate footwear when ambulating. A review of another Risk for Falls Care Plan initiated 2/20/2024, indicated the interventions included PT evaluate and treat as ordered or as needed (PRN). A review of Resident 1's Situation, Background, Assessment, and Recommendation (SBAR) dated 3/24/2024, indicated the resident had a witnessed fall in another resident's room and was found lying on his right side near the foot part of bed A. The SBAR indicated Resident 1 had a skin laceration to his right forehead and was transferred to GACH for further evaluation and treatment. A review of Resident 1's General Acute Care Hospital (GACH) Internal Medicine Progress Note dated 3/24/2024, indicated Resident 1 presented to GACH after a fall and an episode of syncope (fainting or passing out). The right scalp laceration was clean, dry, intact and Resident 1's X-ray showed a displaced fracture of the lateral aspect of the clavicle (a break in the collarbone). A review of Resident 1's GACH Internal Medicine Progress Note dated 3/25/2024, indicated recommendations from the Orthopedic physician to keep the right arm non-weightbearing and to continue with the sling. Resident 1 was transferred back to facility on 3/26/2024. During an interview on 4/9/2024 at 8:41 AM, Resident 1 stated he did not know what happened on 3/24/2024 when he fell in another resident's room. He stated he remembered going to his bed and then transferring to the hospital. Resident 1 also stated he was not in pain and was fine before the transfer. During an interview on 4/9/2024 at 9:48 AM, Certified Nursing Assistant (CNA) 1 stated he usually cared for Resident 1 and worked with the resident a lot. CNA 1 stated on the day of the fall, Resident 1 was walking in the hallway and CNA 1 started a conversation with him to make sure he was okay. He stated Resident 1 was stable during the conversation but then was confused when they found him in another resident's room because Resident 1 thought he was in his own room. During an interview on 4/9/2024 at 10:13 AM, CNA 2 stated on the day of the fall, she noticed Resident 1 walking fast and stumbling and before she could get out of the room to assist, she heard another resident scream for help. Resident 1 was found lying on his right side in between bed A and bed B with blood coming from the right side of his head. She stated Resident 1 did not have a history of falls because the staff often have meetings discussing residents who have previously fallen, and Resident 1 was not one of them. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/9/2024 at 10:40 AM, during an interview the Registered Nurse (RN) Supervisor stated Resident 1 did not have a history of falls. During a concurrent interview and record review on 4/11/2024 at 9:49 AM, with the MDS Coordinator (MDSC), Resident 1's Risk for Fall Care Plan related to confusion, gait/balance problems, incontinence, unaware of safety needs, and muscle weakness initiated 10/11/2023 was reviewed. The MDSC stated Resident 1 did not have family, was self-responsible and the interventions should not have included family. The MDSC stated the care plan was not person centered to Resident 1. During a concurrent interview and record review on 4/11/2024 at 10:38 AM, with the Director of Nursing (DON), Resident 1's Risk for Fall Care Plan related to confusion, gait/balance problems, incontinence, unaware of safety needs, and muscle weakness initiated 10/11/2023 was reviewed. The DON stated there was a leeway of 7 days to complete / update the Care Plan, which should have been done on 1/18/2024. The DON stated the Care Plan revision was late because it was done on 1/26/2024. During a concurrent interview and record review on 4/11/2024 at 12:40 PM, with the DON, Resident 1's Risk for Fall Care Plan related to syncope, gait/balance problems, psychoactive drug use, and muscle weakness initiated 2/20/2024 was reviewed. The DON stated the intervention should have included PT screening or Rehab screening in case of fall not PT evaluation and treat as ordered or as needed. Resident 1 was not receiving PT at the time and was part of the RNA program. A review of the facility's policy and procedure (P&P) titled, Screening, dated August 2023, indicated Quarterly and Annual screens (both Rehabilitation and/or Joint Mobility Screening forms) may be done as per facility policy and in conjunction with the MDS assessment schedule. A review of the facility's P&P titled, Develop-Implement Comprehensive Care Plans, revised March 2023, indicated care plans must be person-centered and reflect the resident's goals for admission and desired outcomes, interventions that reflect the resident's cultural preferences, values and practices.