

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  056438	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/28/2024
NAME OF PROVIDER OR SUPPLIER  Flower Villa, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE  1480 S. LA Cienega Bl Los Angeles, CA 90035	

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)
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43454</p> <p>Based on observation, interview and record review, the facility failed to ensure one of four sampled residents (Resident 1), who are at high risk of fracture (break in the bone) and who required maximum assistance with at least two-people assist during repositioning and perineal (involves washing the genital and rectal areas of the body) care was provided an environment to prevent accident, by failing to:</p> <ol style="list-style-type: none"> <li>1. Properly reposition Resident 1 with at least two- three persons assist on 6/10/2024 during perineal care and utilizing according to Resident 1's plan of care dated 7/16/2023</li> <li>2. Implement the facility's policy and procedures (P&amp;P) titled, Refusal of Treatment to not force a resident on any medical treatment, to document detailed information relating to the refusal and to notify the supervisors if resident refuses care.</li> <li>3. Implement the Care Plan (CP) dated 7/16/23, on behavior related to Resident 1's resistance of care as evidenced by Resident 1 telling staff to not change me (Resident 1), I'm okay during perineal care. The CP intervention included, Do not force resident to comply against their wishes.</li> <li>4. Develop a change of condition (COC, a decline or improvement in a resident's status that requires review or revision to the CP) as indicated in the facility's P&amp;P titled, Change in a Resident's Condition or Status, revised in 2024 when Resident 1 sustained a humerus (upper arm bone) fracture (break in bone) on 6/11/2024 according to radiology report (a series of tests that take pictures or images of parts of the body).</li> </ol> <p>These deficient practices resulted in Resident 1 sustaining a humerus fracture and experiencing pain on the left arm with pain rate of seven out of 10 (7/10 - numeric pain rating scale; [7 means severe pain]) on 6/11/2024 and verbalizing in resident's primary language, tengo dolor, por favor ayudame (I have pain, please help me). On 6/12/2024, Resident 1 was transferred to General Acute Care Hospital 1 (GACH 1) for humerus fracture.</p> <p>Findings:</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 1's Admission Record indicated Resident 1 was initially admitted to the facility on [DATE] with diagnoses including osteoporosis (a bone disease that develops when bone mineral density and bone mass decreases, or when the structure and strength of bone changes), hemiplegia (loss of the ability to move in one side of the body) following cerebral infarction (lack of blood flow resulting in severe damage to some of the brain tissue) affecting left non-dominant side, and unspecified dementia (loss of cognitive functioning-thinking, remembering, and reasoning).</p> <p>A review of Resident 1's Care Plan for ADL's, dated 7/16/2023 indicated Resident 1 needs total assist with bed mobility and toileting with two to three (2-3) staff assist. The CP included an approach plan (intervention) to assist the resident with transfers, request extra help (staff) as needed.</p> <p>A review of Resident 1's Care Plan for behavior problem as evidenced by Resident 1 telling staff to not change me, I'm okay, I'm dry, dated 7/16/2023, indicated a goal Resident will not harm herself with an intervention including for staff to anticipate care needs and provide them before resident becomes overly stressed, staff to be calm and self-assured, re-approach resident later when resident is no longer agitated.</p> <p>A review of Resident 1's Minimum Data Set (MDS - a comprehensive assessment and screening tool), dated 6/12/2024, indicated Resident 1's cognitive skill (mental action or process of acquiring knowledge and understanding) for daily decision-making were severely impaired and required total dependence from staff with two person-assists for activities of daily living (ADL-bed mobility, dressing, toilet use, eating and personal hygiene). The MDS indicated Resident 1 required maximal assistance to dependent from staffs for activities of daily living (ADL - toileting hygiene, shower/bathe self, lower body dressing and personal hygiene). The Resident 1 also required partial to substantial assistance with mobility including sit to lying, chair/bed-to-chair transfer and toilet transfer.</p> <p>A review of Resident 1's Licensed Personnel Progress Notes indicated the following:</p> <p>i. On 6/11/2024 at 3 p.m., at approximately 2:30 p.m., nurse informed the staff in the nurse's station that resident was complaining of (c/o) pain . skin discoloration was noted to the left arm. During assessment, swelling was noted to the surrounding area, when resident was asked what happened, she (Resident 1) stated in Spanish, tengo dolor, po favor ayudame . pain 7/10 to the left arm using numeric pain scale. The progress further indicated pain medication was administered and left arm was stabilized with the utilization of pillows.</p> <p>ii. On 6/11/2024 at 9 p.m., laboratory (lab test - a medical procedure that involves testing a sample of blood, urine, or other substance from the body) order reviewed, Medical Doctor (MD) 1 notified with order for Motrin (used to relieve pain, fever, and inflammation [A normal part of the body's response to injury or infection]) and 600 milligram (mg - unit of measurement) every six hours as needed for pain, transfer to hospital for humerus fracture.</p> <p>A review of Resident 1's Physician Order dated 6/11/2024 at 3pm, indicated X-Ray (an electromagnetic radiation of an extremely short wavelength that can penetrate various thicknesses of solids and to act on photographic film as light does) of left arm.</p> <p>A review of Resident 1's Radiology Report, dated 6/11/2024 at 6:33 p.m., indicated, elbow and humerus with acute distal humeral fracture (a break in the lower end of the humerus - a fracture in this area can be very painful and make elbow motion difficult or impossible).</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 1's Licensed Personnel Progress Notes indicated, On 6/12/2024 at 11:59 a.m., Resident 1 was transported to GACH 1 by ambulance.</p> <p>A review of GACH 1's Consultation Report by Medical Doctor (MD) 2, dated 6/14/2024 indicated a chief complaint of left humerus fracture. The MD 2's notes indicated, a recommendation to not perform surgery and to allow the bone to heal naturally. A well-padded long arm posterior splint (used for certain injuries requiring immobilization of the elbow and forearm) was applied on the resident's arm for comfort, support, and protection.</p> <p>During an observation on 6/28/2024 at 10:39 a.m., Resident 1 was observed with a long arm splint on the left arm.</p> <p>During an interview with Certified Nursing Assistant (CNA) 2, on 6/28/2024 at 10:41 a.m., CNA 2 stated, Resident 1 refused to be moved and turned because of pain. CNA 2 stated, prior to hospitalization on [DATE], Resident 1 allowed staff to turn her with assist. CNA 2 further stated, at least two persons assist when always turning Resident 1.</p> <p>During an interview with Licensed Vocational Nurse (LVN) 1, on 6/28/2024 12:41 p.m., stated on 6/11/2024, it was reported to her (did not state by whom) that Resident 1 complained of pain and refused her incontinent brief (is a type of reusable undergarment designed to absorb urine) to be changed. Upon assessment of Resident 1 on 6/11/2024, LVN 1 stated she observed bruises and swelling on the resident's arm and the resident complained of pain. LVN 1 further stated on 6/10/2024 (day prior), Resident 1 did not complain of pain on the left arm. LVN 1 stated she was unaware of how Resident 1 sustained a bruise or swelling to the left arm.</p> <p>During an interview with LVN 2, on 6/28/2024 at 12:52 p.m., LVN 2 stated, on 6/10/2024 at evening shift (time unknown), Resident 1 complained of pain on her left arm when touched and during perineal changed. LVN 2 stated, he was not notified if Resident 1 had an accident of fall or injury on 6/10/2024.</p> <p>During a review and a concurrent interview with the Director of Nursing (DON), on 6/28/2024 at 1:10 p.m., Resident 1's Medical Record was reviewed. There was no COC documented after Resident 1 sustained a humerus fracture on 6/11/2024. The DON confirmed and stated there was no COC completed on 6/11/2024 but they should have done so. The DON stated, COC was needed for a complete assessment of resident's condition to be conducted. The DON further stated Resident 1 has hemiplegia requiring total care with two persons assist during bed mobility. Resident 1 is unable turn side to side while in bed on her own without assistance from staff. The DON stated, he observed Resident 1 had discoloration on left arm and complained of pain level of 7/10 on the left arm on 6/11/2024. The DON stated, after investigation, he found out that on morning of 6/10/2024, CNA 1 repositioned and changed Resident 1's incontinent brief. The DON stated, upon interview, CNA 1 failed to reposition Resident 1 properly while doing incontinent care. The DON stated, CNA 1 did not follow their protocol on turning and repositioning, since Resident 1 is hemiplegic on left side, she shouldn't be turned to her left for a long period of time and there should not be a lot of pressure put on her (Resident 1) left side. The DON stated, Resident 1 was resistance with care on the morning of 6/10/2024 while being changed but CNA1 proceeded on turning and changing Resident 1, furthermore, CNA1 did not utilize at least two persons assist during ADL care. The DON further stated, CNA 1 did not report to the charge nurse (LVN 2) about the incident (of Resident 1 refusing care). The DON stated, there was no COC completed after Resident 1 sustained a humerus fracture.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with CNA 1 on 6/28/2024 at 1:37 p.m., CNA1 stated, on 6/10/2024 at around 6:00 a.m., Resident 1 needed to be changed (incontinent brief) because she was wet. CNA1 stated, Resident 1 was combative and resistance with care, however, he proceeded on changing her (Resident 1). CNA1 stated, he turned her to facing the window (left side) and since she was resistance with care, it took him longer to change her (Resident 1). CNA1 further stated, he didn't ask for any assistance and didn't report the incident to the charge nurses.</p> <p>During a follow-up interview with the DON, on 6/28/2024 at 3:21 p.m., DON stated, Resident 1's fracture was avoidable, and it could have been prevented if CNA1 followed their protocol on proper repositioning during perineal care and he should have reported the incident to the charge nurse and management.</p> <p>A review of the facility's P&amp;P titled, Turning a Resident on His/her Side Away from You, revised on 2024, indicated, the purpose of this procedure are to provide comfort to the resident, to prevent irritation and breakdown, and to promote good body alignment. Steps in the Procedure: .</p> <ol style="list-style-type: none"> <li>a) Slide both your arms under the resident's back to his/her far shoulder.</li> <li>b) Slide the resident's shoulders toward you on your arms.</li> <li>c) Slide both your arms under the resident's buttocks</li> <li>d) Slide the resident's buttocks toward you.</li> <li>e) Slide both arms under the resident's feet and ankles.</li> <li>f) Slide the resident's feet toward you.</li> <li>g) Cross the resident's arms over his/her chest.</li> <li>h) Cross the resident's leg nearest you over the leg farthest from you .</li> <li>i) Place one hand on the resident's shoulder nearest you</li> <li>j) Place your second hand under the resident's buttocks.</li> <li>k) Gently turn the resident away from you</li> <li>l) Should the resident become weak or faint during the procedure, cease the procedure and summon the staff/charge nurse .</li> <li>m) Position the resident's arms and legs in a comfortable position and free from pressure.</li> </ol> <p>The following should be recorded in the resident's medical record: if and how the resident participated in the procedure or any changes in the resident's ability to participate in the procedure and any problems or complaints made by the resident related to the procedure. The same P&amp;P also indicated, notify the supervisor if the resident refuses the care.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the facility's P&amp;P titled, Perineal Care, revised on 2024, the P&amp;P indicated that the following information should be recorded in the resident's medical record: how the resident tolerated the procedure or any changes in the resident's ability to participate in the procedure, if the resident refused the procedure, the reason(s) why and the intervention taken, notify the supervisor if the resident refused the perineal care.</p> <p>A review of the facility's P&amp;P titled, Refusal of Treatment, revised on 4/2024, the P&amp;P indicated that the resident is not forced to accept any medical treatment and may refuse specific treatment even though it is prescribed by a physician. If a resident refuses treatment, the Unit Manager, Charge Nurse, or Director of Nursing Services will interview the resident to determine what and why the resident is refusing in order to try to address the resident's concerns and explain the consequences . Should the resident refuse to accept treatment, detailed information relating to the refusal must be entered into the resident's medical record.</p> <p>A review of the facility's P&amp;P titled, Change in a Resident's Condition or Status, revised on 2024, the P&amp;P indicated that the nurse supervisor/charge nurse will notify the resident's attending physician or on-call physician when there has been: an accident or incident involving the resident; a discovery of injuries of an unknown source . a significant change in the resident's physical/emotional/mental condition; refusal of treatment of medications . The nurse supervisor/charge nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status.</p>		