

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555028	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/11/2024
NAME OF PROVIDER OR SUPPLIER  Palos Verdes Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 26303 Western Ave. Lomita, CA 90717	

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** 44898</b></p> <p>Based on interview, and record review, the facility failed to ensure the resident, who was transported from the medical appointment in a facility van did not fall backwards in a wheelchair and sustained injury for one of three sampled residents (Resident 1). The facility failed to:</p> <ol style="list-style-type: none"> <li>1. Ensure Driver 1 secured Resident 1 in the van using a four-point straps (secures a wheelchair with four straps attached to the wheelchair at four separate securement points and attached to the vehicle at four separate anchor points) when the resident was in a wheelchair while being transported back to the facility after a medical appointment in the facility's van.</li> <li>2. Ensure Certified Nursing Assistant (CNA 1) who accompanied Resident 1 to her medical appointment was educated on how to properly secure Resident 1 using the four-point straps and the seatbelts (a strap going over the shoulder and torso) when resident was in a wheelchair while being transported in the facility's van.</li> <li>3. Ensure CNA 1 verified Driver 1 secured Resident 1 in a van with four-point straps and a seatbelt before heading back to the facility after a medical appointment.</li> <li>4. Ensure CNA 1 and Driver 1 followed the facility's policy and procedure (P&amp;P) titled, Transportation/Appointments revised 2020, which indicated, Employees and their passengers who are driving/riding in a vehicle on facility business purposes must wear a seat belt at all times in which the car is being operated. Wheelchair is properly strapped.</li> </ol> <p>As a result, Resident 1's wheelchair tilted back and hit her head on the van lift when Driver 1 made a left turn towards the facility, which was on a slight uphill slope. Resident 1 was transferred to a general acute care hospital (GACH) on 10/1/2024 at 11:04 a.m. Resident 1 sustained a right occipital (the back of the head) scalp laceration (a cut or tear in the skin or underlying tissue) and hematoma (a pool of mostly clotted blood that forms in an organ, tissue or body space), neck sprain (a soft tissue injury that occurs when a ligament [attach bone to bone] in a joint {two or more bones are connected} is stretched too far or torn) and a right shoulder sprain. Resident 1 was discharged from GACH on 10/1/2024 at 6:56 p.m., to Resident 1's home.</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>During a review of Resident 1's Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including end stage renal disease ([ESRD]-irreversible kidney failure), muscle weakness, difficulty walking, lack of coordination (the ability to use different parts of the body together smoothly efficiently), right arm pain, osteoporosis (a condition in which the bones become weak and brittle), and malaise (a general feeling of discomfort, illness, or lack of wellbeing).</p> <p>During a review of Resident 1's History and Physical (H&amp;P), dated 9/21/2024, the H&amp;P indicated Resident 1 had the capacity to understand and make decisions.</p> <p>During a review of Resident 1's Minimum Data Set ([MDS]- federally mandated resident assessment tool), dated 9/24/2024, the MDS indicated Resident 1 had intact cognition (ability to think, understand, learn, and remember). The MDS indicated Resident 1 required supervision or touching assistance (helper provides verbal cues) from nursing staff with eating. The MDS indicated Resident 1 needed partial to moderate assistance (helper does less than half the effort) from nursing staff with oral hygiene and rolling from left to right in bed. The MDS indicated Resident 1 needed substantial to maximal assistance (helper does more than half the effort) from nursing staff with toileting, showering, and upper body dressing. The MDS indicated Resident 1 was dependent (helper does all the effort) on nursing staff with lower body dressing, putting on and taking off footwear, the ability to sit and stand, and the ability to transfer from the bed to the chair.</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 on 10/10/2024 at 11:58 a.m., with CNA 1, CNA 1 stated that on 10/1/2024 at approximately 10:20 a.m., after Resident 1's medical appointment she called the facility driver (Driver 1), to inform Resident 1 was done with the medical appointment and was ready to be picked up. CNA 1 stated Driver 1 placed Resident 1 on the lift located at the back of facility's van and lifted Resident 1 up inside the van facing forward towards the front of the van. CNA 1 stated she saw Driver 1 strap a gray seatbelt over the Resident 1's lap. CNA 1 stated she (CNA1) sat in the front passenger seat. CNA 1 stated Driver 1 shut the van's back door and got into the driver's seat. CNA 1 stated when approaching the facility, Driver 1 made a left turn towards the facility, which was on a slight uphill slope. CNA 1 stated she heard a loud bang sound at the back of the van with Resident 1 yelling for help. CNA 1 stated Driver 1 stopped the van went to open the side door of the van. CNA 1 stated Resident 1 wheelchair was tilted in a straight back position with resident lying on the floor of the van still strapped in the wheelchair with the gray seatbelt over the Resident 1's lap. Resident 1's head was touching the van's lift and continue yelling and verbalizing My head, my head, I think it is bleeding. CNA 1 stated she told Driver 1 to open the van's lift door at the back and to go get help inside the facility. CNA 1 stated Resident 1's head was bleeding from the back of the head. CNA 1 stated she (CNA 1) took off her jacket to add pressure to the back of Resident 1's head to stop the bleeding. CNA 1 stated after the fall, she noticed Resident 1's wheelchair was not anchored to the van floor using the four-point strap. CNA 1 stated she asked Driver 1 to remove the wheelchair from under Resident 1 while she was holding Resident 1's back and both legs. CNA 1 stated Driver 1 removed the wheelchair from under Resident 1. CNA 1 stated Registered Nurse Supervisor (RNS 1) and Licensed Vocational Nurse (LVN 1) came to the van and informed them (RNS 1 and LVN 1) Resident 1 was bleeding on the back of her head. CNA 1 stated LVN 1 called 911 (medical emergency number) and assessed Resident 1. CNA 1 stated Resident 1 remained alert. CNA 1 stated she should have ensured Resident 1's wheelchair was anchored in the van during the resident's transport back to the facility. CNA 1 stated she failed to check if Resident 1's wheelchair was anchored and strapped securely. CNA 1 stated she was not familiar with the straps used to secure the wheelchair during transport in the facility van. CNA 1 stated this was her first time to escort a resident to a medical appointment and did not check Resident 1 to make sure Resident 1 was strapped in the wheelchair with a seatbelt and her wheelchair was anchored to the van floor using the four-point straps.</p> <p>During an interview on 10/10/2024 at 12:51 p.m., with Restorative Nurse Assistant (RNA) 1, RNA 1 stated when transporting a resident in the van, the driver puts the resident wheelchair on the lift and lift resident up inside the van. RNA 1 stated the resident should be facing forward (front of the van). RNA 1 stated the driver should hook up the wheelchair two straps in the back and two straps in the front of the wheelchair and apply a seatbelt over the resident. RNA 1 stated the driver should check the four-point straps to make sure the straps were secured. RNA 1 stated the driver must ensure the four-point straps were secured to ensure safety in the event the driver will abruptly stop the van. RNA 1 stated if the resident was not properly strapped and secured in the wheelchair the resident will fall from the wheelchair.</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 on 10/10/2024 at 1:27 p.m., with Driver 1, Driver 1 stated on 10/1/2024 at 10 a.m., CNA 1 called him to pick up Resident 1 from her medical appointment. Driver 1 stated he put Resident 1 on the lift and into the van. Driver 1 stated he put the gray seatbelt over the Resident 1's lap and drove back to the facility. Driver 1 was unable to answer when asked if Resident 1's wheelchair was anchored to the van floor by using a four-points straps, two in the front of the wheelchair and two in the back of the wheelchair and a seat belt. Driver 1 stated, upon driving to the facility's parking lot, he heard a bang at the back of the van. Driver 1 stated Resident 1 was yelling for help. Driver 1 stated he realized he did not secure the wheelchair to the van floor. Driver 1 stated he did not hook the straps on the four points of the wheelchair. Driver 1 stated CNA 1 told him to open the back door of the van and to call RNS 1 and LVN 1. Driver 1 stated the wheelchair was tilted straight back. Driver 1 stated CNA 1 asked him to remove the wheelchair from under Resident 1's body. Driver 1 stated RNS 1 and LVN 1 came and checked Resident 1 for any injury and called 911. Driver 1 stated 911 came immediately to assist Resident 1. Driver 1 stated he failed to use the four-point straps that were provided for use when transporting a resident.</p> <p>During an interview on 10/10/2024 at 1:58 p.m., with LVN 1, LVN 1 stated on 10/1/2024 the facility receptionist came to the nurses' station and stated Resident 1 needed assistance in the van. LVN 1 stated he told RNS 1 to grab the crash cart (a portable cart that contains emergency medical equipment, drugs, and supplies for treating sudden, severe medical problems). LVN 1 stated when he approached the van, he saw CNA 1 applying pressure on the back of Resident 1's head. LVN 1 stated Resident 1 was bleeding from the back of the head and verbalized pain 8 out of 10 on a zero to ten pain scale (a numeric pain scale with zero meaning no pain and 10 meaning the worst pain imaginable). LVN 1 stated RNS 1 came with the crash cart and stayed with Resident 1. LVN 1 stated he then called 911. LVN 1 stated before Resident 1 left for the medical appointment on 10/1/2024, he checked to make sure Resident 1 was safe. LVN 1 stated he made sure Resident 1 was strapped using the four-point strap. LVN 1 stated before Resident 1 left the facility he verified the four-point contact on the wheelchair and checked the straps to make sure the resident was strapped in properly.</p> <p>During an interview on 10/10/2024 at 2:32 p.m., with the Administrator (Adm), the ADM stated he did a verbal training with facility staff on transporting residents using the facility's van. (unknow date) Adm stated he bought new straps and explained the use of the straps and how to properly anchor the wheelchair safely in the van. Adm stated he did a return demonstration (teaching strategy that involves the learner demonstrating their understanding or mastery of a skill or concept by performing it themselves) with the staff on how to secure the four-point straps to the wheelchair. Adm stated Driver 1 did not strap Resident 1 in the wheelchair using the four-point straps/contacts of the wheelchair and use of a seatbelt on 10/1/2024. Adm stated Resident 1 was no longer a resident at the facility and was not coming back to the facility. Adm stated Resident 1 was discharged from GACH to her home on 10/1/2024.</p> <p>During a review of Resident 1's Physician's Order Summary, dated 10/1/2024, the Physician's Order summary indicated Resident 1 had an order to be transferred to GACH for further evaluation after the fall in a van during transportation.</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 a review of the Facility's Investigation Report, dated 10/1/2024, the Facility's Investigation Report indicated, Driver 1 turned left into the facility's parking lot on an uphill slope and when the driver stepped on the brakes Resident 1's wheelchair toppled backwards causing Resident to fall with the wheelchair and hit the floor of the van. The facility's Investigation Report indicated, Driver 1 admitted that he failed to properly secure Resident 1's wheelchair and had been trained on how to properly secure residents' wheelchairs to prevent accidents and or injuries.</p> <p>During a review of Resident 1's emergency room report (GACH records), dated 10/1/2024 timed at 3:36 p.m. , the emergency room report indicated, Resident 1 had a right occipital scalp laceration and hematoma, neck sprain and a right shoulder sprain. The GACH records indicated Resident 1 was given Norco ([Hydrocodone-Acetaminophen] medication used to relieve moderate to severe pain) 5-325 milligram ([mg] a unit of measurement) one tablet for pain. The GACH records indicated after the wound of Resident 1's head on the right back of the head was cleaned, there were two small lacerations less than one centimeter ([cm] unit of measurement) each.</p> <p>During a review of the facility's P&amp;P titled, Transportation/Appointments revised 2020, the P&amp;P indicated, Employees and their passengers who are driving/riding in a vehicle on facility business purposes must wear seat belts at all times in which the car is being operated. Wheelchair is properly strapped.</p> <p>During a review of Four-Point Straps instruction attached to the straps (undated), the instructions indicated To attach buckle hook to proper anchor point, attach strap hook to second anchor point, place strap overload, insert end of strap through buckle and pull it to eliminate slack, push lever closed to secure strap, keep fingers clear of mechanism, to release strap open lever.</p>

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44898</b></p> <p>Based on interview and record review the facility failed to ensure facility staff including Certified Nursing Assistant (CNA 1 had training and competency evaluation on transporting resident using facility van.</p> <p>This failure resulted in, Resident 1's wheelchair tilted back and hit her head on the van lift when Driver 1 made a left turn towards the facility that was slightly uphill slope. Resident 1 sustained a right occipital (the back of the head) scalp laceration (a cut or tear in the skin or underlying tissue) and hematoma (a pool of mostly clotted blood that forms in an organ, tissue or body space), neck sprain (a soft tissue injury that occurs when a ligament [attach bone to bone] in a joint {two or more bones are connected} is stretched too far or torn) and a right shoulder sprain. Resident 1 was discharged from GACH on 10/1/2024 at 6:56 p.m., to Resident 1's home. This failure had the potential for other resident to fall while being transported in the facility van.</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including end stage renal disease ([ESRD]-irreversible kidney failure), muscle weakness, difficulty walking, lack of coordination (the ability to use different parts of the body together smoothly efficiently), right arm pain, osteoporosis (a condition in which the bones become weak and brittle), and malaise (a general feeling of discomfort, illness, or lack of wellbeing).</p> <p>During a review of Resident 1's History and Physical (H&amp;P), dated 9/21/2024, the H&amp;P indicated Resident 1 had the capacity to understand and make decisions.</p> <p>During a review of Resident 1's Minimum Data Set ([MDS]- federally mandated resident assessment tool), dated 9/24/2024, the MDS indicated Resident 1 had intact cognition (ability to think, understand, learn, and remember). The MDS indicated Resident 1 required supervision or touching assistance (helper provides verbal cues) from nursing staff with eating. The MDS indicated Resident 1 needed partial to moderate assistance (helper does less than half the effort) from nursing staff with oral hygiene and rolling from left to right in bed. The MDS indicated Resident 1 needed substantial to maximal assistance (helper does more than half the effort) from nursing staff with toileting, showering, and upper body dressing. The MDS indicated Resident 1 was dependent (helper does all the effort) on nursing staff with lower body dressing, putting on and taking off footwear, the ability to sit and stand, and the ability to transfer from the bed to the chair.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/10/2024 at 11:58 am with CNA 1, CNA 1 stated on 10/1/2024 at 9:30 am it was her first time escorting a resident to a medical appointment and being transported via a facility van. CNA 1 stated she failed to check if Resident 1's wheelchair was anchored and strapped securely during transport from the medical appointment returning to the facility. CNA 1 stated she was not familiar with the straps used to secure the wheelchair during transport in the van. CNA 1 stated this was her first time to escort a resident to a medical appointment and did not check Resident 1 to make sure Resident 1 was strapped in the wheelchair with a seatbelt and her wheelchair was anchored to the van floor using the four-point straps.</p> <p>During an interview on 10/10/2024 at 1:27 p.m., with Driver 1, Driver 1 stated on 10/1/2024 at 10 a.m., CNA 1 called him to pick up Resident 1 from her medical appointment. Driver 1 stated he put Resident 1 on the lift and into the van. Driver 1 stated he put the gray seatbelt over the Resident 1's lap and drove back to the facility. Driver 1 was unable to answer when asked if Resident 1's wheelchair was anchored to the van floor by using a four-points straps, two in the front of the wheelchair and two in the back of the wheelchair and a seat belt.</p> <p>During an interview on 10/10/2024 at 2:20 pm with the Director of Staff Development (DSD), the DSD stated there was no documentation of any in-services regarding transporting residents using the facility's van's seatbelts, and four-point straps (secures a wheelchair with four straps attached to the wheelchair at four separate securement points and attached to the vehicle at four separate anchor points) to anchor resident wheelchair to the van floor. DSD stated an in-service was held to facility staff on how to strap resident in the wheelchair while being transported on 10/2/2024 after the incident with Resident 1 on 10/1/2024.</p> <p>During a review of the facility's P&amp;P titled, Transportation/Appointments revised 2020, the P&amp;P indicated, Employees and their passengers who are driving/riding in a vehicle on facility business purposes must wear seat belts at all times in which the car is being operated. Wheelchair is properly strapped.</p> <p>During a review of Four-Point Straps instruction attached to the straps (undated), the instructions indicated To attach buckle hook to proper anchor point, attach strap hook to second anchor point, place strap overload, insert end of strap through buckle and pull it to eliminate slack, push lever closed to secure strap, keep fingers clear of mechanism, to release strap open lever.</p> <p>Cross reference F689</p>		