STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555028	A. Building B. Wing	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palos Verdes Health Care Center	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)
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** 49145 Based on observation, interview, and record review, the facility failed to ensure the resident, who was transported to a shower room, did not get hit by a shower room door and sustain an injury to a left great toe for one of three sampled residents (Resident 1). The facility failed to: 1. Ensure Certified Nurse Assistant (CNA 1) requested assistance to hold the door to Shower room [ROOM NUMBER] while he was pulling Resident 1 on a shower chair into the Shower room [ROOM NUMBER]. 2. Ensure CNA 1 and Licensed Vocational Nurse (LVN 1) reported Shower room [ROOM NUMBER]'s door malfunctioning by documenting about it in the Maintenance Logbook. 3. Ensure CNA 1 and LVN 1 reported to the Maintenance Supervisor (MS) that the door to Shower room [ROOM NUMBER] was not staying wide open to transport the residents safely through the Shower room [ROOM NUMBER]. 3. Ensure MS followed the facility's policy and procedure (P&P) titled, Maintenance Service, which indicated The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. These deficient practices resulted in Resident 1 left great toe hit by door to Shower room [ROOM NUMBER] and sustaining a fracture (broken bone) of the left medial (middle) cortex of the left fourth proximal (closer to center of the body) phalanx (small toe bone) and a left great toe laceration (skin tear). On 11/16/2024 Resident 1 was transferred to a general acute care hospital (GACH) where the resident had the left great toe sutured (a medical thread used by doctors to stitch up a wound or cut). Findings: During a review of Resident 1's Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease (a disease characterized by a progressive decline mental abilities) and osteoporosis (disorder of bone density and structure). (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	During a review of Resident 1's Minimum Date Set ([MDS]- a resident assessment tool), dated 10/4/2024, the MDS indicated Resident 1 had impairment in cognitive (ability to think, understand, learn, and remember) skills for daily decision making. The MDS indicated Resident 1 required substantial/maximal assistance (helper does more than half the effort) with toileting, personal hygiene, and lower body dressing. During a review of Resident 1's Change of Condition ([COC]- documentation of a resident's sudden change from regular state of being) assessment dated [DATE], the COC assessment indicated Resident 1's physician was notified of Resident 1 had left great toe hit by a shower room door on 11/6/2024 at 10:30 a.m. During a review of Resident 1's Physician's Orders Summary Report for November 2024, the Physician's Orders Summary Report indicated an order dated 11/6/2024 to transfer Resident 1 to the emergency room (ER) via ambulance (a vehicle that transports people who are sick or injured to the hospital in an emergency) for a left great toe wound treatment. During a review of Resident 1's Radiology (x-ray-imaging that creates pictures of the inside of the body) Final Report, the Radiology Final Report dated 11/6/2024 at 1:58 p.m., indicated Resident 1 had the distal medial cortex of the left fourth proximal phalanx fracture. During a review of Resident 1's Emergency Department (ED) Discharge Instructions from the GACH dated 11/6/2024, the ED Discharge Instructions indicated to remove the resident's left foot sutures in seven to 10 days. During a review of Resident 1's Interdisciplinary Team ([IDT]- group of different professionals working together in a case, all collaborating to provide the best care for a patient) Skin Note dated 11/7/2024, the IDT Skin Note indicated Resident 1 was transferred to the GACH for 11/6/2024 or the left foot wound evaluation and treatment and was transferred back to the facility the same day (11/6/2024) with intact sutures on a left great toe wound (laceration). During a review of CNA 1's written statement dated 11/7/2024, CNA 1's written statement indicated CNA 1 was pulling Resident 1 on a shower chair into Shower room [ROOM NUMBER] while using my right foot to stop the door then the resident's left foot was accidentally hit by the door. During a review of the facility's Maintenance Logbook for the period of time from 7/26/2024 -11/20/2024 located at Nurses Station 1, the Maintenance Logbook indicated no documentation regarding Shower room [ROOM NUMBER]'s door malfunctioning. During a review of Resident 1's Nurses Progress Notes dated 11/22/2024, the Nurses Progress Notes indicated there were four sutures removed from Resident 1's great left toe laceration and Resident 1 received Tylenol (medication used to relieve pain) for pain management. Resident 25 was not able to state the pain level but had a facial grimacing (a facial expression that usually conveys pain) indicating the resident was in pain. During an observation on 11/22/2024 at 9:20 a.m., of Resident 1's left great toe wound (laceration) dressing change, Resident 1's left great toe wound was observed being without redness or swelling. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview with CNA 1 on 11/22/2024 at 9:35 a.m., CNA 1 stated on 11/6/2024 he was transporting Resident 1 on a shower chair to Shower room [ROOM NUMBER], and while trying to pull him inside, the door to the shower room would not stay open, causing the door to hit Resident 1's left foot. CNA 1 stated he should have requested help while attempting to pull Resident 1 into the shower room to avoid the door striking Resident 1's left foot. CNA 1 stated that he verbally informed LVN 1 about the malfunctioning door of Shower room [ROOM NUMBER], but he did not record it in the Maintenance Logbook. CNA 1 stated it was the facility's policy to document broken equipment in the maintenance logbook. CNA 1 acknowledged that he should have documented about malfunctioning shower door in the Maintenance Logbook. CNA 1 stated the incident with Resident 1 could have been avoided if the door to Shower room [ROOM NUMBER] had been working properly. During an interview with LVN 1 on 11/22/2024 at 10:20 a.m., LVN 1 stated Shower room [ROOM NUMBER]'s door had a stopper (device used to keep a door open or closed) that prevented the door from being fully opened or stay open, so staff needed to use their foot to keep the door propped open. LVN 1 stated CNA 1 should have requested someone to hold the door for him while he was pulling Resident 1 on a shower chair into the shower room, which could have prevented Resident 1's foot from being struck. LVN 1 stated that she did not consider reporting the shower room door failure to stay open because it had always functioned that way, and she did not see it as being broken since the door stopper was a part of the door. LVN 1 stated she did not think the shower room door was a problem until it hit Resident 1's foot. During an interview on 11/22/2024 at 11:27 a.m., the MS stated room [ROOM NUMBER]'s shower door was closing automatically unless someone was holding door open. MS stated that the week before Resident 1's accident on 11/6/2024, he was informed that there was an issue with the room [ROOM NUMBER]'s shower door. MS stated on 11/5/2024, he removed the door stopper to allow the door to open wider, but someone (unknown) reattached it. During a concurrent interview and record review on 11/22/2024 at 12:45 p.m., Registered Nurse Supervisor (RNS) stated due to the accident on 11/6/2024 Resident 1 sustained a wound (laceration) to the left great toe that required suturing. RNS stated that CNA 1 should have asked for assistance to keep door open while transporting/pulling Resident 1 on a shower chair into the shower room to prevent the accident. RNS 1 stated CNA 1 should have documented in the Maintenance Logbook that Shower room [ROOM NUMBER]'s door was not staying open and was malfunctioning. After reviewing the Maintenance Logbook, RNS 1 stated there was no documentation regarding the malfunctioning Shower room [ROOM NUMBER]'s door. During an interview on 11/22/2024 at 1:01 p.m., the Administrator (ADM) stated when there were equipment issues or repairs needed, staff was expected to document these problems in the Maintenance Logbook. The ADM stated that CNA 1 should have reported (documented) the issue with the Shower room [ROOM NUMBER]'s door, as this could have prevented the accident involving Resident 1. During a review of the facility's policy and procedure (P&P) titled, Maintenance Services, revised 12/2009, the P&P indicated, The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. Maintaining the building in good repair and free from hazards. During a review of the facility's P&P titled Homelike Environment, revised 2/2024, the P&P indicated, Residents are provided with a safe, clean, comfortable, and homelike environment.