

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555065	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/12/2024
NAME OF PROVIDER OR SUPPLIER View Park Convalescent Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3737 Don Felipe Drive Los Angeles, CA 90008	

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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44253</p> <p>Based on observation, interview and record review, the facility (Skilled Nursing Facility-SNF) failed to provide a safe environment to prevent falling for one of two sampled residents (Resident 1), by failing to ensure:</p> <ol style="list-style-type: none"> 1. Maintenance Worker 1 (MW 1) notified Resident 1 and the resident's roommate/s that the floor was wet after mopping Resident 1's room with a wet mop. 2. MW 1 placed a wet floor sign on the floor in Resident 1's room to alert Resident 1 that the floor was wet. 3. MW 1 supervised/monitored the wet floor and re-directed Resident 1 to avoid the wet floor. <p>As a result, on 10/25/2024, Resident 1 slipped and fell , and suffered severe pain of 10 out of 10 (10/10- a numerical pain scale assessment tool where zero is no pain and 10 is severe pain) to the left knee treated with opioids (a class of drugs used to treat moderate to severe pain). Resident 1 was transferred to General Acute Care Hospital 2 (GACH 2) via 911 (a telephone number used to reach emergency medical, fire, and police services). GACH 2 diagnosed Resident 2 with a left femur fracture (broken thigh bone). On 10/29/2024, GACH 2 performed open reduction and internal fixation (ORIF - a type of surgery used to stabilize and repair broken bones, using screws, plates, sutures, or rods to hold the bone together and for healing) on Resident 1.</p> <p>Findings:</p> <p>During a review of Resident 1's General Acute Care Hospital 1 (GACH 1) History & Physical (H&P), dated 10/6/2024, the H&P indicated Resident 1 presented to GACH 1 Emergency Department (ED - The department of a hospital responsible for the provision of medical and surgical care to patients arriving at the hospital in need of immediate care) after having a mechanical fall at home. The H&P further indicated the resident was attempting to get out of bed, reached for a walker, tripped, and fell on to the left wrist with no injuries.</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, the Admission Record indicated the SNF originally admitted Resident 1 on 10/11/2024 and readmitted the resident on 10/31/2024. The Admission Record indicated Resident 1's diagnoses included left femur fracture, left eye blindness, history of falling and history of healed traumatic fracture (occurs when significant or extreme force is applied to a bone).</p> <p>During a review of Resident 1's Admission Assessment, dated 10/11/2024, the Admission Assessment indicated Resident 1 was admitted to the facility from GACH 1. The Admission Assessment further indicated Resident 1 was alert and oriented times four (person, place, time/date, and situation) with period of forgetfulness. The admission assessment indicated the resident was continent (the ability to voluntarily control) of bladder and bowel, generalized weakness, ambulated with assist, and was admitted for physical therapy (PT - treatment that uses physical activities and exercises to help improve movement, relieve pain, and strengthen muscles) and occupational therapy (OT -therapy that helps improve one's ability to perform everyday tasks, like eating and drinking).</p> <p>During a review of Resident 1's Fall Risk assessment dated [DATE], the Fall Risk Assessment indicated Resident 1 scored 16 for risk for fall (the resident was at low risk for falls).</p> <p>During a review of Resident 1's Admission Rehabilitation Screening, dated 10/12/2024, the Admission Rehabilitation Screening indicated Resident 1 did not have any impairment (a significant difference or absence in a person's body structure or function or mental functioning) in functional range of motion (ROM -how far you can move a joint in any direction) to the lower extremities (hip, knee, ankle, and foot).</p> <p>During a review of Resident 1's care plan titled, At Risk for Falls/Injury, initiated on 10/14/2024, indicated Resident 1 was at risk for falls due to general weakness, history of falls, history of left ankle fracture, osteopenia (low bone density), and muscle weakness. The care plan goal was to reduce the risk of falls and injury to Resident 1. The care plan interventions indicated staff would visibly observe the resident frequently and provide resident with a safe and clutter-free environment.</p> <p>During a review of Resident 1's Admission Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 10/15/2024, indicated Resident 1's cognition (ability to think, understand, and reason) was intact. The MDS also indicated Resident 1 ' s vision was impaired, and the resident required substantial/maximal assistance (helper does more than half the effort) with toileting hygiene, showering, dressing, and personal hygiene. The MDS further indicated Resident 1 required partial/moderate assistance (helper does less than half the effort) with walking 10 feet. The MDS also indicated Resident 1 used a walker for mobility.</p> <p>During a review of Resident 1's Change of Condition (COC- clinically important deviation from a patient's baseline) form, dated 10/25/2024 timed at 9:45 AM, the COC indicated Resident 1 was observed lying on the floor on the left side by housekeeping staff and the charge nurse. The COC also indicated the resident reported 6/10 pain level to the left leg and Resident 1 was transferred to a General Acute Care Hospital 2 (GACH 2).</p> <p>During a review of Resident 1's Physician Order, dated 10/25/2024 timed at 10 AM, the Physician order indicated to transfer Resident 1 to GACH 2 via 911 for evaluation after a fall onto her left side with left leg pain.</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 11/8/2024 at 1:17 PM, the Director of Rehabilitation (DOR) stated prior to the fall on 10/25/2024, Resident 1 was able to walk with maximum assistance. The DOR stated maintenance usually places a wet floor sign down once they have mopped. The DOR stated that a wet floor is a fall risk for any person. The DOR further stated after the fall, Resident 1 was unable to walk because the resident is in a lot of pain. The DOR stated, we premedicate (the administration of medication before a treatment or procedure to prepare the patient) her for pain before her therapy sessions.</p> <p>During an interview with Treatment Nurse 1 on 11/12/2024 at 9:54 AM, Treatment Nurse 1 stated staff are monitoring Resident 1's incision for swelling. During a concurrent observation, Resident 1 was lying in bed with head of bed up. Resident 1 was observed in a full leg immobilizing brace (a device that completely restricts movement in the leg) on her left leg with straps securing the brace closed from her upper thigh to her ankle. Resident 1 has 3 incisions along her lateral (situated at or on the side) left leg that is closed with Stryker's zip skin closure system (a non-invasive skin closure device).</p> <p>During an interview on 11/12/2024 at 12:14 PM, Licensed Vocational Nurse 1 (LVN 1) stated on 10/25/2024, LVN 1 exited Resident 1's room because MW 1 was sweeping the floor. LVN 1 stated MW 1 came out of Resident 1's room and stated, your resident [Resident 1] is on the floor. LVN 1 stated LVN 1 found Resident 1 on floor and that the resident crying out in pain. LVN 1 stated Resident 1 told LVN 1 that the floor was wet. LVN 1 stated LVN 1 could tell the floor was wet and that there was no Wet Floor sign posted. LVN 1 further stated, maintenance must make residents and staff aware that the floor is wet. Maintenance is to tell us verbally and should place a sign on the floor. LVN 1 stated she asked MW 1, where was your sign [wet floor sign], and then MW 1 placed a sign down. LVN 1 further stated, MW 1, should have placed a sign down and let the residents know the floor was wet because a wet floor is a fall hazard and that is just what happened. LVN 1 also stated Resident 1 was a fall risk because the resident already had problems with her leg before admission to the facility.</p> <p>During a phone interview on 11/12/2024 at 12:45 PM, MW 1 stated he started mopping Resident 1's room with a wet mop after Resident 1 went to the restroom and exited/left Resident 1's room after mopping the floor. MW 1 stated that Resident 1 fell after coming out of the bathroom. MW 1 stated MW 1 did not tell Resident 1 or Resident 2 that the floor was wet, and MW 1 did not put down a wet floor sign and I should have place the wet floor sign MW 1 stated MW 1 exited Resident 1's room MW 1 stated MW 1 knew that the floor was wet and f a fall hazard. MW 1 stated MW 1 forgot to place the wet floor sign. MW 1 stated this was the first time in [AGE] years, MW 1 forgot to place the sign. MW1 also stated, I feel really bad because she was really yelling in pain.</p> <p>During an interview on 11/12/2024 at 2:34 PM, the Administrator (ADM) stated, I would say the wet floor promoted or assisted the fall. The ADM further stated ADM went to Resident 1's room at the time of the fall and observed that the floor was wet.</p> <p>During a review of the facility's policy and procedures (P&P) titled, Falls and Fall Risk, Managing, revised 3/23, the P&P indicated staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. The P&P further indicated an environmental factor that contribute to the risk of falls included wet floors.</p> <p>During a review of the facility's P&P titled, Housekeeping Cleaning Sanitizing, Disinfecting, & Sterilizing, undated, the P&P indicated floor cleaning procedures are as follows:</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. Vacuum or sweep floor thoroughly, paying close attention to corners and areas near or under furniture.</p> <p>b. Using a container of water with a detergent dash germicide added, wet mop one side of corridor or floor at a time, making sure that the first side is dry before mopping the other side.</p> <p>c. Obtain a fresh solution when water is dirty.</p> <p>d. Post a warning sign WET FLOOR on both ends of wet areas.</p> <p>Based on observation, interview and record review, the facility (Skilled Nursing Facility-SNF) failed to provide a safe environment to prevent falling for one of two sampled residents (Resident 1), by failing to ensure:</p> <ol style="list-style-type: none"> Maintenance Worker 1 (MW 1) notified Resident 1 and the resident's roommate/s that the floor was wet after mopping Resident 1's room with a wet mop. MW 1 placed a wet floor sign on the floor in Resident 1's room to alert Resident 1 that the floor was wet. MW 1 supervised/monitored the wet floor and re-directed Resident 1 to avoid the wet floor. <p>As a result, on 10/25/2024, Resident 1 slipped and fell , and suffered severe pain of 10 out of 10 (10/10- a numerical pain scale assessment tool where zero is no pain and 10 is severe pain) to the left knee treated with opioids (a class of drugs used to treat moderate to severe pain). Resident 1 was transferred to General Acute Care Hospital 2 (GACH 2) via 911 (a telephone number used to reach emergency medical, fire, and police services). GACH 2 diagnosed Resident 2 with a left femur fracture (broken thigh bone). On 10/29/2024, GACH 2 performed open reduction and internal fixation (ORIF - a type of surgery used to stabilize and repair broken bones, using screws, plates, sutures, or rods to hold the bone together and for healing) on Resident 1.</p> <p>Findings:</p> <p>During a review of Resident 1's General Acute Care Hospital 1 (GACH 1) History & Physical (H&P), dated 10/6/2024, the H&P indicated Resident 1 presented to GACH 1 Emergency Department (ED - The department of a hospital responsible for the provision of medical and surgical care to patients arriving at the hospital in need of immediate care) after having a mechanical fall at home. The H&P further indicated the resident was attempting to get out of bed, reached for a walker, tripped, and fell on to the left wrist with no injuries.</p> <p>During a review of Resident 1's Admission Record, the Admission Record indicated the SNF originally admitted Resident 1 on 10/11/2024 and readmitted the resident on 10/31/2024. The Admission Record indicated Resident 1's diagnoses included left femur fracture, left eye blindness, history of falling and history of healed traumatic fracture (occurs when significant or extreme force is applied to a bone).</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 11/8/2024 at 1:17 PM, the Director of Rehabilitation (DOR) stated prior to the fall on 10/25/2024, Resident 1 was able to walk with maximum assistance. The DOR stated maintenance usually places a wet floor sign down once they have mopped. The DOR stated that a wet floor is a fall risk for any person. The DOR further stated after the fall, Resident 1 was unable to walk because the resident is in a lot of pain. The DOR stated, we premedicate (the administration of medication before a treatment or procedure to prepare the patient) her for pain before her therapy sessions.</p> <p>During an interview with Treatment Nurse 1 on 11/12/2024 at 9:54 AM, Treatment Nurse 1 stated staff are monitoring Resident 1's incision for swelling. During a concurrent observation, Resident 1 was lying in bed with head of bed up. Resident 1 was observed in a full leg immobilizing brace (a device that completely restricts movement in the leg) on her left leg with straps securing the brace closed from her upper thigh to her ankle. Resident 1 has 3 incisions along her lateral (situated at or on the side) left leg that is closed with Stryker's zip skin closure system (a non-invasive skin closure device).</p> <p>During an interview on 11/12/2024 at 12:14 PM, Licensed Vocational Nurse 1 (LVN 1) stated on 10/25/2024, LVN 1 exited Resident 1's room because MW 1 was sweeping the floor. LVN 1 stated MW 1 came out of Resident 1's room and stated, your resident [Resident 1] is on the floor. LVN 1 stated LVN 1 found Resident 1 on floor and that the resident crying out in pain. LVN 1 stated Resident 1 told LVN 1 that the floor was wet. LVN 1 stated LVN 1 could tell the floor was wet and that there was no Wet Floor sign posted. LVN 1 further stated, maintenance must make residents and staff aware that the floor is wet. Maintenance is to tell us verbally and should place a sign on the floor. LVN 1 stated she asked MW 1, where was your sign [wet floor sign], and then MW 1 placed a sign down. LVN 1 further stated, MW 1, should have placed a sign down and let the residents know the floor was wet because a wet floor is a fall hazard and that is just what happened. LVN 1 also stated Resident 1 was a fall risk because the resident already had problems with her leg before admission to the facility.</p> <p>During a phone interview on 11/12/2024 at 12:45 PM, MW 1 stated he started mopping Resident 1's room with a wet mop after Resident 1 went to the restroom and exited/left Resident 1's room after mopping the floor. MW 1 stated that Resident 1 fell after coming out of the bathroom. MW 1 stated MW 1 did not tell Resident 1 or Resident 2 that the floor was wet, and MW 1 did not put down a wet floor sign and I should have place the wet floor sign MW 1 stated MW 1 exited Resident 1's room MW 1 stated MW 1 knew that the floor was wet and f a fall hazard. MW 1 stated MW 1 forgot to place the wet floor sign. MW 1 stated this was the first time in [AGE] years, MW 1 forgot to place the sign. MW1 also stated, I feel really bad because she was really yelling in pain.</p> <p>During an interview on 11/12/2024 at 2:34 PM, the Administrator (ADM) stated, I would say the wet floor promoted or assisted the fall. The ADM further stated ADM went to Resident 1's room at the time of the fall and observed that the floor was wet.</p> <p>During a review of the facility's policy and procedures (P&P) titled, Falls and Fall Risk, Managing, revised 3/23, the P&P indicated staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. The P&P further indicated an environmental factor that contribute to the risk of falls included wet floors.</p> <p>During a review of the facility's P&P titled, Housekeeping Cleaning Sanitizing, Disinfecting, & Sterilizing, undated, the P&P indicated floor cleaning procedures are as follows:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555065	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/12/2024
NAME OF PROVIDER OR SUPPLIER View Park Convalescent Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3737 Don Felipe Drive Los Angeles, CA 90008	

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>a. Vacuum or sweep floor thoroughly, paying close attention to corners and areas near or under furniture.</p> <p>b. Using a container of water with a detergent dash germicide added, wet mop one side of corridor or floor at a time, making sure that the first side is dry before mopping the other side.</p> <p>c. Obtain a fresh solution when water is dirty.</p> <p>d. Post a warning sign WET FLOOR on both ends of wet areas.</p>