STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555329	A. Building B. Wing	11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Palma Nursing Center	1130 LA Palma Ave Anaheim, CA 92801

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 - Minimal harm or potential for 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** 44175 Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure one of three sampled residents (Resident 1) received the necessary care and services to prevent accident hazards. * The facility failed to thoroughly investigate and document Resident 1's subacute closed fracture (a broken bone that has started to heal and is not breaking the skin) of multiple ribs of the left side. In addition, the facility failed to request the physician to complete the fracture progress report and failed to conduct the root cause analysis by IDT as per the facility's P&P when the subacute fracture of Resident 1's left multiple ribs was identified after the fall incident. * The facility failed to ensure the change in condition and neurological evaluations were conducted and documented the physician's recommendations after the unwitnessed fall incident on 10/25/24, for Resident 1. These failures had the potential to negatively impact the residents' wellbeing. Findings: Review of the facility's P&P titled Fall Risk and Prevention of Injury to Include Pathological Fractures dated 3/2019 showed the following: - If a resident sustains a fall, the licensed nurse is to be notified immediately prior to moving the resident. The licensed nurse will assess the resident immediately and an incident report will be completed with an investigation. Specially emphasis should be placed on events leading up to the fall, the condition of the resident at the time of the fall and the environment where the resident fell ; - The incident report and investigation will be given to the Director of Nurses for review; - The incident report and the investigation will be reviewed by the interdisciplinary team with recommendation for additional approaches in an attempt to prevent further falls; (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 - Minimal harm or potential for actual harm Residents Affected - Few	- If the resident sustains a fracture, a root cause analysis is to be completed by the IDT to identify risk factors, any medical condition placing the resident at risk's for unavoidable fractures, any medication affecting the resident's gait or balance, lab values that could affect the residents risk for falls and/or fractures, current process in place at the time of the fall or fracture and recommendation by the IDT for additional approaches to reduce fractures, including pathological fractures. Further review of the facility's P&P showed if the resident sustains a fracture, the physician will be requested to complete the physician fracture progress report. This will identify the etiology of the fracture and to identify any condition or diagnosis that place the resident at risk for unavoidable fractures with recommendations such as orthopedic consultation, rehab assessment, pain management and/or pharmacist medication regimen review. Review of the facility's P&P titled Neurological Checks dated 9/2016 showed it is the policy of the facility that if a resident sustains a fall and hits his/her head, neurological checks will be conducted. Neurological checks will be done as follows: - Vital signs shall be taken along with the level of consciousness and pupillary response; - The appropriate form will be utilized for proper documentation and timetable for neuro checks for 72 hours; and, - Any abnormalities are to be reported to the resident's attending physician immediately. Review of the facility's document titled 72 Hours Neuro - Checklist (undated) showed the neurological evaluation are to be completed as follows: - every 30 minutes x (times) 2, - every one-hour x 3; - every two hours x 2; - every four hours x 4; and, - every eight hours x 6. Further review of the 72 Hour Neuro Checklist showed the following: - Level of consciousness (alert, drowsy, stuporous, semi-comatose, comatose); - Pupil response (equal and responsive, ipsilateral {one side} dilation, bilateral dilation, or fixation or unable); and, - Hand grip (firm or weak). Closed medical record review for Resident 1 was initiated on 10/30/24. Resident 1 was admitted to the facility on [DATE], and transferred to the acute care hospital on 10/29/24. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 1's H&P examination dated 10/4/24, showed Resident 1 was not able to make his medical decisions. Review of Resident 1's MDS dated [DATE], showed Resident 1 had a severe cognitive impairment. a. Review of Resident 1's SBAR dated 10/16/24, showed Resident 1 was found sitting next to his bed and unable to state what happened. Resident 1's skin was free of cuts and scratches with no visible bumps and bruises. Further review of the SBAR showed the physician was notified on 10/16/24 at 0600 hours, and recommended to transfer Resident 1 to the acute care hospital. Review of Resident 1's Licensed Nurses Progress Notes dated 10/16/24 at 0845 hours, showed Resident 1 was transferred to Acute Care Hospital 2 due to a fall. Review of the Resident 1's Acute Care Hospital 2 Records dated 10/16/24, showed a reason for the visit was trauma. Further review of Acute Care Hospital 2 records showed Resident 1 had closed fracture of multiple ribs of the left and right sides. Review of the Resident 1's Acute care Hospital result of the test CTA Chest Trauma dated 10/16/24, showed the following: - Subacute nondisplaced lateral left 6th and 7th rib fractures (broken bone where the pieces of bone remain aligned and don't move far enough to be out of place); - Age indeterminate left 5th and 8th rib buckle fractures (incomplete fracture); and, - Chronic right rib fractures. Review of Resident 1's medical record did not show documentation of the multiple rib fractures prior to the fall incident on 10/16/24. Review of Resident 1's Licensed Progress Notes dated 10/18/24, showed Resident Representative 1 was aware of Resident 1's multiple falls resulting in multiple rib fractures prior to the admission in the facility. However, review of Resident 1's medical record did not show if the subacute nondisplaced lateral left 6th and 7th rib fractures identified after the fall incident on 10/16/24 were discussed with Resident Representative 1. Further review of Resident 1's medical record failed to show if the facility investigated to identify the cause of the subacute nondisplaced lateral left 6th and 7th rib fractures and age indeterminate left 5th and 8th rib buckle fractures of Resident 1. In addition, there was no documentation if the physician was requested to complete the fracture progress report and if the IDT conducted the root cause analysis as per the facility's P&P. On 10/31/24 at 1136 hours, a concurrent interview and closed medical record review for Resident 1 was conducted with LVN 3. LVN 3 verified the above findings and stated she was not able to find documentation if Resident 1 had multiple fractures of the ribs before he was admitted to the facility and before the fall incident on 10/16/24, in the facility. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/1/24 at 1329 hours, a concurrent interview and closed medical record review for Resident 1 was conducted with the DON. The DON verified the above findings and stated she spoke to the Resident Representative 1 on 10/18/24, and discussed about the Resident 1's history of the multiple falls and multiple rib fractures. The DON stated Resident Representative 1 was aware about Resident 1's multiple fall and multiple rib fractures before Resident 1 was admitted to the facility; however, she did not ask specific to Resident 1's subacute nondisplaced lateral left 6th and 7th rib fractures and age indeterminate left 5th and 8th rib buckle fractures. The DON acknowledged the facility should have investigated Resident 1's subacute multiple fracture of the left ribs, requested the physician to complete the fracture progress report, and the IDT team in the facility should have conducted the root cause analysis of the fractures as per the facility's policy. 2. Review of the Resident 1's Progress Note dated 10/25/24 at 0919 hours, showed Resident 1 was found lying on floor next to bed with head towards foot of the bed. Resident 1 was able to communicate how he fell , denied having pain, and bump to the right side of the back of head. Resident 1 was assisted back to bed with no other injury. The neuro checks for Resident 1 were initiated and the physician and family were notified. Review of Resident 1's Physician Order Summary dated 10/3/24, showed to give eliquis (blood thinner) oral tablet 2.5 mg by mouth two times a day. Review of Resident 1's MAR dated 10/1/24-10/31/24, showed Resident 1 had been receiving eliquis 2.5 mg oral tablet by mouth two times a day starting 10/3/24 to 10/29/24. Further review of Resident 1's closed medical record failed to show if the change in condition and neurological evaluations were conducted after the fall incident on 10/25/24. In addition, the medical record failed to show the physician's recommendations after the incident. On 11/1/24 at 1329 hours, a concurrent interview and closed medical record review for Resident 1 was conducted with the DON. The DON verified the above findings. The DON stated she and the other staff in the facility were not notified about the above fall incident. The DON further stated licensed nurse should have completed the change in condition evaluation and neurological check and should have followed up with the physician and documented the physician recommendation after the fall incident of Resident 1 on 10/25/24.