STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555375	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunset Villa Post Acute	3232 E. Artesia Blvd. Long Beach, CA 90805

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45425 Based on interview and record review, the facility to ensure Licensed Vocational Nurse 1 (LVN 1) notified the physician and the Responsible Party (RP) for one out of three sampled residents (Resident 1) when Resident sustained an unwitnessed fall and complained of severe pain. This deficient practice resulted in Resident 1 being found on the floor after sustaining an unwitnessed fall, experiencing unrelieved pain for approximately two hours, and Resident 1 ' s RP and physician being unaware that Resident 1 fell , thus causing a delay in care and/or the inability for Resident 1 ' s physician to prescribe treatment and transfer for a higher level of care in a timely manner. Findings: 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 the diagnosis including history of a fall and subdural hemorrhage (a buildup of blood on the surface of the brain). During a review of Resident 1 ' s Nursing Admission assessment dated [DATE], the Nursing Admission Assessment indicated Resident 1 was alert, oriented to self and nonverbal. The Nursing Admission Assessment indicated Resident 1 required transfer assistance and assistance with activities of daily living ([ADLs] routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 1 ' s Change of Condition (COC) dated 10/7/2024 and timed at 2:21 p.m., the COC indicated Resident 1 was found on the floor by facility staff. The COC indicated Resident 1 was unable to explain how it happened, there was no complaints of pain, and no swelling or redness was noted. The COC indicated the MD was notified. During a review of Resident 1 ' s Joint Mobility Screen dated 10/7/2024 and timed at 8:59 a.m., the Joint Mobility Screen indicated Resident 1 was guarding (involuntary reaction to protect an area of pain) and holding her left leg upon movement and screaming. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/9/2024 at 11:30 a.m., Resident 1 ' s RP stated he visited Resident 1 on 10/7/2024 at 10:30 a.m. and found Resident 1 was in excruciating pain. The RP stated Resident 1 was screaming and wailing as if she had been hit by a car, she was grabbing her left hip, and grabbing his arm, trying to say something to him. The RP stated he informed one of the facility staff of Resident 1 ' s pain and how she was acting differently than her normal self. The RP stated facility staff were trying to give Resident 1 medication and he could hear her yelling bloody murder, which was when he decided to have the facility call 911. The RP stated when the paramedics attempted to move Resident 1 to the gurney she screamed in pure pain, and they had to administered Fentanyl (a very strong pain medication used to treat patients with severe pain) to Resident 1 prior to moving her to the gurney. The RP stated at that time he was not aware Resident 1 had fallen prior to his arriving at the facility, no one had notified him. During an interview on 10/9/2024 at 3:10 p.m., LVN 1 stated on 10/7/2024 around 9:20 a.m., she was called to Resident 1 ' s room by CNA 1, when she entered Resident 1 ' s room she found Resident 1 on the floor lying on her left side in a fetal position facing the restroom. LVN 1 stated Resident 1 was non-verbal and could not say she was in pain but Resident 1 was combative, held on to the linen, she would not let go of staff ' s hands, and she (LVN 1) could not tell if Resident 1 was experiencing pain. LVN 1 stated Resident 1 ' s RP came to visit Resident 1 (10/7/2024 at 10:30 a.m.) and informed her that Resident was in pain and requested to have her transferred to the GACH, via 911. LVN 1 stated she did not inform the RP that Resident 1 had experienced an unwitnessed fall because the RP was rude to her and would not let her get a word in. During an interview on 10/10/2024 at 9:15 a.m., RNS 1 stated on 10/7/2024 around 10:40 a.m., LVN 1 reported to her that Resident 1 ' s RP was very agitated and was requesting pain medication for Resident 1. RNS 1 stated she asked LVN 1 if Resident 1 was in pain and LVN 1 told her that Resident 1 had a baseline behavior of screaming and she (Resident 1) was not experiencing anything different from her baseline behavior. RNS 1 stated when she assessed Resident 1, Resident 1 would move her (RNS 1) hands away to prevent her from touching or assessing her (Resident 1). RNS 1 stated Resident 1 screamed when she (RNS 1) barely touched her gown, guarded her left hip, and grimaced (facial expression of pain or disgust). RNS 1 stated Resident 1 was combative and uncooperative when LVN 1 attempted to give her pain medication and was subsequently given intravenous ([IV] given directly into the blood stream) pain medication prior to being transferred to the gurney when the paramedics arrived. RNS 1 stated LVN 1 never reported to her that Resident 1 had sustained a fall earlier that day and she (LVN 1) still did not report that Resident 1 had fallen while she (RNS 1) was assessing Resident 1, before or after the paramedics arrived. RNS 1 stated LVN 1 should have notified her and Resident 1 ' s physician when she found Resident 1 on the floor. During an interview on 10/10/2024 at 5:06 p.m., the DON stated LVN 1 should have notified himself (DON), Resident 1 ' s physician, RNS 1 and the Resident 1 ' s RP following Resident 1 ' s unwitnessed fall. During a review of the facility ' s policy and procedure (P/P) titled Change in a Resident ' s Condition or Status dated 9/2015, the P/P indicated the nurse supervisor or charge nurse will notify the resident ' s physician when there has been an accident or incident involving the resident and if there is a significant change in the resident ' s physical/emotional/mental conditions. The policy indicated the nurse supervisor/charge nurse will notify the resident ' s family or representative when there is a significant change in the resident ' s physical, mental or psychosocial status.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45425 Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1), who had an unwitnessed fall, did not experience extreme pain for over two hours after she was found on the floor, before care and treatment were rendered, when: 1. Licensed Vocational Nurse 1 (LVN 1) failed to report to Resident 1 ' s physician, that Resident 1 had an unwitnessed fall, so that care instructions including an order for pain medication could be prescribed and administered. 2. LVN 1 failed to conduct a post-fall assessment of Resident 1 to determine if an injury occurred or to determine Resident 1 ' s pain level. 3. LVN 1 failed to report to Resident 1 ' s physician when the Physical Therapist (PT 1) reported to her, following PT 1 ' s evaluation of Resident 1, that Resident 1 was screaming and guarding (involuntary reaction to protect an area of pain) her left hip on evaluation. 4. LVN 1 failed to report to RNS 1 that Resident 1 had an unwitnessed fall when Resident 1 ' s RP visited the resident and reported that Resident 1 was in excruciating pain. These deficient practices resulted in Resident 1 experiencing unrelieved pain for over two hours following an unwitnessed fall, a delay in evaluation, treatment, and transfer to the GACH. Resident 1 was subsequently transferred to a GACH on 10/7/2024, where she was assessed with a comminuted left intertrochanteric fracture (a broken hip where the bone is broken into multiple pieces) and underwent a surgical procedure to repair the fracture. This deficient practice had the potential for Resident 1 ' s pain to continue to go unmanaged if Resident 1 ' s RP had not intervened and reported Resident 1 ' s pain. Findings: 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 the diagnosis including a history of falls and a subdural hemorrhage (a buildup of blood on the surface of the brain). During a review of Resident 1 ' s Nursing Admission assessment dated [DATE], the Nursing Admission Assessment indicated Resident 1 was alert, oriented to self and nonverbal. The Nursing Admission Assessment indicated Resident 1 required transfer assistance and assistance with activities of daily living ([ADLs] routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 1 ' s Change of Condition (COC) dated 10/7/2024 and timed at 2:21 p.m., the COC indicated Resident 1 was found on the floor by facility staff (Certified Nursing Assistant 1 [CNA 1]). The COC indicated Resident 1 was unable to explain how the fall happened, did not complaint of pain, and no swelling or redness was noted on Resident 1. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1 ' s Joint Mobility Screen dated 10/7/2024 and timed at 8:59 a.m., the Joint Mobility Screen indicated Resident 1 was screaming, guarding, and holding her left leg upon movement. During a review of Resident 1 ' s Transfer Form dated 10/7/2024 and timed at 11:45 a.m., the Transfer Form indicated Resident 1 was transferred to a GACH due to uncontrolled pain on the back of her left iliac crest (the curved part at the top of the hip bone). The Transfer Form indicated Resident 1 had a pain level of 9 out of 10, on an 11 eleven-point scale (0 = no pain, 1-3 = mild pain, 4-6 = moderate pain, and 7-10 = severe pain, and 10 = worst imaginable pain). During a review of the Paramedic ' s Report, dated 10/7/2024, the Paramedic ' s Report indicated they were dispatched to the facility at 11:13 a.m., arrived at the facility at 11:19 a.m., left the facility at 11:47 a.m., and arrived at the GACH at 11:49 a.m. The Paramedic ' s Report indicated Resident 1 complained of hip pain, without any traumatic events or reported falls and was in significant pain. The Paramedic ' s Report indicated Resident 1 was administered 50 micrograms ([mcg] a unit of measurement) of intravenous ([IV] directly into the blood stream via a vein) Fentanyl at 11:36 a.m., and 50 mcg of IV Fentanyl at 11:41. During a review of Resident 1 ' s GACH ' s Admission record, the Admission record indicated Resident 1 was admitted to the GACH on 10/7/2024. During a review of Resident 1 ' s GACH Radiology (a branch of medicine that uses imaging technology to diagnose and treat disease) report dated 10/7/2024, the Radiology report indicated Resident 1 had a comminuted left intertrochanteric fracture. During a review of Resident 1 ' s GACH Post-Operative Note dated 10/9/2024, the Post-Operative Note indicated Resident 1 had surgery to repair the left hip fracture. During an interview on 10/9/2024 at 11:30 a.m., with Resident 1 ' s RP, the RP stated he visited Resident 1 on 10/7/2024 at 10:30 a.m. and found Resident 1 in excruciating (unbearable) pain. The RP stated Resident 1 was screaming and wailing as if she had been hit by a car, she was grabbing her left hip, and grabbing his (the RP ' s) arm, trying to say something to him (the RP). The RP stated he informed one of the facility staff that Resident 1 was in pain and how she was acting differently than her normal self. The RP stated facility staff tried to give Resident 1 pain medication and he could hear her yelling bloody murder, which was when he asked the facility to call 911. The RP stated when the paramedics arrived, they attempted to move Resident 1 to a gurney to transfer her to the GACH, and Resident 1 screamed in pure pain and the Paramedics administered Fentanyl (a very strong pain medication used to treat patients with severe pain) to Resident 1 prior to moving her to the gurney. During an interview on 10/9/2024 at 2:30 p.m., with Certified Nursing Assistant 1 (CNA 1), CNA 1 stated on 10/7/2024, between 7 a.m. and 9:30 a.m., she found Resident 1 in her room on the floor, on her left side. CNA 1 stated she asked Resident 1 if she was okay, but Resident 1 was agitated and did not respond. CNA 1 stated she called CNA 2 and LVN 1 to Resident 1 ' s room. CNA 1 stated she, LVN 1, and CNA 2 transferred Resident 1 back to bed. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Actual harm Residents Affected - Few	During an interview on 10/9/2024 at 3:10 p.m., with LVN 1, LVN 1 stated on 10/7/2024 around 9:20 a.m., she was called to Resident 1 ' s room by CNA 1, when she entered Resident 1 ' s room she observed Resident 1 on the floor lying on her left side in a fetal position (when a person curls up on their side with their arms and legs drawn up toward their chest and their head bowed forward) facing the restroom. LVN 1 stated Resident 1 was non-verbal and could not say she was in pain but was combative, held on to the linen, would not let go of staff ' s hands, and she (LVN 1) could not tell if Resident 1 was experiencing pain. LVN 1 stated on 10/7/2024 at 10:30 a.m., Resident 1 ' s RP came to visit Resident 1 and informed her that Resident was in pain. LVN 1 stated the RP requested that Resident 1 be transferred to the GACH, via 911. During an interview on 10/10/2024 at 9:15 a.m., with RNS 1, RNS 1 stated on 10/7/2024 around 10:40 a.m., LVN 1 notified her that Resident 1 ' s RP was very agitated and requested pain medication for Resident 1. RNS 1 stated she asked LVN 1 if Resident 1 was in pain and LVN 1 told her that Resident 1 had a baseline behavior of screaming and was not experiencing anything different from her baseline behavior. RNS 1 stated when she assessed Resident 1, Resident 1 moved her (RNS 1) hands away to prevent her from touching or assessing her (Resident 1). RNS 1 stated Resident 1 screamed when she (RNS 1) barely touched her gown, guarded her left hip, and grimaced (facial expression of pain or disgust). RNS 1 stated Resident 1 was combative and uncooperative when LVN 1 attempted to give her pain medication and was subsequently given intravenous ([IV] directly into the blood stream) pain medication (Fentanyl), by the paramedics, just before she was transferred to the gurney when the paramedics arrived. RNS 1 stated LVN 1 should have notified her and Resident 1 ' s physician when she (LVN 1) observed Resident 1 on the floor, so that resident 1 ' s physician could be notified to obtain an order for pain medication. RNS 1 stated LVN 1 should have assessed Resident 1 ' s mentation (mental activity), neurological status (brain and nervous system functioning), skin condition, range of motion ([ROM] the amount of movement that a particular joint or series of joints can achieve in a specific direction) to her extremities, and her vital signs ([v/s] measurements of the body ' s most basic functions including the body temperature [BT], blood pressure [BP], heart rate [HR] and respiratory rate [RR]). During an interview on 10/10/2024 at 10:51 a.m., with PT 1, PT 1 stated on 10/7/2024 around 9:30 - 9:45 a. m., he assessed Resident 1 because Resident 1 ' s physician ordered PT to complete an initial assessment and evaluation on Resident 1. PT 1 stated when he tried to assess Resident 1 ' s mobility, she guarded her left leg and screamed when he moved her left leg. PT 1 stated he reported to LVN 1 that Resident 1 was guarding her left leg and in pain during her evaluation. PT 1 stated he was unaware Resident 1 had an unwitnessed fall that morning. During an interview on 10/10/2024 at 6:44 p.m., with LVN 1, LVN 1 stated PT 1 reported to her that Resident 1 was guarding her left hip during PT 1 ' s evaluation. LVN 1 stated she did not have time to report PT 1 ' s findings to Resident 1 ' s physician or RNS 1 because on 10/7/2024, at 10:30 a.m., Resident 1 ' s RP came to the facility and reported Resident 1 was in pain and 911 was called. During an interview on 10/10/2024 at 5:06 p.m., the Director of Nursing (DON) stated LVN 1 should have notified himself (DON), Resident 1 ' s physician, RNS 1 and the Resident 1 ' s RP following Resident 1 ' s unwitnessed fall. The DON stated if RNS 1 had been notified of Resident 1 ' s unwitnessed fall, RNS 1 could have assessed Resident 1 immediately when Resident 1 was found on the floor. The DON stated, if Resident 1 was in pain, staff should have given her pain medication. The DON stated Resident 1 was transferred to a GACH because Resident 1 ' s pain was uncontrollable. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	During a review of the facility ' s Policy and Procedure (P/P), titled Pain-Clinical Protocol dated 2001, the P/P indicated the nursing staff will assess each individual for pain upon admission to the facility, at the quarterly review, whenever there is a significant change in condition, and where there is onset or new pain or worsening existing. The staff and physician will identify the characteristics of pain such as location, intensity, frequency, pattern, and severity. Staff will use a consistent approach and a standardized pain assessment instrument appropriate to the resident ' s cognitive level. During a review of the facility ' s P/P titled Change in a Resident ' s Condition or Status dated 9/2015, the P/P indicated the nurse supervisor or charge nurse will notify the resident ' s physician when there has been an accident or incident involving the resident and if there is a significant change in the resident ' s physical/emotional/mental conditions.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45425 Based on interview and record review, the facility failed to ensure Licensed Vocational Nurse (LVN 1) was competent to care of one of three sampled resident (Resident 1) who sustained an unwitnessed fall, by ensuring LVN 1 was in-serviced on fall assessment, prevention of falls and procedures following a fall, when their Fall Prevention in Long Term Care Part 1: Risk Assessment video was available in 9/2024. This deficient practice resulted in Resident 1 sustaining an unwitnessed fall and no one being aware that Resident 1 fell and/or was in pain, when LVN 1 did not conduct an initial assessment of Resident 1 following her fall, did not report to Resident 1 ' s physician, that Resident 1 fell in order to obtain instructions for care and pain management, did not report to the Registered Nurse Supervisor (RNS 1) or Resident 1 ' s Responsible Party (RP) following Resident 1 ' s fall and did not report the physical therapist ' s (PT 1) findings that Resident 1 was guarding her left leg and screaming during PT 1 ' s evaluation. Findings: 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 the diagnosis including a history of falls and a subdural hemorrhage (a buildup of blood on the surface of the brain). During a review of Resident 1 ' s Nursing Admission assessment dated [DATE], the Nursing Admission Assessment indicated Resident 1 was alert, oriented to self and nonverbal. The Nursing Admission Assessment indicated Resident 1 required transfer assistance and assistance with activities of daily living ([ADLs] routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 1 ' s Change of Condition (COC) dated 10/7/2024 and timed at 2:21 p.m., the COC indicated Resident 1 was found on the floor by facility staff (Certified Nursing Assistant 1 [CNA 1]). The COC indicated Resident 1 was unable to explain how the fall happened, did not complaint of pain, and no swelling or redness was noted on Resident 1. During a review of Resident 1 ' s Joint Mobility Screen dated 10/7/2024 and timed at 8:59 a.m., the Joint Mobility Screen indicated Resident 1 was screaming, guarding, and holding her left leg upon movement. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/9/2024 at 11:30 a.m., with Resident 1 ' s RP, RP 1 stated he visited Resident 1 on 10/7/2024 at 10:30 a.m. and found Resident 1 in excruciating (unbearable) pain. The RP stated Resident 1 was screaming and wailing as if she had been hit by a car, she was grabbing her left hip, and grabbing his arm, trying to say something to him. The RP stated he informed one of the facility staff that Resident 1 was in pain and how she was acting differently than her normal self. The RP stated facility staff tried to give Resident 1 pain medication and he could hear her yelling bloody murder, which was when he asked the facility to call 911. The RP stated when the paramedics arrived, they attempted to move Resident 1 to a gurney to transfer her to the GACH, and Resident 1 screamed in pure pain and the Paramedics administered Fentanyl to Resident 1 prior to moving her to the gurney. The RP stated at that time he was not aware that Resident 1 had fallen prior to his arrival at the facility, because no one notified him. During an interview on 10/9/2024 at 2:30 p.m., with Certified Nursing Assistant 1 (CNA 1), CNA 1 stated on 10/7/2024, between 7 a.m., and 9:30 a.m., she found Resident 1 in her room on the floor, on her left side. CNA 1 stated she asked Resident 1 if she was okay, but Resident 1 was agitated and did not respond. CNA 1 stated she called CNA 2 and LVN 1 to Resident 1 ' s room. CNA 1 stated she, LVN 1, and CNA 2 transferred Resident 1 back to bed. During an interview on 10/9/2024 at 3:10 p.m., with LVN 1, LVN 1 stated on 10/7/2024 around 9:20 a.m., she was called to Resident 1 ' s room by CNA 1, when she entered Resident 1 ' s room she observed Resident 1 on the floor lying on her left side in a fetal position facing the restroom. LVN 1 stated Resident 1 was non-verbal and could not say she was in pain but was combative, held on to the linen, would not let go of staff ' s hands, and she (LVN 1) could not tell if Resident 1 was experiencing pain. LVN 1 stated on 10/7/2024 at 10:30 a.m., Resident 1 ' s RP came to visit Resident 1 and informed her that Resident was in pain. LVN 1 stated the RP requested that Resident 1 be transferred to the GACH, via 911. LVN 1 stated she did not inform the RP that Resident 1 had an unwitnessed fall because the RP was rude to her and would not let her get a word in. LVN 1 stated if a resident fell , it should be reported to the Administrator (ADM), the Director of Nursing (DON), Rehabilitation Department, and if the resident had a major issue, 911 was supposed be called. During an interview on 10/10/2024 at 9:15 a.m., with RNS 1, RNS 1 stated on 10/7/2024 around 10:40 a.m., LVN 1 notified her that Resident 1 ' s RP was very agitated and requested pain medication for Resident 1. RNS 1 stated she asked LVN 1 if Resident 1 was in pain and LVN 1 told her that Resident 1 had a baseline behavior of screaming and was not experiencing anything different from her baseline behavior. RNS 1 stated when she assessed Resident 1, Resident 1 moved her (RNS 1) hands away to prevent her from touching or assessing her (Resident 1). RNS 1 stated Resident 1 screamed when she (RNS 1) barely touched her gown, guarded her left hip, and grimaced (facial expression of pain or disgust). RNS 1 stated Resident 1 was combative and uncooperative when LVN 1 attempted to give her pain medication and was subsequently given intravenous ([IV] directly into the blood stream) pain medication just before she was transferred to the gurney when the paramedics arrived. RNS 1 stated LVN 1 never reported to her that Resident 1 had a fall earlier that day and she (LVN 1) still did not report that Resident 1 had fallen while she (RNS 1) was assessing Resident 1, before or after the paramedics arrived. RNS 1 stated LVN 1 should have notified her and Resident 1 ' s physician when she observed Resident 1 on the floor and she should have assessed Resident 1 ' s mentation (mental activity), neurological status (brain and nervous system functioning), skin condition, range of motion ([ROM] the amount of movement that a particular joint or series of joints can achieve in a specific direction) to her extremities, and her vital signs (v/s). (continued on next page)

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/10/2024 at 10:51 a.m., with PT 1, PT 1 stated on 10/7/2024 around 9:30 - 9:45 a. m., he assessed Resident 1 because Resident 1 ' s physician ordered PT to complete an initial assessment and evaluation on Resident 1. PT 1 stated when he tried to assess Resident 1 ' s mobility, she guarded her left leg and screamed when he moved her left leg. PT 1 stated he reported to LVN 1 that Resident 1 was guarding her left leg and in pain during her evaluation. PT 1 stated he was unaware Resident 1 had an unwitnessed fall that morning. During an interview on 10/10/2024 at 3:14 p.m., the Director of Staff Development (DSD) stated as of 9/2024, new hires during orientation watch a video titled Fall Prevention in Long Term Care Part 1: Risk Assessment which addresses how to assess a resident after a fall, how to prevent falls and the procedure after a resident has sustained a fall. The DSD stated LVN 1 ' s hire date was prior to 9/2024, so she (LVN 1) did not watch the video during her orientation. The DSD stated fall education is complete yearly and in-services should be completed after a resident sustains a fall. During an interview on 10/10/2024 at 6:44 p.m., with LVN 1, LVN 1 stated PT 1 reported to her that Resident 1 was guarding her left hip during PT 1 ' s evaluation. LVN 1 stated she did not have time to report PT 1 ' s findings to Resident 1 ' s physician or RNS 1 because on 10/7/2024, at 10:30 a.m., Resident 1 ' s RP came to the facility and reported Resident 1 was in pain and 911 was called. During a review of the facility ' s P/P titled Change in a Resident ' s Condition or Status dated 9/2015, the P/P indicated the nurse supervisor or charge nurse will notify the resident ' s physician when there has been an accident or incident involving the resident and if there is a significant change in the resident ' s physical/emotional/mental conditions. During a review of the facility ' s Job Description for Licensed Vocational Nurses (LVN) dated 11/2018, the Job Description indicated one of the LVN ' s nursing care functions include notifying the resident ' s attending physician and next of kin when there is a change in the resident ' s condition and when the resident is involved in an accident or incident.