STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555397	A. Building B. Wing	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Rehabilitation Center of Los Angeles	340 South Alvarado Street Los Angeles, CA 90057

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** 49571 Based on observation, interview, and record review the facility failed to implement its ' policy and procedures (P&P) titled Fall Management Program, for one of three sampled residents (Resident 1), who was identified as fall risk and was dependent on staff for orientation and ambulation. This deficient practice resulted in Resident 1 ' s having recurrent unwitnessed falls within 30 days (on 12/17/24; 1/2/2025; and 1/21/2025) in the facility and had the potential for a serious injury or harm to Resident 1. Findings: Resident 1 had three unwitnessed falls on 12/17/2024, 1/2/2025, and 1/21/2025. Resident 1 was transferred to acute general care hospital (GACH) for computed tomography (CT scan- a medical diagnostic imaging procedure to produce images of the inside of the body) to rule out a head injury status post fall. On 1/2/2025 Resident 1 had a fall while trying to get out of bed unassisted to go to bathroom, Resident 1 was sent out to GACH for CT scan. On 1/21/2025 Resident 1 was found sitting on the floor mat next the bed. Resident 1 was attempting to go to bathroom and fell , call light was not answered for an hour while Resident 1 ' s family member was on face time phone call. During a review of Resident 1 ' s Admission Record, indicated, Resident 1 was initially admitted on [DATE] and readmitted to the facility on [DATE] with a diagnosis including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness or inability to move one side of the body), unspecified abnormalities of gait and mobility, unspecified lack of coordination, and benign prostatic hyperplasia (BPH-an enlarged prostate gland that makes it difficult to urinate). During a review of Resident 1 ' s History and Physical (H&P), dated 1/3/2025, the H&P indicated, Resident 1 had altered mental status (a mental function disorientation, confusion). It indicated, Resident 1 was seen earlier in the emergency department for a fall and was cleared by the previous emergency department provider. (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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NAME OF PROVIDER OR SUPPLIER The Rehabilitation Center of Los Angeles		STREET ADDRESS, CITY, STATE, ZIP CODE 340 South Alvarado Street Los Angeles, CA 90057	

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1 ' s Fall Risk Evaluation dated 12/4/2024, the fall risk evaluation indicated, Resident 1 was a high risk for falls with a score of 16 (A score of 10 or higher, the resident should be considered at high risk for potentials falls). The fall risk evaluation indicated, Resident 1 is disoriented, has a history of one to two falls in the past three months, regularly incontinent, and has one to two predisposing diseases such as hypotension (low blood pressure) and cerebrovascular accident (CVA- stroke, loss of blood flow to a part of the brain). During a review of Resident 1 ' s Care Plan, initiated and revised on 1/7/2025, the Care Plan related to resident at risk for fall related to gait/balance problems, the goal for the care plan was the resident will minimize risk of injury from falls until next review date. The care plan interventions indicated, anticipate and meet the resident ' s needs. During the review of Resident 1 ' s Minimum Data Set (MDS, a resident assessment tool) dated 12/10/2024, the MDS indicated, Resident 1 ' s Brief Interview for Mental Status (BIMS- to determine the individual's attention, orientation and ability to register and recall new information) score was 06, indicating Resident 1 was severely impaired (limiting an individual's physical or mental ability to perform basic work activities on a daily basis). The MDS indicated Resident 1 requires walker, wheelchair for mobility, requires substantial/maximal assistance (Helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) to sit and stand and for toilet transfer. The MDS indicated, Resident 1 did not have a fall history prior to admission to the facility. During a review of Resident 1 ' s Order Summary dated 12/17/2024, it indicated, transfer GACH 1 emergency room for CT scan of head status post fall on 12/17/2024 to rule out hematoma (a collection of blood outside of blood vessels/broken blood vessels caused by injury). The CT scan indicated angio Head/Neck indicated Negative exam for acute vascular pathology. During a review of Resident 1 ' s post fall evaluation Interdisciplinary team (IDT) review, dated 1/2/2025, the IDT review indicated, Resident 1 had unwitnessed fall from bed on 1/21/2025, had two falls in the last thirty days. The IDT note further indicated; Resident 1 was trying to get out of bed unassisted to go to the bathroom. Resident 1 was sent to acute care hospital for CT scan. The CT scan indicated angio Head/Neck indicated Negative exam for acute vascular pathology. During a review of Resident 1 ' s post fall evaluation Interdisciplinary team (IDT) review, dated 1/21/2025, the IDT review indicated, Resident 1 had unwitnessed fall from bed, on 1/21/2025 at 9:15 AM, had two falls in the last thirty days. The plan was to continue with low bed, floor mat pad, alarm as restrictive device, new medication ordered for BPH. During a review of Resident 1 ' s Progress Notes, dated 1/21/2025, it indicated Resident 1 was found sitting on the floor mat next to the bed on 1/21/2025 at 9:15am. During a concurrent observation and interview on 1/22/2025 at 10:05 AM, Resident 1 was observed sitting in a wheelchair trying to self-ambulate in a hallway in front of nursing station on second floor. Resident 1 stated, I came to the facility in November, I don ' t remember falling, I did not fall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/22/2025 at 10:54 AM with certified nursing assistant (CNA 1), CNA 1 stated, I am usually assigned for Resident 1 most of the time. He fell a couple times in the past month, the last fall was yesterday, 1/21/2025. He turns off the bed alarm, he finds a way to reach for it and turn it off. Unless he has a sitter, his falls are unavoidable, even when he was given a urinal, he forgets he has the urinal and gets up to go to bathroom. During an interview with Licensed Vocational Nurse (LVN)1, on 1/22/2025 at 1:19 PM, LVN 1 stated, Resident 1 was admitted to the facility to recover from a stroke. He can be non-compliant, never aggressive but very forgetful, tried to get up all the time. One of the CNAs witnessed Resident 1 turning off his bed alarm earlier today around 11 AM. Resident 1 might benefit from a sitter assigned to him because all measures taken to prevent his fall did not prevent it. During an interview with the Registered Nurse Supervisor (RN), on 1/22/2025 at 1:45 PM, the RN stated, Resident 1 is unstable, has weakness on one side of his body, and wheelchair bound. His last fall was yesterday 1/21/2025 his call light was on, staff found him in a sitting position on the floor in his room. He was on face time, we asked the family member on facetime, the family member said, I think he wants to go to bathroom. The RN further stated the fall could be avoidable and preventable, the resident can benefit from a sitter, we have been discussing it, his doctor has agreed to have a sitter assigned. During an interview with the Director of Nursing (DON), on 1/22/2025 at 2:39 PM, the DON stated, Resident has a history of fall, his first fall occurred in December 2024, second fall occurred first week of January, he was sent out to a GACH for CT scan of the brain. The CT came back negative. DON further stated, Resident 1 is forgetful, his last fall was yesterday (1/21/2025) he was on facetime with his family member, his family member was telling him no to get up and to call for help, but he ended up falling. During a follow up telephone interview, on 2/5/2025 at 10:08 AM with family member (FM) 3, FM 3 stated, on 1/2/2025 I was on a facetime phone call with Resident 1. Resident 1 was calling staff for an hour to go to bathroom. FM 3 stated after an hour, I called the facility front desk and I was put on hold, while I was on hold, Resident 1 put his phone on the table and I lost the visuals, few minutes later I heard a facility staff entering Resident 1 ' s room raising their voices because they were concerned with what happened. FM 3 further stated Resident 1 fell and was on the ground. FM 3 stated I did not see the actual fall; the facility ' s Staff informed me Resident 1 was sitting on the floor. Family 3 further stated, Resident 1 had a fall on December 17, 2024, and January 21, 2025, as well. FM 3 further stated, I understand accidents in Resident 1 ' s medical conditions are expected and happen, but the number of falls Resident 1 had in one month is very concerning. FM 3 further stated, during the last fall, when I spoke to a male nurse if he saw Resident 1 hit his head, the male nurse told me no, I asked how do you know, the male nurse then told me he found Resident 1 on the ground on his side, that is when another family member had to ask to have Resident 1 be transferred to GACH for evaluation. During the review of the facility ' s P&P titled Fall Management Program, reviewed 11/20/2024, the P&P indicated, Supervision/Adequate Supervision: An intervention and means of mitigating the risk of an accident. Facilities are obligated to provide adequate supervision to prevent accidents.