STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555397	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/05/2025

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 - 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** 50714 Based on interview and record review, the facility failed to provide a safe and accident-free environment for one of three sampled residents (Resident 2), who was assessed as high fall risk, impaired gait (walking pattern different than normal) and mobility, and had diagnosis of dementia (a chronic condition that causes a gradual decline in cognitive abilities, such as thinking, remembering, and reasoning) by failing to: -Provide Resident 2 supervision to prevent falls, per the facility's policy titled, Fall Management Program. -Develop and implement a person-centered care plan which included supervision to prevent falls and injury. As a result, Resident 2 had a fall on 1/19/2025 at 6:30 AM, in his room, and complained of pain rated at 10 out of 10 (the most severe pain). On 1/19/2025 at 6:03 PM, Resident 2 fell again in his room. Resident 2 received a Stat (immediate) X-ray of the right shoulder on 1/20/2025, which resulted in a minimally displaced acute (fresh fracture, bone shifted slightly but not significantly) acromion fracture (a flattened piece of bone that forms the top of the shoulder, meets the collarbone and a key part for wide range of motion) and was transferred to the General Acute Care Hospital (GACH) for further evaluation. Findings: A review of Resident 2's admission record indicated the resident was admitted to the facility on [DATE] with diagnoses including cerebral infarction (a type of stroke that occurs when an area of brain tissue dies due to a lack of blood flow), dementia), and Parkinson's Disease (a progressive disease of the nervous system marked by tremor, muscular rigidity [muscles become stiff and resistant to movement], and slow, imprecise movements). A review of Resident 2's At Risk for Falls care plan related to confusion and incontinence(having no or insufficient voluntary control over urination or defecation), dated 1/4/2025 indicated interventions to place call light within reach, encourage the resident to use the call bell for assistance, and to anticipate and meet the resident's needs. (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

A review of Resident 2's Fall Risk assessment dated [DATE] indicated with a total score of 10 or greater, the resident should be considered a high risk for potential falls, a fall prevention protocol should be initiated immediately, and documented on the resident's care plan. The fall risk assessment indicated Resident 2 was disoriented times three ([NAME], place time), and under gait / balance / ambulation had decreased muscle coordination and jerking movements. The fall risk assessment indicated Resident 2 had no falls in the past three months, scored a 14, and was considered a high risk for potential falls.

A review of the Physician's Orders Summary Report dated 1/4/2025 indicated Resident 2 received an indwelling catheter due to benign prostatic hyperplasia (BPH - a common condition in older men where the prostate gland enlarges, putting pressure on the urethra [the tube that carries urine from the bladder to the outside of the body]).

According to a review of Resident 2's History and Physical (H&P) dated 1/6/2025 the resident did not have the capacity to understand and make decisions due to dementia, had right sided weakness, and a history of CVA-stroke. The H&P indicated Resident 2 also had a history of Parkinson's Disease, rigidity (being stiff, inflexible, or unable to bend) in both lower extremities.

A review of Resident 2's Minimum Data Set (MDS - a resident assessment tool) dated 1/8/2025, indicated the resident's cognitive skills for daily decision-making skills was severely impaired, had problems with short and long-term memory, and the resident was dependent for hygiene, showering/bathing. The MDS indicated Resident 2 had impairment on both sides for upper and lower extremities, was always incontinent of bowel, and had decreased ability to make himself understood (spoke a different language other than English). The MDS indicated Resident 2 did not have a fall in the last 2-6 months, was at high risk for falls/injuries, had impaired gait and mobility, and sit to stand nor transfer was attempted due to the resident's medical condition and safety.

A review of the At Risk for Falls and Injuries care plan dated 1/17/2025 indicated Resident 2 had risk factors including a history of falls, poor safety awareness and poor mobility. The care plan goal indicated Resident 2 would have no injuries related to falls. The interventions indicated to encourage Resident 2 to call for assistance in ambulation.

A review of the Post Fall Evaluation / Interdisciplinary Team note (IDT, a team of professionals from various fields who work together toward the goals of the resident) dated 1/19/2025 at 7:30 AM, indicated Resident 2 was found on the floor facing the bathroom. The IDT note indicated Resident 2 wanted to go to the bathroom and his bed had no bowel movement noted. The IDT note indicated Resident 2 pointed to his right shoulder when the facility assessed him for pain.

A review of the Physician's Order Summary Report dated 1/19/2025 indicated Resident 2 received a stat X-ray of the right shoulder.

Further review of the Physician's Orders indicated there was no order for Resident 2 to receive supervision, padded mats, or a bed alarm (a device that monitors a person's movements in bed and alerts caregivers when the person is trying to get up) prior to 1/19/2025.

A review of the Progress Note dated 1/19/2025 at 5:03 PM indicted the physician was informed of the fall and gave an order to transfer Resident 2 to the GACH due to abnormal right shoulder X-ray.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of the Post Fall Evaluation / Interdisciplinary Team note dated 1/19/2025 at 10:24 PM indicated at 6:03 PM Resident 2 had another fall in his room. A visitor of Resident 2's roommate informed the staff that Resident 2 was on the floor. Resident 2 had no complaints of pain and there were no injuries noted. A review of the facility's X ray report dated 1/20/2025 at 9:14 AM indicated Resident 2 had one view of the right shoulder completed. The X-ray report findings indicated Resident 2 had a minimally displaced acute acromion fracture. According to a review of the fax document from the facility to the Department dated 1/20/2025, Resident 2 was found on the floor on his back next to his bed, with his head facing the restroom on 1/19/2025 at 6:30 AM. The fax document indicated Resident 2 complained of pain rated at 10 out of 10 (most severe pain). A review of the facility's fax document dated 1/20/2025, at around 4:20 PM, the facility was notified by the Physician (MD) that Resident 2's x-ray at the GACH was a confirmed fracture of the acromion. According to the MD, Resident 2 was stable, no surgery would be performed, and Resident 2 would return to the facility. A review of the GACH History and Physical (H&P) dated 1/20/25 indicated Resident 2 was brought in by ambulance due to two unwitnessed falls and an x-ray showed an acromion fracture. The H&P indicated Resident 2 had been very restless/agitated a few days prior to hospitalization to the GACH, pulled his catheter out and was noted to have hematuria (blood in your urine) in the catheter. The GACH Emergency Department Note indicated Resident 2 was admitted to the telemetry unit (continuous cardiac monitoring). A review of Resident 2's GACH Progress Notes dated 1/21/2025 indicated the resident continued to complain about his shoulder pain. The progress notes indicated Resident 2 would need a sling for four weeks for the right acromion fracture and could not bear weight (should not put any weight) on the right upper extremity (right arm) for four weeks. A review of Resident 2's GACH Progress Notes dated 1/22/2025 indicated the physician was called by nursing because Resident 2 had become agitated late in the afternoon and was more agitated than he had been earlier in the day. The progress notes indicated the GACH could not transfer Resident 2 to the skilled nursing facility with restraints, therefore mittens were applied, and Ativan (a medication that can make the user feel calm and physically relaxed) was ordered. A review of the facility's Physician's Order Summary Report dated 1/23/2025 indicated Resident 2 received a right upper arm sling for right acromion fracture, may remove for shower. A review of the facility's post fall evaluation dated 1/24/2024 indicated Resident 2 fell on [DATE] at 6:30 AM (first fall) after he wanted to go to the bathroom and the plan was to transfer Resident 2 to the hospital. Another post fall evaluation indicated Resident 2 fell again on 1/19/2025 at 6:03 PM (second fall) which occurred before the transfer to GACH. (continued on next page)

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F 0689

Level of Harm - Actual harm

Residents Affected - Few

According to a review of Resident 2's post fall evaluation dated 1/27/2025, the root cause analysis of the resident was a risk for falls and injuries due to history of falls, incontinence bowel and bladder, poor safety awareness, history of CVA, weakness, dementia, toxic encephalopathy (a condition where the brain becomes inflamed and damaged due to exposure to toxins or other harmful substances), Parkinson's disease, and use of psychoactive drugs (a drug or other substance that affects how the brain works and causes changes in mood, awareness, thoughts, feelings, or behavior).

A review of Resident 2's post fall evaluation dated 2/4/2025 indicated Resident 2 fell on [DATE] (third fall) due to agitation and restlessness and was transferred to the GACH again for further evaluation.

During an interview on 2/5/2025 at 8:15 am, the Director of Nursing (DON) stated Resident 2's family member visited the day of the fall, and the resident was calm. The DON stated Resident 2 was later found on the floor and this was most likely when he broke his right acromion. The DON stated Family Member 1 left for the day and Resident 2 had another fall around 7 PM the same day (1/19/2025). The DON stated Resident 2 was transferred to the GACH, returned to the facility on [DATE], then was transferred back again to the GACH on 1/31/2025 (approximately one week later) after a third fall.

During an interview on 2/5/2025 at 12:40 PM, Family Member 1 stated, via Spanish language line interpreter, that there were some loose bedding at the bottom of Resident 2's bed and she asked the staff to fix it, but staff fixed and changed the mattress and not the bedding. Family Member 1 stated she received a call from the facility on 1/19/2025 around 8 AM that Resident 2 had a fall, so she asked staff to monitor Resident 2 to prevent falls. Family Member 1 stated that Resident 2 was anxious and confused because he wanted to get out of bed. Family Member 1 stated she did not feel that the facility did a good job protecting Resident 2 from falls. She stated the facility did not do enough to prevent the multiple falls, and that, The facility could have been more careful. Family Member 1 stated she did not get education or information on how the staff would prevent future falls.

On 2/5/2025 at 2:47 PM, during an interview, Licensed Vocational Nurse (LVN) 4 stated she worked with Resident 2 and was notified by the Certified Nursing Assistant (CNA) 2 that Resident 2 had a fall on 1/19/2025 in the morning. LVN 4 stated there was no floor mat at the time of the fall, that Resident 2 was confused, and she could not remember if Resident 2 was a high fall risk. LVN 4 stated Resident 2 had a urinary catheter (a thin, flexible tube that a doctor inserts into your bladder to drain urine), was trying to go to the bathroom on his own the day before, and the resident was reminded not to get out of bed. LVN 4 stated Resident 2 continued trying to get out of bed. LVN 4 stated that having a care plan lets staff know how to care for a resident. LVN 4 stated fall precautions were important for safety to prevent injury.

During the investigation an attempt to call night Registered Nurse Supervisor 3 (RNS 3) was made on 2/5/2025 at 2:57 PM to discuss Resident 2's fall that occurred on 1/19/2025 at 6:30 AM, but the call was not returned. Another call was attempted for CNA 2 on 2/5/2025 at 2:59 PM, but call was not returned.

During a telephone interview on 2/7/2025 at 10:39 AM, Family Member 1 stated, via Spanish language line interpreter, that before his first fall on 1/19/2025, Resident 2 was too confused to be oriented to the call light. Family Member 1 stated Resident 2 did not know how to use the call light.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of the facility's policy and procedure (P&P) titled, Fall Management Program, dated 3/2023, indicated the facility would provide each resident with adequate supervision and assistance devices to minimize fall risks; and would provide an environment free from accident hazards. The P&P indicated the facility was responsible for resident supervision and would prevent avoidable accidents. The P&P defined an avoidable accident as an accident where the facility failed to implement interventions, including adequate supervision and assistive devises consistent with a resident's needs, goals, care plan and professional standards in reducing fall risk. The P&P indicated the facility would monitor the effectiveness of the interventions and modify the care plan as necessary.