STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555438	A. Building B. Wing	02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kei-Ai Los Angeles Healthcare Center	2221 Lincoln Park Ave Los Angeles, CA 90031

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** 43851 Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 1), who had a history of falls, was cognitively impaired (had impairment in the ability to think, understand, and reason), had poor safety awareness, and required assistance with transferring and toileting was provided with the necessary care and services necessary to prevent falls. By failing to: 1. Follow the Physician's Order dated 11/27/2024 for Resident 1 to receive visual checks every 30 minutes for fall management after Resident 1 had an unwitnessed fall on 11/25/2024. 2. Review and update the High Risk for Falls Care Plan (a plan of care that summarizes a resident's health conditions, specific care needs, and current treatments) after a second fall and change in condition on 12/6/2024. 3. Develop and implement new and/or additional interventions (specific care and services facility staff need to provide a resident to promote healing and prevent a worsening of a condition) to prevent recurring falls and promote safety for Resident 1 during an Interdisciplinary Team Meeting (IDT, a gathering of healthcare professionals to review and update a resident's care plan) on 12/6/2024. As a result, on 2/3/2025 Resident 1 fell (third fall in 2 months 9 days) while in the bathroom, was transferred to General Acute Care Hospital (GACH) 1 and sustained a hematoma (a pool of blood that forms under the skin or in between tissues) to the head and left nondisplaced acromial fracture laterally (a broken left shoulder blade). Findings: (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555438	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2025

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Kei-Ai Los Angeles Healthcare Center	2221 Lincoln Park Ave Los Angeles, CA 90031

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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 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1's Admission Record, the Admission Record indicated the facility readmitted the resident on 6/13/2024 with diagnoses that included non-ST elevation myocardial infarction (a type of heart attack that occurs when a coronary artery is partially blocked), type 2 diabetes (a disorder characterized by difficulty in blood sugar control and poor wound healing), end stage renal disease (ESRD, irreversible kidney damage), dementia (a progressive state of decline in mental abilities), anemia (a condition where the body does not have enough healthy red blood cells), muscle weakness, psychosis (a severe mental condition in which thought and emotions are so affected that contact is lost with reality), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), dependence on renal dialysis (hemodialysis, a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney (s) have failed), and hemiplegia (total paralysis of the arm, leg, and truck on the same side of the body) and hemiparesis (one sided muscle weakness) following cerebral infarction (CVA, stroke, loss of blood flow to part of the brain). During a review of Resident 1's History and Physical (H&P) dated 6/17/2024, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool) dated 11/25/2024, the MDS indicated the resident had severe cognitive impairment (impairment in the ability to think, understand, and reason). The MDS indicated Resident 1 required partial/moderate assistance from staff with toileting hygiene and supervision or touching assistance with personal hygiene, rolling left and right, sitting to lying, lying to sitting on the side of the bed, sit to standing, chair/bed to chair transfers, and toilet transfers. The MDS indicated the resident required partial/moderate assistance from staff for walking 10 feet. The MDS indicated Resident 1 did not have any falls with a major injury since admission to the facility (6/13/2024). During a review of Resident 1's Change in Condition documentation dated 11/25/2024 at 5:45 PM, the documentation indicated Resident 1 had an unwitnessed fall. The documentation indicated Resident 1's physician was notified and recommended to discontinue metoprolol (medication used to treat high blood pressure) and for Resident 1 to wear anti-slip socks only to prevent falls. During a review of Resident 1's Physician Order dated 11/25/2024, the physician order indicated Resident 1 was to wear anti-slip socks only to prevent a fall every shift. During a review of Resident 1's Interdisciplinary Team Meeting - Fall document dated 11/27/2024 at 4:10 PM, the document indicated the resident was found on the floor laying on his back with the back of his head on top of the left footrest of the wheelchair. The document indicated Resident 1 stated he was reaching for crackers then fell on the floor, slid from the wheelchair and hit his head. The document indicated Resident 1 fell while trying to pick up crackers without assistance. The document indicated the IDT recommended new interventions for Resident 1 to continue toileting every 2 hours, to monitor the resident with visual checks every 30 minutes for fall management, and for the resident was to only wear anti-slip socks to prevent falls. The document indicated an intervention for Resident 1 to be screened by Physical Therapy (PT) after the fall. During a review of Resident 1's Physician Order dated 11/27/2024, the physician order indicated to perform visuals checks every 30 minutes every shift for fall management. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Kei-Ai Los Angeles Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 2221 Lincoln Park Ave Los Angeles, CA 90031	

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1's Rehab: Post Fall assessment dated [DATE] at 6:43 PM, the assessment indicated Resident 1 did not have any changes in safety awareness, range of motion, strength, transfers or gait. The assessment indicated Resident 1 did not have any complaints of pain or discomfort and recommended to continue with Restorative Nursing Assistant (RNA) treatment and to continue to monitor the resident for any changes. During a review of Resident 1's Change in Condition documentation dated 12/6/2024 at 7:05 AM, the documentation indicated the resident had a fall. The documentation indicated Resident 1 was found lying on the floor between the bed and the wheelchair. The documentation indicated Resident 1 was found with a skin tear on his right ear with swelling. The documentation indicated Resident 1's physician was notified and recommended to start neuro checks (assess the function of the neuorlogica/nervous system) and treatment to the resident's right ear. During a review of Resident 1's Rehab: Post Fall assessment dated [DATE] at 12:48 PM, the assessment indicated Resident 1 fell in his room. The assessment indicated Resident 1 had a change in safety awareness. The assessment indicated Resident 1 did not have any change in range of motion, strength, transfers, or gait. The assessment further indicated this was Resident 1's second fall in 2 weeks. The assessment indicated Resident 1 would benefit from skilled physical therapy service to include safety awareness and improve functional mobility. During a review of Resident 1's Morse Fall Risk Screen (a fall risk assessment tool that predicts the likelihood a resident will fall) dated 12/6/2024, the fall risk screen indicated the resident was at high risk for falling with a score of 65 (a score of 45 or higher indicated a resident was at high risk for potential falls). The fall risk screen indicated Resident 1 had a history of falling, more than one diagnosis on the chart, did not use any ambulatory aids (was either on bedrest, utilized a wheelchair, or required nurse assistance), exhibited weak gait (stooped but able to lift head without losing balance, steps are short, and resident may shuffle), and overestimated or forgot their limits (to act without considering personal boundaries or capabilities). The fall risk screen indicated Resident 1 was referred to the IDT. During a review of Resident 1's Interdisciplinary Team Meeting-Fall document dated 12/6/2024 at 4:26 PM, the document indicated the resident was lying on the floor of the right side of his bed and his wheelchair noted with a skin tear on his right ear with swelling. The note indicated Resident 1 was wearing shoes at the time of the fall. The document indicated Resident 1 stated he was trying to transfer himself from his bed to the wheelchair. The document indicated Resident 1 had poor judgement, poor safety awareness, CVA with right hemiparesis, and dementia. The document indicated Resident 1 perceived himself as independent and would not call for assistance. The document indicated new intervention recommendations from the IDT for Resident 1 to be screened by physical therapy for transferring from the wheelchair to bed and to continue 30-minute visual checks. During a review of Resident 1's Change of Condition documentation dated 2/3/2025 at 1:47 AM, the documentation indicated the resident had a fall. The documentation indicated Resident 1 was found lying on the floor in the restroom between the toilet and wall. The documentation indicated Resident 1 obtained a skin tear to his left forearm and knee with bleeding noted. The documentation indicated Resident 1's physician was notified and recommended to start neurochecks and treatment to the resident's left forearm and knee. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Kei-Ai Los Angeles Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2221 Lincoln Park Ave Los Angeles, CA 90031	

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1 Q (every) 30 minutes visual checks document dated 2/3/2025, the document indicated on 2/3/2025 at 2:00 AM there was documentation of N/A (not applicable) for Resident 1's location and behavior. During a review of Resident 1's Nurses Notes dated 2/3/2025 at 10:05 AM, the note indicated the resident was picked up by transportation via gurney for dialysis. The note indicated Resident 1 was complaining of pain on his left shoulder. The note further indicated Resident 1 was given 50 milligrams (mg) of Tramadol (a medication used for the short-term relief of moderate to severe pain) by mouth as ordered for the resident's pain. During a review of Resident 1's Nurses Notes dated 2/3/2025 at 11:40 AM, the note indicated a phone call was received from the dialysis center that Resident 1 was transferred to GACH 1 from the dialysis center for further evaluation due to a hematoma (a localized collection of blood outside of a blood vessel, usually caused by an injury that damages the vessel wall, resulting in a pool of blood that can appear as a bruise or swelling under the skin) to the left side of the head and increased pain to the left shoulder. The note indicated Resident 1's physician and responsible party were notified. During a review of Resident 1's Dialysis Form documentation dated 2/3/2025, the noted indicated that no dialysis treatment was initiated because Resident 1 was sent to the emergency room (ER). During a review of Resident 1's left shoulder x-ray report from GACH 1 dated 2/3/2025 at 2:36 PM, the report suggested the resident had a nondisplaced acromial fracture laterally (a broken left shoulder blade). During a review of Resident 1's Nursing Note dated 2/3/2025 at 10:37 PM, the note indicated the resident returned to the facility at 9:16 PM from GACH 1. The note indicated Resident 1 had a left shoulder x-ray that suggested a non-displaced acromial fracture laterally. The note indicated that per report from GACH 1's emergency department Resident 1 was to keep the left upper extremity (left arm) non-weight bearing (NWB, a restriction that requires a patient to avoid putting weight on an affected limb), follow up with orthopedics (a physician that specializes in the treatment of injuries to bones), and receive Tylenol (acetaminophen, a medication used to treat pain) 650 mg by mouth every 6 hours. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1's Interdisciplinary Team Meeting - Fall document dated 2/4/2025 at 10:45 am, indicated staff responded to Resident 1 yelling from his room at approximately 1:45 AM. The document indicated Resident 1 was found lying on the floor in the restroom between the toilet and the wall. The document indicated Resident 1 was noted with a skin tear on his left forearm and knee with bleeding. The document indicated Resident 1 stated he did not know how he fell and may have tripped over his foot. The document indicated Resident 1's physician ordered for neurochecks monitoring. The document indicated Resident 1 proceeded to go to dialysis and left the facility at 10:05 AM. The document indicated at 11:30 AM, a call was received from the hemodialysis staff stating Resident 1 was transferred to the GACH from dialysis for further evaluation due to a hematoma to his left head and increased pain to his left shoulder. The documented indicated at 9:16 PM Resident 1 returned to the facility from the GACH with findings that included left shoulder nondisplaced acromial fracture laterally (broken left shoulder blade). The document indicated Resident 1 had poor judgment, poor safety awareness, CVA with right hemiparesis, gait/balance problems, non-compliant behavior, and dementia. The document indicated Resident 1 perceived himself as independent and would not call for assistance. The document did not indicate any new interventions to prevent future falls. During a review of Resident 1's Care Plan revised 2/5/2025, the care plan indicated the resident was at high risk for falls and injury related to limitation of mobility, history falls, use of psychotropic medication (medication used to treat mental health disorders), ascites (a condition where excess fluid accumulates in the abdominal cavity), dementia, ESRD on hemodialysis, hepatic encephalopathy (brain dysfunction caused by liver dysfunction), hyperlipidemia, seizure disorder (a neurological condition characterized by recurrent, unprovoked episodes of abnormal brain electrical activity), type 2 diabetes, hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side, hypertension (high blood pressure), psychosis, anxiety disorder (excessive and persistent worry, fear, and nervousness that can interfere with daily life), depression, Congestive Heart Failure (CHF, a condition where the heart muscle is weakened and cannot pump blood efficiently throughout the body), and a recent fall. The care plan indicated goals of managing Resident 1 were to minimize fall and injury, managing risk factors to minimize falls and injury, and for the resident to follow safe technique when performing functional mobility and Activities of Daily Living (ADL, basic self-care tasks that individuals perform on a daily basis) to prevent falls and injury. The care plan indicated interventions that included Resident 1 wearing anti-slip socks only, 30-minute visual monitoring for fall management, and providing the resident with assistance as needed with transfers and ambulation. The care plan indicated the interventions were updated after Resident 1 fell on [DATE] and 2/3/2025. The care plan did not indicate the interventions were updated after Resident 1's fall on 12/6/2024. During a telephone interview with Resident 1's Responsible Party (RP) on 2/19/2025 at 11:42 AM, the RP stated the facility called the RP to let her know Resident 1 fell on [DATE]. The RP stated she was told Resident 1 fell in the bathroom. The RP stated Resident 1 needed a lot of help. The RP stated Resident 1 would get confused because the resident had a stroke and had dementia. The RP stated half of Resident 1's body did not work because of the stroke. The RP stated Resident 1 thought he could do things on his own but did not realize he needs help especially when going to the bathroom. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview on 2/19/2025 at 1:09 PM with Certified Nursing Assistant (CNA) 1, CNA 1 was the assigned to Resident 1 when he fell on [DATE]. CNA 1 stated Resident 1 fell around 1:40 AM to 2:00 AM. CNA 1 stated she did not witness Resident 1 fall because she was on break at the time. CNA 1 stated prior to taking her break she notified the registry (staffing agency) CNA that she was going to take her break. CNA 1 stated when she came back from her 10-minute break, Resident 1 was already back in bed. CNA 1 stated the charge nurse informed her Resident 1 fell . CNA 1 stated Resident 1 was a major fall risk. CNA 1 stated Resident 1 would get out of bed frequently. CNA 1 stated Resident 1 needed assistance with transferring from the bed to the wheelchair and to the bathroom. CNA 1 stated Resident 1 was not stable when out of bed and walking. CNA 1 stated Resident 1 was on visual checks every 30 minutes because he was not safe to get out of bed on his own. During a telephone interview on 2/19/2025 at 1:20 PM with Licensed Vocational Nurse (LVN) 1, LVN 1 stated she was assigned to take care of Resident 1 when the resident fell on [DATE]. LVN 1 stated she did not remember what time Resident 1 fell . LVN 1 stated she remembered hearing Resident 1 yell out, and when she went to the resident's room, found the resident in the bathroom face down between the toilet and wall. LVN 1 stated she and another CNA helped the resident back to bed. LVN 1 stated Resident 1 had a skin tear on his left arm from the fall. LVN 1 stated she notified Resident 1's physician of the resident's fall, and the physician ordered neurochecks and treatment for the resident's skin tear. LVN 1 stated Resident 1 did not have a stable gait when walking. LVN 1 stated Resident 1 needed one-person assistance when going to the bathroom. LVN 1 stated Resident 1 was non-compliant, did not call for help, and would get up by himself. LVN 1 stated this made Resident 1 a high fall risk and was why the resident was on visual checks every 30 minutes. LVN 1 further stated Resident 1 had orders for anti-slip socks but was not wearing them when the resident fell on [DATE]. LVN 1 stated Resident 1 was wearing shoes. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review on 2/19/2025 at 3:11 PM, Resident 1's IDT meetings dated 11/27/2024 and 12/6/2024 were reviewed with Registered Nurse Supervisor (RNS) 1. RNS 1 stated she was familiar with Resident 1. RNS 1 stated she was part of the IDT meetings that took place on 11/27/2024, 12/6/2024, and 2/4/2025 regarding Resident 1's falls. RNS 1 stated Resident 1 fell on [DATE], 12/6/2024, and 2/3/2024. RNS 1 stated the IDT would meet after each fall, during the IDT meetings the IDT reviewed the fall incident and discusses what interventions could be put into place to prevent future falls. RNS 1 stated because Resident 1 had a history of falls the interventions the IDT recommended during the IDT meetings should have been different than the previous interventions recommended in previous IDT meetings. RNS 1 stated after Resident 1's fall on 11/25/2024 the IDT recommended to continue toileting every 2 hours, to monitor the resident with visual checks every 30 minutes for fall management, for the resident was to only wear anti-slip socks to prevent falls, neuro checks, and for Resident 1 to be screened by PT after the fall. RNS 1 stated after Resident 1's fall on 12/6/20254, the IDT recommended interventions for Resident 1 to be screened by PT for transferring from the wheelchair to bed and continuing 30-minute visual checks. RNS 1 stated the IDT did not recommend additional and new interventions after Resident 1's second fall on 12/6/2024. RNS 1 stated a physical therapy screening and continuing 30-minute visual checks were also the interventions recommended on the IDT meeting on 11/27/2024. RNS 1 stated after each IDT meeting the recommendations should have been reflected on Resident 1's high risk for falls care plan. RNS 1 stated the high risk for falls care plan should have been updated after each fall. RNS 1 stated Resident 1's high risk for fall care plan was not updated after Resident 1's fall on 12/6/2024. RNS 1 stated the care plan was developed to inform staff about the care the resident needs. RNS 1 stated the care plan was a way for the IDT to inform staff about the updated recommendations and interventions. RNS 1 stated not updating the care plan could result in the resident not getting the care needed. RNS 1 stated Resident 1 had recurring falls. RNS 1 stated updating Resident 1's high risk for fall care plan and recommending new interventions after each fall could have helped prevent Resident 1 from falling. During a concurrent observation and interview on 2/19/2024 at 4:07 PM, in Resident 1's room, Resident 1 was observed sitting on the side of the bed. Resident 1 was observed grimacing, crying and holding his left shoulder. Resident 1 stated he was having pain to his left shoulder. Resident 1 stated he fell in the bathroom but could not remember when he fell . Resident 1 stated his arm started to hurt after he fell . During a concurrent interview and record review on 2/20/2025 at 11:01 AM Resident 1's Rehab: Post Fall Assessments dated 11/27/2024 and 12/6/2024, and IDT Meetings dated 11/27/2025 and 12/6/2024 were reviewed with the Director of Rehabilitation (DOR). The DOR stated a physical therapy screening was done after a resident had a fall and the findings were documented on the Rehab: Post Fall Assessment. The DOR stated a physical therapy screening after a fall assessed the resident for any changes in their mobility, ability to transfer, and functioning. The DOR stated she was a part of the IDT meetings on 11/27/2024, 12/6/2024, and 2/4/2025 regarding Resident 1's falls. The DOR stated the recommendations from the IDT on 11/27/2024 and 12/6/2024 were the same. The DOR stated both IDT meetings on 11/27/2024 and 12/6/2024 both indicate a recommendation for a PT screening and 30-minute visual checks. The DOR stated no new recommendations were developed or initiated for Resident 1's falls during the IDT meeting on 12/6/2024; The DOR further stated, It looks as if the recommendations were just continued. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a concurrent record review and telephone interview on 2/20/2025 at 11:51 AM, Resident 1's Q30 minutes visual checks dated 2/2/2025 to 2/3/2025 was reviewed with CNA 1. CNA 1 stated during the 11 PM to 7 AM shift, N/A was documented for Resident 1's location and behavior at 2 AM on 2/3/2025 because she wasn't there at the time to check on Resident 1. CNA 1 stated that was the time she went on break. CNA 1 stated she told the registry CNA she was going on break. CNA 1 stated when she went on break the registry CNA was covering for her. During a telephone interview on 2/20/2025 at 12:33 PM with CNA 2, CNA 2 stated she was the only registry CNA on the unit during the 11:00 PM to 7:00 AM shift when Resident 1 fell on [DATE]. CNA 2 stated LVN 1 called her into Resident 1's room to help pick up the Resident 1 when he fell at around 2:00 AM. CNA 2 stated the CNA assigned to take care of Resident 1 could not be found when Resident 1 fell . CNA 2 stated CNA 1 did not tell her to watch Resident 1 while CNA 1 went on break. CNA 2 stated we're supposed to tell another CNA when we go on our breaks, and we're supposed to tell them which residents were on visual checks. CNA 2 stated CNA 1 did not tell her she was taking her break or that Resident 1 was on visual checks. During a concurrent interview and record review on 2/20/2025 at 1:41 PM, Resident 1's high risk for falls care plan and IDT meeting dated 11/27/2024 and 12/6/2024 were reviewed with the Director of Nursing (DON). The DON confirmed that Resident 1's recommended interventions for a physical therapy screening and 30-minute visual checks by the IDT to prevent falls on 11/27/2024 and 12/6/2024 were the same. The DON reviewed Resident 1's high risk for falls care plan and confirmed the care plan was not updated after the resident's fall on 12/6/2024. The DON stated visual checks every 30 minutes were done because Resident 1 was a high risk for falls. The DON confirmed that on the Q 30-minute visual check there was documentation of N/A for Resident 1 location and behavior on 2/3/2025 at 2:00 AM. The DON stated the N/A was because CNA 1 indicated she was on break the time the Resident 1 fell on [DATE]. The DON stated it was important to make sure the facility had a progressive approach with care planning and reviewing previous interventions during the IDT meetings. The DON stated given Resident 1 had a history of falls prior to his fall on 2/3/2025. The DON stated it was important to ensure visual checks were completed every 30 minute. The DON stated it was important to update the high risk for falls care plan timely, and new and creative interventions needed to be developed to help prevent Resident 1 from falling again. The DON stated it was important to provide Resident 1 with a safe environment to ensure the resident was free from harm. During a review of the facility's policy and procedure titled Care Planning (IDT) Policy reviewed 10/10/2024, the policy indicated Care plans are revised per RAI [Resident Assessment Instrument: a standardized assessment tool used in long-term care settings to evaluate the health, functional status, and needs of resident] schedules and as changes in the resident's condition dictates or in preparation for discharge. During a review of the facility's policy and procedure titled Fall Risk Assessment reviewed 10/10/2024, the policy indicated The nursing staff, in conjunction with the attending physician, consultant pharmacist, therapy staff, and others, will seek to identify and document resident risk factors for falls and establish a resident-centered falls prevention plan based on relevant assessment information .The staff, with the support of the attending physician, will evaluate functional and psychological factors that may increase fall risk, including ambulation, mobility, gait, balance, excessive motor activity, activities of daily living (ADL) capabilities, activity tolerance, continence, and cognition. (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 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of the facility's policy and procedure titled Falling Star Program, reviewed 10/10/2024, the policy indicated Residents identified as high risk and moderate risk for falls and those with recurrent falls of 3 and more in a month will be placed in the Falling Star Program .Residents placed on a falling star program will have the following in place: .Any resident with multiple falls of 3 or more in a month will be monitored visually every 30 minutes .IDT team will update the residents' plan of care to include appropriate interventions. During a review of the facility's policy and procedure titled Falls - Clinical Protocol reviewed 10/10/2024, the policy indicated If the individual continues to fall, the staff and physician will re-evaluate the situation and reconsider possible reasons for the resident's falling (instead of, or in addition to those that have already been identified) and all reconsider the current interventions. During a review of the facility's policy and procedure titled Falls and Fall Risk, Managing reviewed 10/10/2024, the policy indicated Based on previous evaluations and current data, the 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 .Environmental factors that contribute to the risk of falls include: wet floors; poor lighting; incorrect bed height or width; obstacles in the footpath; improperly fitted or maintained wheelchairs; and foot wear that is unsafe or absent .The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor (s) of falls for each resident at risk or with a history of falls .If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant .if underlying causes cannot be readily identified or corrected, staff will try various interventions, based on assessment of the nature or category of falling, until falling is reduced or stopped, or until the reason for the continuation of the falling is identified as unavoidable .If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions. As needed, the attending physician will help the staff reconsider possible causes that may not previously have been identified.