STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555700	A. Building B. Wing	11/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beverly Hills Rehabilitation Centre	580 S San Vicente Blvd. Los Angeles, CA 90048

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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49836 Based on interview and record review, the facility failed to ensure a comprehensive assessment was completed after one sampled resident (Resident 1) had a fall on 10/20/2024. Resident 1 had a bruise and a cut on the right eye, but there was no documentation from the staff regarding the injury. This deficient practice placed Resident 1 at an increased risk for a delay in treatment. Findings: A review of the Admission Record indicated Resident 1 was admitted to the facility on [DATE], with diagnoses including dementia, difficulty walking, muscle weakness, and history of falling. A review of the history and physical dated 10/17/2024, indicated Resident 1 did not have the capacity to understand and make decisions. A review of Resident 1's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 10/21/2024, indicated Resident 1 had an active diagnosis of dementia, severe cognitive impairment (problems with ability to remember, understand, or make decisions) and needed maximum assistance with bed mobility (ability to move around in bed, such as rolling, scooting, or moving from sitting to lying), and toilet use. The MDS further indicated Resident 1 had one fall since admission. A review of Resident 1's Change in Condition (CIC) Evaluation report dated 10/20/2024, indicated Resident 1 tried to get up by herself, lost her balance, and fell . The CIC indicated that Resident 1 forgot to use the call light, but was able to stand up and walk a short distance with assistance and the physician and family member were informed. The CIC did not indicate that Resident 1 had any injuries. The CIC also did not indicate that a comprehensive assessment of Resident 1 was completed. During an interview with Resident 1's Family Member (FM 1) on 11/6/2024 at 11:30 AM, FM 1 stated that on 10/23/2024 they visited Resident 1. FM 1 stated when they saw Resident 1, Resident 1 had a black eye and a cut above the right eye. When FM 1 asked the facility staff what happened the staff was unsure. FM 1 stated the facility transferred her mother to a General Acute Hospital (GACH). During an interview on 11/6/2024 at 1 PM, the Director of Nursing (DON) stated Resident 1 did not have a black eye and that it was a very small discoloration on the right eyebrow. The DON also stated that they did not know how or when the resident sustained the discoloration. The DON stated that there was no documentation of an assessment but that one should have been done. (continued on next page)

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

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedure (P&P) titled, Falls-Clinical Protocol, revised January 2024, indicated the nurse shall assess and document any recent injury, especially fracture or head injury.

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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 0744 Level of Harm - Actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49836 Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1), who had history of falls and a diagnosis of dementia (a chronic condition that causes a gradual decline in cognitive abilities, such as thinking, remembering, and reasoning that interferes with doing everyday activities) received the necessary care needs and services by failing to: -Identify and develop an appropriate care plan for Resident 1's dementia through an Interdisciplinary Team (IDT) approach, with appropriate interventions including implementation of individualized care and maximizing the resident's safety. -Implement a bed alarm or provide supervision for Resident 1. As a result, on 10/20/2024, Resident 1 was found on the floor of her room and there was no proper staff assessment hours after the fall. Once Family Member 1 noticed the bruising and cut above Resident 1's right eye, the resident was then transferred to the General Acute Care Hospital (GACH) for Xray on 10/23/2024. At the GACH, Resident 1 was diagnosed with an acute impacted fracture (a type of fracture where the ends of the bone are driven into each other) of the right femoral neck (broken thigh bone), and an acute nondisplaced (pieces of bone remain aligned and do not move out of place) right anterior third rib fracture (broken rib). Findings: A review of the Admission Record indicated Resident 1 was admitted to the facility on [DATE], with diagnoses including dementia, history of falling, difficulty walking, and muscle weakness. A review of the history and physical (H&P) dated 10/17/2024, indicated Resident 1 had advanced dementia, did not have the capacity to understand and make decisions, and had a thrombectomy (when a blood clot blocks blood flow to brain or major organ, a medical procedure to remove a blood clot from the blood vessels) on 6/24/2024. The H&P indicated Resident 1 had falls at home with risk of head bleed. A review of Resident 1's Fall Risk assessment dated [DATE], indicated Resident 1 was considered a high risk for potential falls (a score of 16 or higher indicated a resident was a high risk for falling). The fall risk assessment indicated Resident 1 had confusion, poor safety awareness, required assistance with elimination, had poor vision, and had the inability to walk without assistance. A review of the Risk for Falls care plan dated 10/17/2024, indicated this was related to Resident 1's altered mental status (confusion), difficulty walking, muscle weakness, and history of falling. The goal was to minimize the risk for falls and for Resident 1 to not have any major injuries related to falls. The care plan interventions indicated the use of safety devices such as fall mats, keeping the call light within reach, both upper side rails up, and having a low bed. The care plan interventions did not include any monitoring or supervision of Resident 1 or to anticipate and meet the resident's needs. (continued on next page)

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F 0744 Level of Harm - Actual harm Residents Affected - Few	According to a review of the Connective Tissue / Altered Mental Status / Difficulty Walking / Muscle Weakness / Difficulty in Walking care plan dated 10/17/2024, the goal for Resident 1 was to minimize risk for falls and the resident would have no major injuries related to falls. The care plan interventions indicated to monitor for changes in condition affecting risk for falls and notify physician. A review of the Impaired Cognitive Function care plan related to dementia with agitation, vascular dementia without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety dated 10/17/2024 indicated interventions to cue, reorient and supervise Resident 1 as needed. A review of the Clinical Progress Notes dated 10/17/2024 indicated Resident 1 could not verbalize needs, was confused and staff would continue to monitor. On 10/18/2024 the progress notes indicated Resident 1 was stable and staff would continue to monitor. On 10/19/2024 the progress notes indicated Resident 1 was adjusting well to new environment, all needs were anticipated, and staff would continue with plan of care. A review of Resident 1's Change in Condition (CIC) Evaluation report dated 10/20/2024 at 8:57 PM, indicated Resident 1 tried to get up by herself, lost her balance, and fell . Resident 1 forgot to use the call light. The CIC indicated Resident 1 was able to stand up and walk a short distance with assistance, the physician and family member were informed. The CIC indicated Resident 1 was relaxing in bed with no complaints of pain or discomfort noted. The CIC did not indicate that Resident 1 had any injuries, who found the resident, or who observed the resident get up by herself and fall. A review of the Physician's Orders dated 10/20/2024 (after the fall), indicated Resident 1 to receive a tab alarm (bed alarm) while in bed and wheelchair. A review of Resident 1's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 10/21/2024, indicated the resident had severe cognitive impairment (problems with ability to remember, understand, or make decisions), diagnosis of dementia, needed maximum assistance with bed mobility (ability to move around in bed, such as rolling, scooting, or moving from sitting to lying), and maximum assistance with toilet use. The MDS indicated that once standing, the ability to walk 10 feet was not attempted due to safety concerns and medical condition, and that Resident 1 had a fall within the last 2-6 months prior to admission. A review of the Interdisciplinary Team (IDT- a coordinated group of experts from several different fields who work together toward a common resident goal) Fall review on 10/21/2024 for Resident 1, indicated that on 10/20/2024 at 8:40 PM, Resident 1 was found on the floor facing the door of her room because Resident 1 tried to get up unassisted. The IDT fall review included to continue previous interventions, neurological checks for 72 hours, and bed alarm while in bed and wheelchair. The IDT review did not indicate physician's orders for transfer to the GACH or supervision for Resident 1. A review of the Physician's Orders dated 10/23/2024, indicated to transfer Resident 1 to the GACH emergency room (ER) for CT (cat scan, noninvasive medical imaging procedure that uses X-rays to create detailed pictures of the inside of the body) of the head due to right eye discoloration. (continued on next page)

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F 0744 Level of Harm - Actual harm Residents Affected - Few	According to a review of the GACH ED Provider Notes dated 10/23/2024, Resident 1 had a bruised eye, a fall and altered mental status was brought in by ambulance for an unwitnessed fall. The ED provider notes indicated Resident 1 was admitted to the GACH for an acute impacted fracture of the right femoral neck (broken thigh bone), and an acute nondisplaced right anterior third rib fracture (broken rib) with a plan for arthroplasty (a surgical procedure that replaces a joint with an artificial joint to restore function and help relieve long-term symptoms of pain and stiffness). During a concurrent interview and record review with Licensed Vocational Nurse (LVN) 1 on 11/6/2024 at 10:27 AM, Resident 1's At Risk for Falls care plan was reviewed. LVN 1 stated Resident 1 should have had a bed alarm, close supervision, and been moved closer to the nurse's station because the resident was a high risk for falls and would get out of bed unassisted. Staff members (LVN 2 and Registered Nurse 2) who were assigned to Resident 1 during the 3:30 PM - 11 PM shift on 10/20/2024 were called for an interview, but there was no answer and no return phone call. A review of Resident 1's Progress Notes on 11/6/2024 indicated there was no documentation by staff regarding Resident 1's injuries. During an interview on 11/6/2024 at 11:30 AM, Resident 1's Family Member (FM) 1 stated that on 10/23/2024 they visited Resident 1 during the day. FM 1 stated when they saw Resident 1, Resident 1 had a black eye and a cut above the right eye. When FM 1 asked the staff what happened, the staff was unsure. FM 1 stated the facility transferred her mother to a GACH and the GACH diagnosed Resident 1 with a broken rib and broken thigh bone. During an interview on 11/6/2024 at 1 PM, the Director of Nursing (DON) stated Resident 1 did not have a black eye and that it was a very small discoloration on the right eyebrow. The DON stated, The resident was constantly trying to get up, out of bed, and should have been moved to a room in front of the nurse's station. The DON stated Resident 1 should have had a bed alarm in place and a sitter for supervision since Resident 1 was a high fall risk and that this could have potentially prevented Resident 1 from falling. The DON stated he did not know how or when Resident 1 sustained the eye discoloration as there was no documentation or reports from the staff regarding any injuries or discoloration to the eye area. During a phone interview on 11/8/2024 at 11:08 AM, CNA 2 stated Resident 1 was confused most of the time and needed assistance with getting up out of bed. CNA 2 stated that before Resident 1's fall, the resident did not have a bed alarm. CNA 2 stated Resident 1 should have been moved closer to the nurse's station because Resident 1 was constantly trying to get out of the bed. A review of the facility's policy and procedure (P&P) titled, Falls and Fall Risk, Managing, revised January 2024, indicated based on previous evaluations and current data, the staff would identify interventions related to the resident's specific risk and causes to try to prevent the resident from falling and to try to minimize complications from falling. A review of the facility's P&P titled, Dementia-Clinical Protocol, revised January 2024, indicated staff would monitor the individual with dementia for changes in condition and decline in function and would report these findings to the physician. The P&P indicated the physician and staff would adjust interventions depending on the individual's responses to those interventions.