STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555823	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Intercommunity Care Center	2626 Grand Avenue Long Beach, CA 90815

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** 46537 Based on interview and record review, the facility failed to ensure a resident, who was totally dependent on staff for care and required a two-person physical assist to complete her activities of daily living ([ADL] task such as bathing, showering, dressing, transferring between surfaces including in and out of bed or a chair, walking, using the toilet and eating) did not sustain an injury while being transferred from a Geri-chair (a large, padded chair that is designed to help seniors with limited mobility) to a bed for one of three sampled residents (Resident 1). The facility failed to: 1. Ensure a Certified Nurse Assistant (CNA 1) did not transfer Resident 1 from a Geri-chair to a bed by himself without assistance from another staff, per Resident 1's Minimum Data Set ([MDS] a standardized assessment and care screening tool) dated 6/7/2024 and Care Plan, titled, Self-Care Deficit dated 6/3/2023. 2. Ensure CNA 1 reported to a licensed nurse when he heard a popping sound while transferring Resident 1 from a Geri-chair to a bed by himself, without assistance from another staff. 3. Ensure staff followed the facility policy and procedure (P&P) titled, Certified Nursing Assistant (CNA), which indicated to report changes in a resident's condition to a charge nurse and/or supervisor. These deficient practices resulted in Resident 1 sustaining an acute comminuted displaced oblique fracture (the bone breaks into several pieces diagonally across the width of the bone) of the distal (the part of the body that is away from the center of the body than another part) right femoral (thigh bone) shaft (straight part of thigh bone), requiring Resident 1 to be transferred to a General Acute Care Hospital (GACH) on 8/13/2024. At the GACH Resident 1 underwent a retrograde intramedullary nailing (a metal rod is inserted into the center of the femur then fixed at both ends with screws) surgical procedure to the right femur to repair the fracture. 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

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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 (Face Sheet), the Face Sheet indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills, and eventually, the ability to carry out the simple tasks) and anxiety (a feeling of fear, dread, and uneasiness). During a review of Resident 1's MDS, dated [DATE], the MDS indicated, Resident 1's cognitive skills for daily decision making were moderately impaired (decisions were poor, cues/supervision required). The MDS indicated Resident 1 required dependent assistance (helper does all of the effort) from two or more staff for chair to bed/bed to chair transfers, rolling from left to and right, toileting and personal hygiene. During a review of Resident 1's Care Plan, revised 6/3/2023, the Care Plan indicated Resident 1 had self-care deficits with bed mobility, transfers, personal hygiene, bathing, and dressing. The Care Plan's goal indicated, Resident 1's ADL needs would be met every shift. One of the Care Plan's interventions included to have a two-person assist for Resident 1's transfers and bed mobility. During a review of Resident 1's Situation Background Assessment, and Recommendation ([SBAR] a form of communication between members of a health care team) communication form, dated 8/13/2024, the SBAR indicated there was swelling above Resident 1's right knee and right posterior (back of) thigh. The SBAR indicated Resident 1 had facial grimaces and moaning during repositioning. During a review of Resident 1's Physician's Order Report dated 8/13/2024 and timed at 2 p.m., the Physician's Order Report indicated an order to obtain a right hip and right knee X-ray (a medical procedure that creates pictures of the structures of the inside of the body) due to swelling and to rule out a fracture. During a review Resident 1's right hip X-ray Report, dated 8/13/2024, the X-ray Report indicated Resident 1 sustained a right hip intertrochanteric fracture (a broken hip) with varus deformity (a condition that causes an abnormal position of the knee joint and lower leg bone). Resident 1's right knee X-ray Report indicated a distal femoral oblique fracture (a break in the thigh bone, or femur, that occurs just above the knee joint and has an angled line across the shaft). During a review of Resident 1's Physician's Order Report dated, 8/13/2024 and timed at 10 p.m., the Physician's Order Report indicated to transfer Resident 1 to the GACH via paramedics. During a review of the GACH's Emergency Department (ED) Provider Note, dated 8/13/2024, the GACH's ED Provider Note indicated, Resident 1 was admitted to the GACH ED on 8/13/2024, at 10:40 p.m. During a review of the GACH's X-ray report, dated on 8/13/2024, the X-ray report indicated Resident 1 sustained an acute comminuted displaced oblique fracture of the distal right femoral shaft. During a review of the GACH's Surgical Case Report, dated 8/17/2024, the Surgical Case Report indicated, Resident 1 underwent a retrograde intramedullary nailing of the right femur on 8/17/2024. (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 0689 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview on 8/15/2024, at 9:44 a.m., Resident 1's Family Member (FM 3) stated, she and FM 2 visited Resident 1 on 8/13/2024, around 11:20 a.m., and found Resident 1 grimacing in pain and noted her right thigh was really swollen. FM 3 stated, they asked staff to assess Resident 1. During a telephone interview on 8/15/2024, at 11:20 a.m., and a subsequent interview at 3:09 p.m., CNA 1 stated on 8/13/2024 at approximately10 a.m., Resident 1 was in her room sitting in a Geri-chair. CNA 1 stated Resident 1's diaper needed to be changed, so he pulled Resident 1 up from the Geri-chair to put her in bed so he could change her diaper. CNA 1 stated when he pulled Resident 1 up from the Geri-chair he heard a popping sound that sounded like something hitting plastic. CNA 1 stated he looked around to see if he could figure out where the popping sound came from, but he could not find anything. CNA 1 stated at the time he heard the popping sound; he noticed that Resident 1 became more agitated than usual, but he did not pay much attention to it because Resident 1 had a behavior of being agitated during care. CNA 1 stated he transferred Resident 1 from the Geri-chair to the bed by himself without assistance from other staff because Resident 1's family was coming to visit her, and he wanted her to be ready before they arrived. CNA 1 stated he knew Resident 1 needed a two-person assist with transfers, but he thought that was more for female CNAs, he was a guy, and it was not necessary for him to ask for help unless Resident 1 was combative or became irritable. CNA 1 stated it was probably better to have extra help when caring for Resident 1 and he should have asked someone to help him transfer the resident from the Geri-chair to the bed. CNA 1 stated, he was a little concerned about Resident 1 when he heard the strange popping sound, so he waited with her until she calmed down and then left Resident 1's room. CNA 1 stated he did not report to anyone when he heard the popping sound when he transferred Resident 1. CNA 1 stated, later he heard that Resident 1's hip was fractured, that was when he realized the popping sound he heard could have been when Resident 1's hip broke. CNA 1 stated he should have reported the popping sound he heard when he transferred Resident 1 from the Geri-chair to the bed. During an interview on 8/15/2024, at 11:55 a.m., the Unit Manager (UM 1), who was a Licensed Vocational Nurse (LVN), stated Resident 1 required a two-person assist for transfers because Resident 1 was bed bound and totally dependent on staff for care. During a telephone interview on 8/15/2024, at 1:51 p.m., LVN 1 stated Resident 1 required two people to assist during her care, repositioning, and transfers, because she had a tendency of grabbing and holding onto staff's arms. LVN 1 stated during the morning huddle (a short nursing staff stand-up meeting in which residents care needs are reviewed and discussed) on 8/13/2024 at 6:45 a.m., they were told Resident 1 needed a two-person assist. LVN 1 stated CNA 1 did not report to her that he heard a popping sound while transferring Resident 1 from the Geri-chair to the bed. During a telephone interview on 8/15/2024, at 4:22 p.m., the Physical Therapist ([PT] a health professional trained to evaluate and treat people who have conditions or injuries that limit their ability to move and do physical activities) stated, a two-person assist is required to prevent accidents and injuries during transfer and care. The PT stated Resident 1 required a two-person assist to complete most of her ADLs in order to be safe, especially during transfers from a chair to a 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 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 8/15/2024, at 4:34 p.m., the Director of Staff Development (DSD) stated, they (nursing staff) have shift huddles every morning at 6:45 a.m., where they discuss residents' safety during care. The DSD stated, she mentions during every huddle that most of the residents require two people to assist during care for their safety. The DSD stated, CNA 1 should have called for help from other staff when he provided care to Resident 1 to prevent any injury. The DSD stated CNA 1 should have reported to LVN 1 immediately after hearing a popping sound. During an interview on 8/15/2024, at 5 p.m., the Director of Nursing (DON) stated, Resident 1's incident could have been avoided if CNA 1 had requested assistance to transfer Resident 1. The DON sated CNA 1 should have reported to a licensed nurse immediately after hearing a popping sound so Resident 1 could have been immediately assessed and there was no delay in the resident's care. During a review of facility's Policy and Procedure (P&P) titled, Safety and Supervision of Residents, revised 7/2017, the P&P indicated to implement interventions to reduce accident risks and hazards. During a review of facility's undated P&P titled, Body Mechanics, the P&P indicated to ask another staff member if you are going to need assistance. During a review of the facility's undated P&P titled, Certified Nursing Assistant (CNA), the P&P indicated, to report changes in patient's condition to a charge nurse and/or supervisor.

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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 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46537 Based on interview and record review, the facility failed to ensure a STAT (immediate or urgent) X-ray (a medical procedure that creates pictures of the structures of the inside of the body) was ordered immediately for one of three sampled residents (Resident 1), when Resident 1 was assessed with swelling above her right knee and right posterior (back of) thigh, following a popping sound that was heard when Resident 1 was transferred from a Geri-chair (a large, padded chair that is designed to help seniors with limited mobility) to a bed. The facility failed to: Follow when STAT X-ray was ordered, and the physician did not return the call, when the STAT X-ray was eventually ordered, and the X-ray technician did not arrive to the facility in a timely manner, and when the STAT X-ray was taken and the results of the STAT X-ray was not received timely. This deficient practice resulted in a delay in evaluation and transfer of Resident 1 to the General Acute Care Hospital (GACH), when STAT X-ray results indicated Resident 1 sustained an acute comminuted displaced oblique fracture (the bone breaks into several pieces diagonally across the width of the bone) of her distal right femoral shaft (a break of the thigh bone between the hip and the knee) and her transfer to a General Acute Care Hospital (GACH) where she underwent a surgical procedure; a retrograde intramedullary nailing of her right femur (a metal rod is inserted into the center of the femur then fixed at both ends with screws). Findings: During a review of Resident 1's Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills, and eventually, the ability to carry out the simples tasks) and anxiety (extreme worry). The Face Sheet indicated Resident 1 was admitted to hospice care on 6/28/2024. During a review of Resident 1's Minimum Data Set ([MDS] a standardized assessment and care screening tool) dated 6/7/2024, the MDS indicated, Resident 1's cognitive skills for daily decision making were moderately impaired (decisions were poor, cues/supervision required). During a review of Resident 1's Situation Background Assessment, and Recommendation ([SBAR] a form of communication between members of a health care team) communication form, dated 8/13/2024, the SBAR indicated there was swelling above Resident 1's right knee and right posterior (back of) thigh. The SBAR indicated Resident 1 had facial grimaces and moaning during repositioning. During a review of Resident 1's Physician's Order Report dated 8/13/2024 and timed at 2 p.m., the Physician's Order Report indicated to obtain a right hip and right knee X-ray due to swelling to rule out a fracture. (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 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review Resident 1's right hip X-ray Report, dated 8/13/2024, the X-ray Report indicated Resident 1 sustained a right hip intertrochanteric fracture (a broken hip) with varus deformity (a condition that causes an abnormal position of the knee joint and lower leg bone). Resident 1's right knee X-ray Report indicated a distal femoral oblique fracture (a break in the thigh bone, or femur, that occurs just above the knee joint and has an angled line across the shaft). During a review of Resident 1's Physician Order Report dated 8/13/2024 and timed at 10 p.m., the Physician Order Report indicated to transfer Resident 1 to the GACH via paramedics. During a telephone interview on 8/15/2024, at 9:44 a.m., Resident 1's Family Member (FM 3) stated, she and FM 2 visited Resident 1 on 8/13/2024, around 11:20 a.m., and found Resident 1 grimacing in pain and noted her right thigh was really swollen. FM 3 stated, they asked staff to assess Resident 1. During an interview on 8/15/2024, at 10 a.m., FM 4 stated, she asked multiple times about the results of Resident 1's X-ray that, per staff, was ordered around 2 p.m. (8/13/2024). FM 4 stated, staff did not provide the results to her until 9 p.m. (8/13/2024). FM 4 stated, she did not understand why it took so long to get the results of the X-ray, while Resident 1 was suffering in pain. During an interview on 8/15/2024, at 12:20 p.m., the Unit Manager 1 ([UM 1] a Licensed Vocational Nurse who oversees the daily duties of medical clerks, nursing aides, support staff, and licensed practical nurses) stated, Resident 1's Hospice nurse did not document the X-ray order as STAT, although she (UM 1) ordered a STAT X-ray due to Resident 1's pain and possible injury. The UM 1 stated, a STAT order should be carried out right away by the X-ray technician, but she was not sure how long the X-ray technician had to get to the facility. The UM 1 stated, she left the facility around 4 p.m., and the X-ray technician had not arrived yet and she did not know when the X-ray technician arrived at the facility because documentation of the X-ray technician's arrival by the 3 p.m., to 11 p.m., Licensed Vocational Nurse (LVN) 2 was illegible. During a telephone interview on 8/15/2024, at 1:51 p.m., LVN 1 stated, she called Resident 1's hospice agency on 8/13/2024 at 12 p.m. and requested via the hospice's telephone operator to speak with Resident 1's hospice physician, but she never heard from the hospice physician. LVN 1 stated she did not follow up with the hospice physician, but Resident 1's hospice nurse arrived at the facility around 2 p.m. and placed the order for an X-ray. LVN 1 stated, she saw that the Examination Request for an X-ray was marked STAT and stated, by the time she left the facility between 3:50 p.m. and 4 p.m. (8/13/2024) the X-ray technician had not arrived at the facility yet and she did not call the Radiology Department (a branch of medicine that uses imaging technology to diagnose and treat disease) to see what the delay was or when they were expected to arrive. During an interview on 8/15/2024, 4:34 p.m., the Director of Staff Development (DSD) stated, a STAT order should be carried out right away and followed up until it was completed. The DSD stated, staff should have endorsed the status of Resident 1's X-ray to next shift (3 p.m., to 11 p.m.) so they could follow up as well. (continued on next page)

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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/15/2024, at 5 p.m., the Director of Nurses (DON) stated, the results of a STAT X-ray report should be received within four hours after the X-ray was taken. The DON stated, Resident 1's X-ray was ordered on 8/13/2024 at 2 p.m., and the results of the X-ray was signed by the Radiologist (a medical doctors that specialize in diagnosing and treating injuries and diseases using medical imaging (radiology) procedures such as X-rays) on 8/13/2024, at 8:27 p.m., (six hours and 27 minutes after the X-ray was ordered) but she could not find documentation when the facility staff received the X-ray results. During a review of the facility's Policy and Procedure (P&P) titled, Request for Diagnostic Services, revised 4/2007, the P&P indicated, orders for diagnostic services will be promptly carried out as instructed by the physician's order.