

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555880	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/08/2025
NAME OF PROVIDER OR SUPPLIER Clear View Convalescent Center		STREET ADDRESS, CITY, STATE, ZIP CODE 15823 So. Western Ave. Gardena, CA 90247	

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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50379</p> <p>Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1) was free from an avoidable fall when the facility:</p> <ol style="list-style-type: none"> 1. Did not conduct an Interdisciplinary Team (IDT, group of different disciplines working together towards a common goal of a resident) meeting as indicated in the Change of Condition (COC) assessment dated [DATE], following Resident 1 ' s fall on 11/12/2024. 2. Did not reassess Resident 1 ' s Fall Risk Assessment following Resident 1 ' s fall on 11/12/2024. 3. Did not develop a comprehensive person-centered care plan to address Resident 1 ' s impulsive behavior, tendency to overestimate abilities and get up without asking for assistance during the daytime or while up in chair and did not specify the type of supervision and monitoring Resident 1 required for safety. <p>These deficient practices had the potential to result in recurrent falls and injuries for Resident 1.</p> <p>Findings:</p> <p>During a review of Resident 1 ' s Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE]. The Admission Record indicated Resident 1 ' s diagnoses included severe dementia (a progressive state of decline in mental abilities), chronic (long-term) venous insufficiency (a condition where blood does not efficiently return to the heart), Vitamin B12 deficiency (a condition when the body doesn't have enough vitamin B12 to produce red blood cells), anemia (a condition where the body does not have enough healthy red blood cells), and polyneuropathy (disease or dysfunction of one or more nerves, typically causing numbness or weakness in the hands and feet).</p> <p>During a review of Resident 1 ' s History and Physical (H&P), dated 7/28/2022, the H&P indicated Resident 1 had a history of glaucoma (nerve damage in the eye that can lead to vision loss or blindness). The H&P indicated Resident 1 did not have the capacity to understand and make decisions.</p> <p>(continued on next page)</p>

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: 555880	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/08/2025
NAME OF PROVIDER OR SUPPLIER Clear View Convalescent Center		STREET ADDRESS, CITY, STATE, ZIP CODE 15823 So. Western Ave. Gardena, CA 90247	
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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1 ' s Minimum Data Set (MDS, a resident assessment tool), dated 10/29/2024, the MDS indicated Resident 1 had severe cognitive impairment (problems with the ability to think, learn, remember, and make decisions). The MDS indicated Resident 1 required supervision to touch assistance (staff provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) for Activities of Daily Living (ADLs) such as eating, oral hygiene, toileting hygiene, sit to stand (the ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed), transfers (ability to transfer to and from a bed to a chair, get on and off a toilet or commode or get in and out of a tub/shower) and ambulating (walking) 10-150 feet.</p> <p>During a review of Resident 1 ' s Fall Risk Assessment, dated 10/29/2024, the assessment indicated Resident 1 was at risk of falling. The Assessment indicated the following for Resident 1 ' s mental status: poor recall, judgement, and safety awareness.</p> <p>During a review of Resident 1 ' s Care Plan titled, Potential for Trauma- Falls, and complications from falls related to dementia, use of hypertensives (medicine for high blood pressure), dated 10/30/2024, the Care Plan indicated staff utilized a sensory alarm in Resident 1 ' s bed during the evening and night shifts and provide frequent visual checks. The Care Plan did not indicate what frequency the visual checks should be for Resident 1. The Care Plan did not indicate safety interventions related to Resident 1 ' s mental status while up in the chair or during the daytime.</p> <p>During a review of Resident 1 ' s Change of Condition (COC), dated 11/12/2024, the COC assessment indicated on 11/12/2024, Resident 1 fell on his right knee while out of the facility at an appointment. The COC assessment indicated Resident 1 sustained a right knee abrasion. The COC indicated an IDT Meeting was required.</p> <p>During a review of Resident 1 ' s Physical Therapy (PT) Discharge Summary, dated 12/24/2024, the PT Discharge Summary indicated Resident 1 had diagnoses of severe dementia and abnormalities of gait (manner of walking) and mobility. The Discharge Summary indicated Resident 1 required verbal cues, redirection, and tactile cues (physical touch) for safety measures due to the resident ' s cognition level. The summary indicated it was not safe for Resident 1 to use RW (Rolling walker) at this time as the resident was unable to recall and demonstrate safe use of RW with locking and unlocking mechanism. The summary indicated Resident 1 needed SBA (stand by assist, staff is nearby to help prevent injury or falls) to supervision level to transfer body weight over center of gravity, perform multi-step tasks, and navigating while ambulating.</p> <p>During a review of Resident 1 ' s Nurses Notes dated 12/29/24, the Nurses Notes indicated Resident 1 ' s vision was highly impaired and object identification was in question. The Notes indicated Resident 1 made poor decisions and required cues/supervision.</p> <p>During a review of Resident 1 ' s COC dated 1/2/2025, the COC indicated Resident 1 had an unwitnessed fall on 1/1/2025 at 6:37 p.m. The COC indicated Licensed Vocational Nurse (LVN) 2 found Resident 1 sitting on floor in Resident 1 ' s room, near the restroom, facing toward Resident 1 ' s bed. The COC indicated Resident 1 complained of right lower extremity (leg) pain. The COC indicated Resident 1 ' s doctor ordered a STAT (immediate) x-ray (imaging procedure to diagnose injuries) to the right leg.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555880	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/08/2025
NAME OF PROVIDER OR SUPPLIER Clear View Convalescent Center		STREET ADDRESS, CITY, STATE, ZIP CODE 15823 So. Western Ave. Gardena, CA 90247	
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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1 ' s Radiology (X-ray) Interpretation, dated 1/2/2025, the Radiology Interpretation indicated Resident 1 had a fracture of the right femur.</p> <p>During a review of Resident 1 ' s Nurses Note dated 1/2/2025, the Nurses Note indicated Resident 1 was transferred to GACH 1 by ambulance on 1/2/2025 at 6:30 a.m. due to Resident 1 ' s acute (sudden) fracture of the right femur.</p> <p>During an interview on 1/7/2025 at 10:10 a.m. with Certified Nursing Assistant (CNA) 1, the CNA 1 stated Resident 1 was impulsive, required constant supervision, and should never walk or transfer from of a chair without staff supervision and assistance.</p> <p>During a concurrent interview and record review on 1/7/2025 at 10:47 a.m. with LVN 1, Resident 1 ' s COC dated 1/2/2025 was reviewed. LVN 1 stated Resident 1 was unsupervised when Resident 1 transferred from sitting to standing and ambulated in Resident 1 ' s room. LVN 1 stated, this resulted in Resident 1 experiencing an unwitnessed fall. LVN 1 stated Resident 1 overestimated his physical abilities, required frequent cueing while ambulating, did not call or use the call light for assistance, and required constant supervision when awake. LVN 1 stated staff should not have left Resident 1 in a chair without supervision. LVN 1 stated Resident 1 should have sat in front of nursing station or in the activity room while awake to ensure supervision for safety. LVN 1 stated staff at the facility could have provided fall pads, call light alarms, and clip alarms for fall prevention and resident safety. LVN 1 stated the COC indicated Resident 1 sustained a right femur fracture after a fall on 1/1/2025. LVN 1 stated resident falls had the potential to result in broken bones and death.</p> <p>During a concurrent interview and record review on 1/7/2025 at 12:34 p.m. with the Director of Nursing (DON), Resident 1 ' s Fall Risk assessment dated [DATE] was reviewed. The DON stated Resident 1 ' s fall risk was not reassessed by nursing after Resident 1 fell on [DATE]. The DON stated a Fall Risk Reassessment should have been performed by the Rehabilitation (Rehab) Department after Resident 1 ' s fall on 11/12/2024. The DON stated implementing a call light alarm or clip alarm could have notified staff of Resident 1 ' s attempt to transfer out of chair and alerted staff to assist Resident 1 for safety. The DON stated Resident 1 did not have a call light alarm or clip alarm installed when Resident 1 transferred out of chair, ambulated in his room, and fell on [DATE].</p> <p>During a concurrent interview and record review on 1/7/2025 at 12:39 p.m. with the Director of Rehabilitation (DOR), Resident 1 ' s PT (Physical Therapy) Discharge Summary dated 12/24/2024 was reviewed. The DOR stated the PT Discharge Summary indicated Resident 1 required supervision to transfer body weight over center of gravity (where the total weight of the body is), transfer from sitting to standing, perform multi-step tasks, and navigating while ambulating. The DOR stated Resident 1 should not transfer from sitting to standing or walk around without supervision. The DOR stated Resident 1 also required safety measures due to cognition level. The DOR stated the Rehab department did not complete Resident 1 ' s Fall Risk Reassessment after Resident 1 ' s fall on 11/12/2024. The DOR stated Nursing staff were responsible for completing a Fall Risk Reassessment and should have incorporated the Rehab ' s post-fall assessments when completing the Fall Risk Reassessment Form.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555880	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/08/2025
NAME OF PROVIDER OR SUPPLIER Clear View Convalescent Center		STREET ADDRESS, CITY, STATE, ZIP CODE 15823 So. Western Ave. Gardena, CA 90247	
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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 1/7/2025 at 4:12 p.m. with CNA 2, CNA 2 stated CNA 2 was assigned to Resident 1 and was the last staff member to see Resident 1 prior to the resident ' s fall on 1/1/2025. CNA 2 stated Resident 1 was confused, needed cueing to find the bathroom and work through his steps. CNA 2 stated Resident 1 did not use the call light and would not wait for staff assistance if staff was not present in the room. CNA 2 stated she left Resident 1 unattended in the resident ' s room while up in the chair at around 6:20 p.m. and was later (time unknown) notified by LVN (unnamed) that Resident 1 fell in his room. CNA 2 stated, she was not aware of Resident 1 ' s prior fall or that the resident was a fall risk.</p> <p>During a concurrent interview and record review on 1/7/2025 at 4:49 p.m. with LVN 2, the facility ' s undated policy and procedure (P&P) titled Policy and Procedure on Fall Prevention and Reduction Program and Resident 1 ' s Care Plan titled Potential for Trauma- Falls, and complications from falls dated 10/30/2024 were reviewed. LVN 2 stated LVN 2 was not aware of Resident 1 ' s history of falling. LVN 2 stated LVN 2 discovered Resident 1 on the floor in Resident 1 ' s room at 6:37 p.m. on 1/2/2025 (17 minutes after Resident 1 was last seen by CNA 2). LVN 2 stated the Care Plan indicated an intervention to perform frequent visual checks. LVN 2 stated frequent was not specific. LVN 2 stated the P&P indicated visual checks every 15 minutes should be performed for residents identified to be a fall risk. LVN 2 stated Resident 1 ' s fall could have been prevented if Resident 1 was supervised.</p> <p>During a concurrent interview and record review on 1/8/2025 at 11:16 a.m. with RN 2, Resident 1 ' s COC dated 11/12/2025, MDS dated [DATE], the IDT Meeting notes dated 11/2024, Care Plan titled Short Term Problem: fell on his right knee dated 11/12/2025, Care Plan titled Potential for Trauma- Falls, and complications from falls dated 10/30/2024, the undated P&P titled Policy and Procedure on Fall Prevention and Reduction Program and undated P&P titled Policy of Care of Dementia Residents were reviewed. RN 2 stated the COC indicated an IDT meeting was required after Resident 1 fell on [DATE] however, it was not done. RN 2 stated the IDT should have reviewed Resident 1 ' s treatment plan related to Resident 1 ' s fall on 11/12/2024 to evaluate the appropriateness of corrective actions taken. RN 2 stated a Fall Risk Reassessment should occur after a significant change of condition (a major change in a resident's health that requires a reassessment and potential change in care plan). RN 2 stated a fall is a significant change of condition, regardless of where the fall occurs. RN 2 stated the Care Plan titled Potential for Trauma- Falls, and complications from falls should have been individualized and specific. RN 2 stated PT recommendations should have been added to Resident 1 ' s care plan but were not. RN 2 stated there were no measures to notify staff of Resident 1 ' s unsupervised transfer out of the chair and ambulation prior to Resident 1 ' s fall. RN 2 stated Resident 1 should have sat at the nursing station for supervision and safety. RN 2 stated specific and individualized care plans, Fall Risk Reassessments, and IDT Meetings were three opportunities to have assessed Resident 1 and developed resident-centered interventions to prevent additional falls. RN 2 stated no interventions were developed based on Resident 1 ' s needs. RN 2 stated Resident 1 ' s fall on 1/1/2025 could have been prevented. RN 2 stated Resident 1 ' s fall on 1/1/2025 resulted in Resident 1 breaking the right femur and transferring to the hospital.</p> <p>During an interview on 1/8/2025 at 4:40 p.m. with the Administrator, the Administrator stated an IDT meeting was not indicated after Resident 1 ' s fall on 11/12/2024.</p> <p>During a review of the facility ' s undated P&P titled, Policy of Care of Dementia Residents, the P&P indicated the IDT shall review the treatment plan of a resident with dementia quarterly or as needed.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555880	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/08/2025
NAME OF PROVIDER OR SUPPLIER Clear View Convalescent Center		STREET ADDRESS, CITY, STATE, ZIP CODE 15823 So. Western Ave. Gardena, CA 90247	

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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility ' s undated P&P titled, Policy and Procedure on Fall Prevention and Reduction Program, the P&P indicated a Fall Risk Assessment shall be reviewed during a significant change in resident condition. The P&P indicated comprehensive care planning should be developed for resident identified to be at high risk for falls or further falls and should identify interventions to prevent falls or further falls. The P&P indicated the facility Administrator, DON, Director of Staff Development, and IDT Members meet to evaluate fall incidents and the appropriateness of corrective actions taken. The P&P indicated residents identified to be at a greater risk or falls or further falls should be monitored closely to prevent further occurrence of fall incidents. The P&P indicated monitoring may be done by placing a high-risk resident near the nurse ' s station for increased visual monitoring, involving the resident in group activities, doing visual checks for the resident at least every 15 minutes, using mobility monitors (Chair Monitoring Device, Sensor Floor Mat, Sensor Pad Alarms), if deemed effective for a particular resident. The P&P indicated the facility must ensure continuous assessment of resident to reflect current status and condition. The P&P also indicated any changes in resident condition that may impact risk of falls should be noted and reflected in the Fall Risk Assessment and Plan of Care. The P&P indicated the facility should have a system in place that will allow for monitoring of fall incidences. The P&P indicated, for example, the incident reports are submitted to the DON and/or designee for further review and assessment and reviewed to ensure appropriate corrective actions/ measures have taken to prevent further falls. The P&P also indicated another example, the Administrator, DON, Director of Staff Development, and IDT members meet on a weekly, monthly and as needed basis to discuss & evaluate nature of fall incidences, appropriateness of corrective actions taken, etc.</p>