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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555894	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Foothill Heights Care Center	1515 North Fair Oaks Ave Pasadena, CA 91103

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 - Minimal harm or potential for 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 45456

Based on observation, interview and record review, the facility failed to prevent a fall (unintentionally coming to rest on the ground, floor, or other lower level, but not as a result of an overwhelming external force) for one (1) out of three (3) sampled residents (Resident 1). On 5/26/2024, Resident 1 was trying to transfer to bed, Certified Nurse Assistant (CNA) 1 was present in the room and did not assist the resident while transferring to bed.

This deficient practice has resulted to Resident 1 had a fall on 5/26/2024 and sustained laceration (measurement not indicated) on her left eyebrow.

Findings:

A review of Resident 1's Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses of dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), history of falling, fracture of left lateral orbital wall (occurs when one or more of the bones around the eyeball break, often caused by a hard blow to the face), lack of coordination and difficulty of walking.

A review of Resident 1's Minimum Data Set (MDS, a standardized assessment and care-screening tool), dated 4/29/2024, indicated Resident 1 has severely impaired cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 1 required partial/moderate assistance (helper does less than half the effort, helper lifts, holds, or supports trunks or limbs, but provides less than half the effort) in toileting hygiene, shower/bathe self, lower body dressing, putting on/taking off footwear, sit to lying, and lying to sitting on side of the bed, sit to stand, chair /bed-to-chair transfer, toilet transfer and walk 10 feet.

A review of Resident 1's Care Plan (CP) initiated on 5/20/2024, Resident 1 was on Falling Star Program (involves assessing patients or residents for their risk of falls and then identifying those at high risk with a visible symbol, usually a falling star graphic placed on the resident's door): At risk for falls related to: Antihypertensive medications, balance deficit, cognitive impairment, decreased strength/endurance, history of falls, non- compliant with request for assistance/non-use of call light. The care plan indicated the following interventions:

- Attach a call light to bed within access of Resident.

(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 - Minimal harm or potential for actual harm Residents Affected - Few	- Falling Star Program - star signs on the door by Resident name, on head of the bed to identify Resident is high risk. - Frequent visual monitoring - Place Resident close to the nursing station for close observation. The CP did not indicate intervention to assist resident during transfer to bed. A review of Resident 1's GACH 1 and 2's Discharge Summary dated on 4/7/2024, GACH 1 (where Resident 1 came from prior to admission to the facility) indicated, Resident 1 has a history of dementia who had a ground level fall. A review of Resident 1's Change of Condition (COC) dated 5/26/2024 at 6 PM, Resident 1 fell in the room while going to get in the bed. Certified Nurse Assistant 1 (CNA 1) witnessed Resident 1 fell . Resident 1 has a laceration to the face to her left eyebrow. During an observation in the Resident 1's room and interview with Resident 1 on 6/11/2024 at 11:50 AM, Resident 1 was walking inside her room with no staff present in the room to supervise the resident. Resident 1 stated she fell before, and it happened months ago, and it was in the afternoon. Resident 1 also stated, she fell on the floor on the left side of her bed (unable to recall exact date) and only remembers that she stood up from her bed and lean forward and then she just fell on the floor. During a concurrent record review of Resident 1's MDS and interview with the MDS Consultant (MDSC) on 6/11/2024 at 4:19 PM, MDS dated [DATE] indicated Resident 1 needs partial/ moderate assist in transfer and mobility. MDSC stated, Resident 1's Section GG meant there should be one physical person there to assist the resident a MDSC also stated, Resident 1, needed partial moderate assistance which meant that the nurse or the CNA would have to do physical assistance where they were doing some physical support to assist the patient with any ADL such as transfer and mobility/bed mobility. During a concurrent review of Resident 1's COC dated 5/26/2024 and interview with the MDSC on 6/11/2024 at 4:29 PM, MDSC stated, Resident 1 needs assistance obviously for all Activities of Daily Living (ADLs, are activities related to personal care including bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet, and eating). MDSC also stated, on 5/26/2024, Resident 1 should have had assistance by the facility staff to go to bed because it looked like that the reason why the resident fell in her room while she was going to get in the bed. MDSC added, if there was a staff in Resident 1's room to assist the resident to transfer to bed on 5/26/2024, then the resident's fall could have been prevented. During a concurrent record review of Resident 1's COC dated on 5/26/2024 and interview with the Director of Nursing (DON) on 6/11/2024 at 4:49 PM, COC dated 5/26/2024 at 10:53PM, the DON stated, Resident 1 fell going into her bed. There was a cut on her (Resident 1) face and left eyebrow. The DON also stated, per the DON's interview with CNA 1, CNA 1 was not able to grab Resident 1 before she fell because she was far from Resident 1 and was not assisting Resident 1 to transfer to bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent review of Resident 1's Fall Risk assessment dated [DATE] and interview with the DON on 6/11/2024 at 5:18 PM, Fall Risk Assessment is the post fall evaluation for 5/26/2024, score is 7 which indicated Resident 1 was low risk for fall. The DON stated the Fall Risk Assessment post fall evaluation for 5/26/2024 done by registry (temporary assignment that requires you to travel to a medical facility to provide coverage when it lacks staff for the day) licensed nurse was incorrect. The DON stated it was missing points on the score because the licensed nurse who completed the form did not mark the other items that needed to be marked (such as history of fall), Resident 1 supposed to be at least on moderate fall risk. During a concurrent review of Resident 1's MDS dated [DATE] and interview with the DON on 6/11/2024 at 5:15 PM, the DON stated, Resident 1's MDS Section GG indicated resident need partial moderate assist means Resident 1 needs assistance from the staff all the time to perform the ADL's. A review of facility's policy and procedure titled, Assessing Falls and Their Causes revised on 3/2018, indicated residents must be assessed upon admission and regularly afterward for potential risk of falls. The policy also indicated, relevant risk factors must be addressed promptly and when a resident falls, the following information should be recorded in the resident's medical record: appropriate intervention taken to prevent future falls. A review of facility's policy and procedure titled, Fall and Fall Risk, managing revised on 3/2018, indicated 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. The staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling.