STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055293	A. Building B. Wing	03/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Santa Anita Convalescent Hospital	5522 Gracewood Ave. Temple City, CA 91780

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** 40773 Based on interview and record review, the facility failed to ensure one of two sampled residents (Resident 1) was free from accidents by ensuring the resident was provided a two-person assistance. Certified nursing assistant (CNA) 1 provided care and repositioned the resident alone while the resident was in bed. This deficient practice resulted Resident 1 falling (unintentionally coming to rest on the ground, floor, or other lower level, but not as a result of an overwhelming external force) and landing on the floor in a prone position (prone position is a body position in which the person lies flat with the chest down and the backup) The resident sustained two lacerations to the right side of the face and was transferred to the general acute hospital (GACH) where the resident was found to have sustained facial fractures. Findings: A review of Resident 1's Face Sheet indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of chronic obstructive pulmonary disorder (COPD- a group of diseases that cause airflow blockage and breathing-related problems), functional quadriplegia (the complete inability to move due to severe disability or frailty caused by another medical condition), and congestive heart failure (heart can't pump enough blood). A review of Resident 1's Minimum Data Set (MDS: a standardized assessment and care planning screening tool) dated 1/3/23, indicated Resident 1 had moderate cognitive impairment. The MDS indicated Resident 1 required extensive assistance (staff provide weight bearing support) with two- persons physical assist for bed mobility (how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture). Resident 1 was totally dependent (full staff performance) requiring two- person physical assist with toilet use. A review of Resident 1's care plan (a document that outlines a resident's health and social care needs and how their needs will be supported) for Risk for Fall, initiated 12/22/22, indicated the goal was for Resident 1 to be free of falls and free of injury. The care plan interventions indicated to anticipate and meet the residents needs and to follow the facility's fall protocol. The Care plan interventions indicated to alter/remove any potential cause of fall if possible. (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 - Actual harm Residents Affected - Few	A review of Resident 1's nursing admission assessment dated [DATE], indicated resident was high risk for fall. A review of Resident 1's care plan for Activity of Daily Living (ADL: a series of basic activities necessary for independent living at home or in the community) for self-care performance, initiated 12/28/22, indicated Resident 1 was totally dependent on staff for repositioning and turning in bed. The care plan indicated Resident 1 was totally dependent on staff for toilet use. A Review of Resident 1's Change in Condition (COC a sudden clinically important deviation from a patient's baseline in physical, cognitive, behavioral, or functional domains), dated 1/7/23 indicated Resident 1 sustained a fall with two (2) lacerations to the right cheek. The COC indicated laceration 1 measuring at 2. 5-centimeter (cm: a unit of measurement) x 0.5cm located by the resident's right ear, and laceration 2 measuring at 0.2cm x 0.1cm with scant moderate amount of bleeding. The COC indicated a physician's order to transfer Resident 1 to the general acute care hospital (GACH). A review of Resident 1's Fall/ Event Interdisciplinary team (IDT) Progress note, dated 1/7/23, indicated certified nurse assistant (CNA)1 was providing care alone, for Resident 1, when Resident 1 fell and landed on the floor in prone position. The IDT note indicated Resident 1 sustained two lacerations to the right side of Resident 1's face. A review of Resident 1's Nurses Notes on 1/7/23 at 7:10PM, Licensed vocational nurse (LVN)1 indicated at 1:40PM, CNA1 notified LVN1 that Resident 1 fell out of bed while CNA1 was providing care. The Note indicated Resident 1 sustained two lacerations to the right cheek. A review of Resident 1's Nurses Note on 1/7/23 at 11:02PM, the Assistant Director of Nurses (ADON) indicated Resident 1 was at the GACH and sustained an occipital (posterior cranial bone) fracture. A review of the GACH Diagnostic Imaging for a computed tomography (CT: medical imaging technique used to obtain detailed internal images of the body) scan of the facial bone without contrast dated 1/7/23 indicated Resident 1 had a nondisplaced fracture (still broken bones, but the pieces weren't moved far enough during the break to be out of alignment) involving the right zygoma (bony arch of the cheek), right lateral maxillary wall (also known as the upper jaw), the right anterior maxillary wall (mouth), the left lateral orbital wall (side of the eye), and the right orbital floor (below the eye). The results indicated the findings were consistent with zygomaticomaxillary complex (ZMC: a major buttress of the midfacial skeleton. The ZMC is important to structural, functional, and aesthetic appearances of the facial skeleton) fracture. The results indicated a non-displaced right occipital (back part of the head) fracture. A review of Resident 1's Nurses note dated 1/8/23 at 1AM, indicated Resident 1 returned from the GACH with discoloration to the right lower eye and right cheek bone, and noted with swelling to the right ear, extending to the jaw line. The note indicated x-ray results indicating fracture to the right occipital, right zygoma (cheekbone) and right lateral maxillary (lateral, border of the nose) sinus. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 2/3/23 at 1:32PM, CNA1 stated Resident 1 sustained a fall in the facility while CNA1 was providing care and changing Resident 1's brief while resident was in bed. CNA1 stated he did not ask for assistance from another facility staff when repositioning Resident 1. CNA1 stated, even before the fall on 1/7/23, every time CNA1 needs to reposition Resident 1 in bed, CNA1 did not ask for assistance and was able to reposition the resident by himself. CNA1 stated on 1/7/23, while repositioning Resident 1 in bed to be on left side lying position, Resident 1 made a sudden movement, and fell on to the side where CNA1 was standing. CNA1 stated he could not stop Resident 1 from falling out of bed. CNA1 stated Resident 1 fell on the floor and had a laceration on Resident 1's face with blood present. CNA1 stated after Resident 1 fell out of bed, CNA1 immediately carried Resident 1 back into bed since CNA1 did not want to leave him on the floor, then notified LVN1. CNA1 stated it was important to ask for assistance when providing care to Resident 1 for safety and stated that CNA1 was unaware that Resident 1 required 2 persons assist for bed mobility. CNA 1 stated two-person assist would be utilized so each person could be on each side of the resident just in case a resident might roll out of bed. CNA1 stated if another facility staff had been present, Resident 1 would not have fallen out of bed. CNA1 stated he was unaware that licensed nurse (LN) should have assessed the resident prior to placing Resident 1 back into bed. CNA1 stated the importance of assessing a resident after a fall and prior to placing a resident back into bed was to identify if there were any other injuries and prevent more injuries. During an interview on 2/3/23 at 2:43 PM, LVN2 stated Resident 1 was totally dependent on staff and required 2 people assist for safety. LVN 1 stated during repositioning and to prevent a resident from falling out of bed, staff must be on each side of the resident to ensure falls or rolling out of bed does not occur, therefore having 2 persons present during resident care, could prevent resident falls. LVN 2 stated after a fall occurs, certified nurse assistants were aware that they should not move or touch the resident and to immediately call for help. LVN2 stated one staff are to stay with the resident, while the other calls for assistance. LVN2 stated moving a resident before being assessed for injuries must be done by a licensed nurse, and a resident was not moved until cleared to move after a body assessment was conducted to rule out other injuries and trauma. LVN2 stated staff are to assist by safely placing the resident back to bed. LVN 2 stated never should a CNA carry a resident alone back into bed. During an interview on 2/3/23 at 2:55PM, the Director of Nurses (DON) stated it was the responsibility of the LN to ensure that CNAs were aware of the type of dependence on staff (one-person, two person) a resident required, and was based on the mobility of a resident. The DON stated CNA1 was alone when providing care for Resident 1 and that two- persons should have been present. The DON stated the fall was avoidable, had two persons been present. The DON stated the purpose of having two person was for safety and because Resident 1 was totally dependent on staff and did not move on his own. The DON stated after Resident 1 sustained a fall, CNA1 independently carried Resident 1 back into bed without a body assessment conducted by licensed nurses. The DON stated the facility's fall protocol was for certified nurse assistants to wait for licensed nurses to assess the resident prior to moving or placing a resident back to bed to avoid further injury to the resident. A review of the facility's policy titled Fall Prevention Program dated 12/16 indicated the facility would identify interventions to prevent the resident from falling and to try and minimize complications from falling. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of the facility's policy titled, Standard of Care Activities of Daily Living (ADL), dated 2/17, indicated to assess resident's skill in performing ADLs on admission, quarterly and as needed. The policy indicated Resident would perform self-care with ADLs at the level on the CNA care plan and assist the resident to be clean.