STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555852	A. Building B. Wing	08/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Avenue Healthcare & Wellness Center	1550 North Park Avenue Pomona, CA 91768

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** 43495 Based on observation, interview and record review, the facility failed to ensure one of two sampled residents (Resident 1), who was assessed at risk for falls, (move downward, typically rapidly and freely without control, from a higher to a lower level) was evaluated for rehabilitation services (improve skills and functioning for daily living that has been lost or impaired) after a change in condition that occurred on 4/1/21 and was adequately supervised while lying in bed to prevent the resident from falling out of bed on 4/3/2021. On 4/3/2021 at 9:25 am, while Certified Nursing Assistant 1 (CNA 1) was changing Resident 1's adult brief, CNA 1 left the resident unwatched on the bed while reaching for the resident's adult brief. These deficient practices resulted to Resident 1's fall on 4/3/2021. Resident 1 suffered a head trauma (any damage to the scalp, skull or brain caused by injury) and sustained a two-centimeter (cm, a metric unit of length) laceration (a deep cut) to the left eyebrow and was transferred to a General Acute Hospital 1 (GACH 1) on 4/3/2021 at 12 pm where the resident received five sutures (a stitch or row of stitches holding together the edges of a wound) to the left eyebrow. Findings: A review of Resident 1's Admission Record indicated the facility admitted the resident on 8/25/2020 with diagnoses of generalized muscle weakness, seizure disorder (sudden, uncontrolled electrical disturbance in the brain which can cause changes in behavior, movements, feelings, and consciousness), emphysema (lung condition that causes shortness of breath), and schizophrenia (mental disorder characterized by abnormal social behavior and failure to understand what is real). A review of Resident 1's Minimum Data Set (MDS, a standardized assessment and care screening tool) dated 1/14/2021, indicated Resident 1 was moderately impaired with cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making and required a one person extensive assistance for bed mobility and transfer. The MDS indicated Resident 1 was total dependent (needs full staff assistance) for dressing, toilet use, personal hygiene, and bathing with one person to assist. A review of Resident 1's Morse Fall Risk Assessment (method of assessing a patient's likelihood of falling), dated 1/14/2021, indicated Resident 1 was assessed at being high risk for falls. (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 untitled care plan dated 1/14/2021, indicated Resident 1 was at risk for fall and the interventions included for the nursing staff to complete a fall risk evaluation upon admission, quarterly, with significant changes and as needed, refer for rehabilitation consultation, and orient resident to environment each time changes were made. A review of Resident 1's Situation- Background- Assessment- Recommendation (SBAR, provides a framework for communication between members of the health care team about a resident's condition), dated 4/1/2021, and timed at 1:57 pm, indicated Resident 1 had change of condition (COC, a sudden clinically important deviation from a patient's baseline in physical, cognitive, behavioral, or functional domains.), a decrease in functional mobility and developed new contracture. A review of Resident 1's clinical record from 4/1/21-4/3/21 indicated no documented evidence a rehabilitation consultation was conducted for the resident in accordance with the resident's care plan intervention or that the resident was re-evaluated for fall risk to provide physical therapy (PT, profession aimed in the restoration, maintenance, and promotion of optimal physical function), consultation after Resident 1 had a decline in functional ability (move independently and safely to participate in the activities of daily living), and development of new contractures (deformity and joint stiffness). A review of Resident 1's Progress Notes dated 4/3/2021, and timed at 12:03 pm, indicated that on 4/3/2021, at 9:25 am, CNA (unidentified) was providing care to Resident 1 on the resident's bed. The notes indicated the CNA (unidentified) reached for an adult brief and Resident 1 slid to the floor and sustained a laceration on the resident's left eyebrow. The notes indicated the facility transferred the resident to GACH 1 at on 4/3/2021, at 12pm. A review of Resident 1's GACH 1 Emergency Department Physician Note, dated 4/3/2021, and timed at 4:49 pm, indicated Resident 1 sustained a traumatic (refers to physical injuries of sudden onset and severity which require immediate medical attention) fall after the resident was being turned over in bed and the railing (barrier made of rails) was down. The notes indicated Resident 1 suffered a head trauma and sustained a two cm laceration over the left lateral (side) aspect of the eyebrow and the resident received five sutures. A review of Resident 1's Care Conference Summary (CCS), dated 4/5/2021, and timed at 11am, indicated Resident 1 slid off the resident's bed on 4/3/2021 (no time identified) while CNA1 was providing care. CCS indicated Resident 1 was on a low air loss mattress (LAL, mattress that operates using a blower-based pump that was designed to circulate a constant flow of air), which was made of slippery material. During an observation and interview with licensed vocational nurse 3 (LVN 3) on 4/14/2021 at 11:52 am, Resident 1 was observed inside the resident's room with a white gauze (bandage) on the left eyebrow. LVN 3 stated Resident 1 fell on [DATE] from the bed, sustained a laceration, and had sutures. During an interview on 4/14/2021 at 2:29 pm, LVN 2 stated on 4/3/2021 at 9:25 am, LVN 2 was giving medications to Resident 1's roommate when she heard a loud thump coming from Resident 1's bed. LVN 2 stated CNA 1 called for her help and when she went to help CNA 1, she saw Resident 1 on the floor. LVN 2 observed the Resident 1 bleeding from the left side of the head near eyebrows. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a concurrent record review and interview on 4/14/2021 at 4:14 pm with MDS nurse, she stated Resident 1's Summary of Physician Orders did not indicate any order for rehabilitation consultation referral from when Resident 1 had a COC on 4/1/2021 until the fall incident on 4/3/2021. MDS Nurse stated Resident 1 required a one person assistance for bed mobility and toilet use according to the MDS on 1/14/2021. MDS nurse stated Resident 1 needed two people assist with Activities of Daily Living (ADL, people's daily self-care activities including changing of adult briefs) after the resident fell on [DATE]. MDS nurse stated there were no updates on the resident's care plan on 4/1/2021 after determination of Resident 1's COC. During a telephone interview on 5/26/2021 at 11:30 am, the facility's Director of Nursing (DON) stated according to the facility's Fall Management Program policy, a licensed nurse (any) would conduct a new fall risk evaluation upon identification of a significant COC. DON stated the policy indicated the licensed nurse (any) would update the resident's fall risk status, update and document the interventions in the resident's care plan. DON stated the fall risk assessment was not completed for Resident 1 due to the decline in mobility and development of new contractures on 4/1/2021. DON stated it was important to complete a new fall risk evaluation after Resident 1's COC was noted to determine how much ADL assistance needed and to update the care plan with interventions to prevent fall. During a telephone interview on 6/2/2021 at 1:51 pm, DON stated Resident 1's care plan dated 1/14/2021 indicated Resident 1 was at risk for fall and the interventions were to refer for rehabilitation consultation. DON stated there was no documented evidence of a rehabilitation consultation referral from when Resident 1 had the COC on 4/1/2021 to the incident of fall on 4/3/2021. DON stated, it was important to have a timely rehabilitation consultation referral to ensure resident receive the necessary treatment and prevent harm and further decline. During a telephone interview on 6/3/2021 at 9:56 am, Nurse Practitioner (NP, a nurse qualified to assess patient needs, order and interpret diagnostic and laboratory tests, diagnose disease, formulate and prescribe treatment plans) stated she gave an order for rehabilitation consultation for Resident 1 on 4/1/2021 after receiving a notification of Resident 1's COC. NP stated it was important for the rehabilitation consultation to be done as ordered to prevent further decline and injury to Resident 1. NP stated the rehabilitation consultation could have prevented Resident 1's fall. During a concurrent record review and telephone interview on 6/4/2021 at 9:01 am, Rehabilitation Department Director (RDD) stated Resident 1's physician order summary did not indicate a rehabilitation consultation order on 4/1/2021 or on 4/2/2021. RDD stated the rehabilitation department was not made aware of any rehabilitation consultation ordered for Resident 1 on 4/1/2021, after the resident's change in condition. RDD stated it was important to make sure residents' received proper rehabilitation consultation and interventions to help residents improve their functional ability, avoid decline and prevent injury. During a telephone interview on 6/25/2021 at 2:44 pm, CNA 1 stated on 4/3/2021, at 9:25 am, she was providing care and she reached out to get an adult brief when Resident slip off the bed and she called for help. (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, Fall Management Program, revised 3/13/2021, indicated a licensed nurse would conduct a new fall risk evaluation quarterly, annually, upon identification of a significant COC, post fall and as needed. The policy indicated the IDT would initiate, review, and update the Resident's fall risk status and care plan at the following intervals quarterly, annually, upon identification of a significant COC, post fall and as needed.