STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055977	A. BUILDING _____ B. WING _____	**06/22/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
KENNEDY POST ACUTE CARE CENTER	**619 N. FAIRFAX AVE LOS ANGELES, CA 90036**

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** Based on interview and record review, the facility failed to identify and evaluate risks for accidents and hazards and did not modify care plan interventions when necessary for one of three sampled residents (Resident 1). Resident 1 was assessed as moderate risk for falls, memory problems, and altered awareness of immediate physical environment. The facility failed to: 1. Develop and implement effective interventions to address Resident 1 not calling for assistance to use the toilet, including toileting schedule. 2. Implement the facility's policy on Falls and Fall Risk Managing by not re-evaluating whether to continue or change current interventions. 3. Re-evaluate Resident 1's increased fall risks after the first fall on [DATE]. 4. Implement the facility's policy on Falls - Clinical Protocol by not ruling out delayed fall complications such as subdural hematoma (a pool of blood between the brain and its outermost covering). As a result, on [DATE] at 9:54 a.m., approximately 35 hours after Resident 1 sustained a second unwitnessed fall, Resident 1 had an altered level of consciousness (the state of being awake and aware of one's surroundings) became less responsive, did not speak, and did not follow commands. Resident 1 was sent to General Acute Care Hospital 1 (GACH 1) where she was diagnosed to have a large left sided subdural hematoma (pooled blood that pushes on the brain), was not a candidate for surgery and was placed on comfort measures. Resident 1 returned to the facility on [DATE], remained on comfort care, and ultimately died on [DATE] at 10:20 a.m. Findings: On [DATE], an unannounced visit was made to the facility to investigate a complaint regarding falls. A review of Resident 1's admission record (face sheet) indicated the facility admitted Resident 1, an [AGE] year old female, on [DATE], with [DIAGNOSES REDACTED]. The face sheet indicated Resident 1 had a Responsible Party (RP). A review of Resident 1's Fall Risk assessment dated [DATE], indicated Resident 1 had no falls within previous six months, but had altered awareness of immediate physical environment. The assessment indicated Resident 1's total score was nine out of 13 which represented moderate fall risk. A review of the Risk for Falls Care Plan dated [DATE], indicated related and due to Resident 1's weakness, dizziness, changes in blood pressure, and orthostatic [MEDICAL CONDITION]. The short-term goal was to minimize falls and risk for injury. The care plan interventions included providing a clutter free environment, well lit room, dry floors, and monitoring for weakness, dizziness and fatigue every shift. The interventions did not include the staff physical assistance Resident 1 required or the use/need of assistive devices (cane, walker, wheelchair). A review of the Physician's Orders and Nursing Progress Notes dated from ,[DATE] - [DATE], indicated there were no orders for Resident 1 to receive a low bed, side rails, or placement of floor mats. A review of the History and Physical form dated [DATE], indicated Resident 1 had the capacity to understand and make decisions. A review of Resident 1's Physical Therapy (PT) Evaluation and Plan of Treatment form dated [DATE], indicated Resident 1 required moderate assistance with bed mobility and transfers, had difficulty in walking, and had balance, gait, and strength impairment. A review of Resident 1's Occupational Therapy (OT) Evaluation and Plan of Treatment form dated [DATE], indicated Resident 1 had a [DIAGNOSES REDACTED]. The OT evaluation indicated Resident 1 required maximal assistance with toileting. A review of the ADL Function care plan dated [DATE] indicated staff would assist Resident 1 with grooming, hygiene, bathing and toileting. A review of the Minimum Data Set (MDS - standardized assessment and care-screening tool) dated [DATE], indicated Resident 1 was able to make decisions and had some memory problems. Resident 1 required one-person guided maneuvering or other non-weight bearing assistance with bed mobility, transfers, toileting and personal hygiene. Resident 1 required extensive assistance with walking, and used a walker or wheelchair to assist with mobility. A review of Resident 1's Investigative Report and the Internal Incident Report dated [DATE], at 11 p.m., indicated Resident 1 had an unwitnessed fall with injuries. The report indicated staff observed Resident 1 laying outstretched in a supine position (flat on the back), on the floor next to her bed. Resident 1 had a head injury, with a large bump to the left side of forehead with bleeding, a skin tear (measured 3 centimeters (cm - unit of measure) in length by 1.5 cm in width) on the left temporal area (located on the side of the head between the forehead and the ear). Resident 1 was also complaining of pain. The staff called 911 and Resident 1 refused to go to the hospital. The staff provided wound care to the skin tear, educated Resident 1 to use the call light, notified the doctor, and initiated 72-hour neurological monitoring (neuro-check, assessment of level of consciousness, and the reaction to light). A review of the facility's report indicated a nurse last saw Resident 1 in her room approximately twenty minutes before the fall. A review of Nursing Progress Notes dated [DATE] at 12 a.m., indicated the on-call physician was notified and ordered to encourage Resident 1 to go to the GACH in the morning. A review of Nursing Progress Notes dated [DATE] at 3:04 a.m., indicated LVN 4 asked Resident 1 if she had any pain, and Resident 1 pointed to the bump on her head. A review of Nursing Progress Notes dated [DATE] at 6:14 a.m., indicated Resident 1 continued to complain of pain to the bump on left forehead. Licensed Vocational Nurse 4 (LVN 4) offered pain medication, but Resident 1 refused. A review of Nursing Progress Notes dated [DATE] at 3:16 p.m., indicated Resident 1 at times remembers the event, was encouraged to go to hospital, but refused. The note indicated neurochecks were conducted with no notable change in cognitive or neurological status. A review of Resident 1's Physician's Progress Notes written by Nurse Practitioner 1 (NP 1) dated [DATE] and timed at 8:42 p.m., indicated Resident 1 had a large ecchymosis (bruise) over the right cheekbone extending toward the neck, and raccoon eyes (bruise around the eyes), the left side larger than the right. NP 1 indicated fall precautions discussed with the staff and the resident and ordered a psychiatric consultation (the medical specialty devoted to the diagnosis, prevention, and treatment of [REDACTED]. A review of Resident 1's Care Plan developed on [DATE] (after the fall on [DATE]) for the resident's activities of daily living (ADLs - dressing, eating transfers, walking, toilet use, and personal hygiene) and non-compliance with the use of the call light when walking to the restroom, had a goal for Resident 1 to call for assistance when she needed to go to the restroom. The interventions included explaining to Resident 1 her fall risk. The care plan did not include Resident 1 required assistance with mobility, transfer, or ambulation per the fall risk assessment. A review of the Physician's Progress Notes dated [DATE], documented by the NP, indicated Resident 1 had a small hematoma on the left forehead covered with a dressing, the left raccoon eye was fading and the large ecchymosis over the right cheekbone extending toward the neck was fading. The progress note indicated Resident 1 had generalized weakness and dizziness. The NP recommended for Resident 1 to change positions slowly and ordered fall precautions, and PT/OT evaluation. A review of the clinical record indicated Resident 1 did not have a re-assessment of Fall Risk to indicate changes in fall history, patient care equipment, mobility, cognition, or a change in total fall risk score. A review of the Fall Scene Investigation Report, dated [DATE], indicated at 10:45 p.m. Resident 1 was in her room when she sustained a second unwitnessed fall (approximately one month after the first fall on [DATE]). The investigation report indicated Resident 1 was found by the Certified Nursing Assistant (CNA), at the foot of the bed, sitting on the floor. The resident indicated she tried to sit down on the bed but fell to the floor. A review of Resident 1's Care Plan developed on [DATE], for the fall sustained the same day, included in the approaches to remind

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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.

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F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) Resident 1 to call for assistance whenever she needed assistance with ADLs. The care plan did not include Resident 1 required assistance or mobility, transfer, or ambulation per the fall risk assessment. A review of Resident 1's medical records for [DATE] to [DATE], indicated the facility did not conduct a fall risk re-assessment after Resident 1's second fall on [DATE]. A review of the Nursing Progress notes, dated [DATE], indicated Resident 1 had no change in level of consciousness, no complaints of pain, and was encouraged to call staff for any assistance as needed. A review of the SBAR dated [DATE] at 9:54 a.m., indicated Resident 1 had altered mental status, decreased level of consciousness, and was unable to follow commands and the NP was notified with no new orders. A review of the Nursing Progress notes, dated [DATE], at 10:07 p.m., indicated Resident 1 was awake, alert and verbally responsive. The note indicated Resident 1 was monitored for confusion with no episodes noted at this time. A review of physician progress notes [REDACTED]. The NP indicated Resident 1 had poor lung effort, not oriented, non-verbal, weakness in the upper and lower extremities, and pupils were round, equal with sluggish response to light. Medical Doctor 1 (MD 1) ordered to transfer Resident 1 to GACH 1 for evaluation on the same day. A review of Resident 1's GACH 1 Computerized Tomography scan (CT - combines a series of X-ray images taken from different angles around the body and uses computer processing to create cross-sectional images) of the brain dated [DATE], indicated a very large left sided subdural hematoma. A review of Resident 1's GACH 1 Discharge Summary dated [DATE], Resident 1 became aphasic (an impairment of language, affecting the production or comprehension of speech and the ability to read or write. [MEDICAL CONDITION] is always due to injury to the brain-most commonly from a stroke, particularly in older individuals) was not a candidate for surgical interventions, the decision was to keep the resident comfortable and transfer back to the facility on comfort measures. A review of the nursing progress notes dated [DATE], indicated Resident 1 was readmitted to the skilled facility and was nonverbal. A review of the progress notes, dated [DATE], indicated Resident 1 had eyes closed and was not responding to verbal or tactile stimuli (touch sensation). Resident 1 was declared expired at 10:20 a.m. A review of the Certificate of Death indicated the primary cause of death to be [MEDICAL CONDITION] (bleeding) and [MEDICATION NAME] head trauma, on [DATE], at 10:20 a.m. During an interview on [DATE] at 10:40 a.m., the responsible party (RP - Resident 1's family member), stated she made many visits to see Resident 1 at the facility and on [DATE], she was at the facility when she observed a black and blue bruising on the left side of Resident 1's face and left arm. The RP stated Resident 1 was grimacing when moving her neck and left arm. The RP stated she asked nursing staff how Resident 1 got her bruises, and they stated Resident 1 fell in her room. During an interview on [DATE] at 12:04 p.m., and 2:29 p.m., the Director of Nursing (DON) stated she was working when Resident 1 had an unwitnessed fall on [DATE] and on [DATE]. During an interview and record review, on [DATE] at 12:02 p.m., the DON stated the licensed nurse did not re-assess Resident 1's fall risk after [DATE]. The DON stated it was not the facility's practice to utilize their fall risk assessment tool after a fall. A review of the Coroner's Report dated [DATE] indicated Resident 1 had a reported medical history of [REDACTED]. The report indicated the causes of death were [MEDICAL CONDITION] and [MEDICATION NAME] head trauma. A review of the facility policy titled, Falls and Fall Risk Managing, revised [DATE], indicated under Monitoring Subsequent Falls and Fall Risk, the staff will monitor and document each resident's response to interventions intended to reduce falling or the risk of falling. If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions A review of the facility policy titled, Fall Risk Assessment, revised [DATE], indicated the nursing staff shall seek to identify and document resident risk factors for falls. The policy indicated the staff would review the resident's record for history of falls, especially falls within the last 90 days. The policy indicated assessment data shall be used to identify underlying medical conditions that may increase the risk of injury from falls. A review of the facility policy titled, Falls - Clinical Protocol, revised [DATE], indicated the nurse shall assess, document and report change in cognition or level of consciousness, all active diagnoses. Under Monitoring and Follow-up, indicated the staff with the physician's guidance would follow up on any fall with associated injury until the resident is stable and delayed complications such as late fracture or subdural hematoma have been ruled out or resolved. The policy indicated that delayed complications such as late fractures and major bruising may occur hours or several days after a fall, while signs of subdural hematomas or other intracranial bleeding could occur up to several weeks after a fall.