STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056023	A. BUILDING _____ B. WING _____	03/11/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AVALON VILLA CARE CENTER	12029 AVALON BLVD LOS ANGELES, CA 90061

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 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility's nursing staff failed to thoroughly and completely document, assess and/or describe the fall and injury for one of three sampled residents (Resident A). This deficient practice placed the resident at risk for an inaccurate reflection of the resident's current status, delay in treatment and non-continuity of care. Findings: During a review of Resident A's clinical record the Admission Records indicated the resident was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. cerebral infarction (stroke) affecting the right dominant side and a history of falling. The Minimum Data Set (MDS) Resident Assessment and Care Screening, dated 11/26/19, indicated Resident A's cognitive skills for daily decision-making were moderately impaired. The resident required extensive assistance with two-person physical assistance and use a wheel chair or walker for mobility. According to a Change in Condition Evaluation, dated 12/29/19, Resident A was found lying on her right side on the floor with the wheelchair in its upright position. Resident A stated she tried to transfer from the wheelchair to the bed, loss her balance and fell . Continued review of the evaluation indicated Resident A was assessed with [REDACTED]. During a review of the Progress Notes, dated 12/29/19, timed at 5:59 p.m. the licensed nurse documented Resident A had an unwitnessed fall at 3:39 p.m. Resident A was alert and oriented times three (name, date, time), the resident was able to explain how she fell . At 6:24 p.m., the licensed nurse documented the resident was transferred to a general acute care hospital (GACH). There was no written description of the swelling to the resident's head (open, bleeding, raised, round, linear), location (other than top of head), approximate size and/or measurement. During an interview with Registered Nurse Supervisor (RN 1) on 12/29/19 at 4:15 p.m., he stated he was called to the resident's room and found the resident on the floor. He stated a complete head to toe assessment was completed. Resident A complained of pain to the back of her head, he assessed her and found an upraised but sunken area that was less than an inch in length and linear. He stated he could not see the wound because of her hair but there was no blood and her pain was less than seven on a scale of 1-10. He stated Resident A was found on the right side of her bed between bed A and bed B, her bed was flat, raised to a normal but not low height, here was no bed alarm or floor mats, and 1/2 side rails were raised near the head of her bed. Her wheelchair was in an upright position on the right side of her bed. He was not able to explain why he was not as descriptive on the progress notes or the change of condition report. During an interview with Licensed Vocational Nurse 1 (LVN 1) on 12/29/19 at 4:35 p.m. she stated Resident A is alert and oriented times three, follows commands, can make her needs know and can engage in conversation. The resident is confused and attempts to do things on her own although they encourage her to use her call light. LVN 1 stated a certified nurse assistant (CNA) reported the resident was on the floor. LVN 1 and RN 1 went to the resident's room, when the resident was asked if she was in pain the resident pointed to her head and nodded yes. LVN 1 stated there was a slightly upraised area on the top of the resident's head that was linear in size, about three inches in length, no open skin and no bleeding was assessed. She stated she was directed by the director of staff development (DSD) to redo the documentation of the resident's fall because the documentation was too brief. However, LVN 1 had no explanation why she did not include a complete description of the resident's wound. During a telephone interview with the DSD on 1/30/2020 at 11:35 a.m., she stated the facility requires staff documentation to include who found the resident, the location, description of the environment (floor, bed, call light, hazards, etc .), assessment of the resident's body, pain and description of injury/wound (size, measurements, bleeding, location, open skin, etc .).
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility's nursing staff failed to develop a care plan for one of three sampled residents (Resident A) after the resident fell and sustained an injury to her head. This deficient practice placed the resident at risk for continued falls and injury. Findings: During a review of Resident A's clinical record the Admission Records indicated the resident was admitted on [DATE], with [DIAGNOSES REDACTED]. cerebral infarction (stroke) affecting the right dominant side and a history of falling. The Minimum Data Set (MDS) Resident Assessment and Care Screening, dated 11/26/19, indicated Resident A's cognitive skills for daily decision-making were moderately impaired. The resident required extensive assistance with two-person physical assistance and use a wheel chair or walker for mobility. According to a Change in Condition Evaluation, dated 12/29/19, Resident A was found lying on her right side on the floor with the wheelchair in its upright position. Resident A stated she tried to transfer from the wheelchair to the bed, loss her balance and fell . Continued review of the evaluation indicated Resident A was assess with swelling on the top of her head. Further review of Resident A's clinical records indicated a Care Plan, revised on 12/29/19, for an actual fall, there were goal or interventions. On 2/25/2020, at 10:56 a.m., during a telephone interview and after reviewing Resident A's clinical records, the Director of Nursing (DON) acknowledged the care plan dated 12/29/19 for actual fall had no goals or interventions and a complete care plan should have been written following the resident's fall. A facility policy and procedure, entitled Falls and Fall Risk, Managing, revised 12/2007, indicate based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risk and causes to try to prevent the resident form falling and to try to minimize complications from falling. The staff, with the input of the attending physician, will identify appropriate interventions to reduce the risk of falls. If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant. If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on assessment of the nature or category of falling, until falling is reduced or stopped, or until the reason for the continuation of the falling is identified as unavoidable. In conjunction with the attending physician, staff will identify and implement relevant interventions to try to minimize serious consequences of falling.
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** Based on interview and record review the facility failed to conduct an investigation for a fall for one of three sampled residents (Resident A). This deficient practice has the potential for the resident to continue falling. Findings; During a review of Resident A's clinical record the Admission Records indicated the resident was admitted on [DATE], with [DIAGNOSES REDACTED]. cerebral infarction (stroke) affecting the right dominant side and a history of falling. The Minimum Data Set (MDS) Resident Assessment and Care Screening, dated 11/26/19, indicated Resident A's cognitive skills for daily

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	(continued... from page 1) decision-making were moderately impaired. The resident required extensive assistance with two-person physical assistance and use a wheel chair or walker for mobility. According to a Change in Condition Evaluation, dated 12/29/19, Resident A was found lying on her right side on the floor with the wheelchair in its upright position. Resident A stated she tried to transfer from the wheelchair to the bed, loss her balance and fell . Continued review of the evaluation indicated Resident A was assess with swelling on the top of her head. During an interview with the DON on 1/29/2020 at 4:05 p.m.,, he stated a certified nursing assistant (CNA), he was not sure of the CNA name, who found the resident on the floor and reported to the registered nurse supervisor (RN 1). During an interview with RN 1 on 1/29/2020 at 4:15 p.m., he stated at approximately 5 p.m., on the day the resident fell he was called by the CNA to the resident's room and he did know the CNA name. During an interview with LVN 1 on 1/29/2020 at 4:35 p.m., she stated a CNA reported to her the resident was on the floor. she to could not remember the CNA name. During an telephone interview with the DON on 1/30/2020 at 11:25 a.m., and an interview on 2/25/2020 at 10:56 a.m., he stated normally a post fall assessment is conducted following a resident's fall, however, after reviewing Resident A's clinical records he could not find a post fall assessment. A review of the facility's policy and procedure titled Fall-Clinical Protocol dated 9/12, indicated for an individual who has fallen, staff will attempt to define possible causes within 24 hours of the fall. After a first fall, staff should watch the individual rise from a chair without using his or her arms, walk several paces, and return to a sitting position. After more than on fall the physician should review the resident's gait,, balance, and current medication that may be associated with dizziness or falling. The staff and physician will continue to collect and evaluate information until either the cause of the falling is identified, or it is determined that the cause cannot be found or that finding a cause would not change the outcome or the management of falling an fall risk.
F 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility's nursing staff failed to indicate addendum or late entry on the progress notes when additional and/or a change in documentation is made. The facility's nursing staff failed to ensure the score of the Morse Fall Scale (fall risk assessment) was printed on the form for one of three sampled residents (Resident A). This deficient practice resulted in confusion regarding the date of the fall and an incomplete evaluation of the resident's risk of falling. Findings: During a review of Resident A's clinical record the Admission Records indicated the resident was admitted on [DATE], with [DIAGNOSES REDACTED]. cerebral infarction (stroke) affecting the right dominant side and a history of falling. The Minimum Data Set (MDS) Resident Assessment and Care Screening, dated 11/26/19, indicated Resident A's cognitive skills for daily decision-making were moderately impaired. The resident required extensive assistance with two-person physical assistance and use a wheel chair or walker for mobility. a. During a review of the Progress Notes, dated 12/29/19, timed at 5:59 p.m., indicated Resident A had an unwitnessed fall at 3:39 p.m. Resident A was alert and oriented times three (name, date, time), the resident was able to explain how she fell . At 6:24 p.m., the licensed nurse documented the resident was transferred to a general acute care hospital (GACH). The Progress Notes, dated 12/30/19, timed at 3:53 p.m. (Resident A was transferred to a GACH on 12/29/19 and had not returned to the facility), indicated at 3 p.m., during rounds Resident A was noted in the hallway by her room sitting up in her wheelchair. Resident A was alert and oriented and verbally responsive, with no complaint/or pain or discomfort. At 3:30 p.m., a certified nursing assistant (CNA) reported Resident A was found in her room by the bed, lying on her left side. Resident A was assessed from head to toe and noted with swelling on the top of her head which was painful to touch. During a telephone interview with the Director of Nursing (DON) on 2/25/2020 at 10:56 a.m., he stated on their computer system when nurses do a follow up entry (late entry or addendum) the computer prompts them to click follow up. However, when the progress notes are printed the word follow up does not appear which gives the impression the documentation is in real time and the charting looks as if it is completed on the wrong date. He stated he was slightly confused as well and initially thought Resident A sustained an additional fall but then realized Resident A was transferred to a GACH on 12/29/19 and was not in the facility on 12/30/19. During a review of the facility policy and procedure, titled General Documentation dated 2/2017, indicated late entries in the clinical record are dated for the day of entry. These entries are to be made to the record in a timely manner. There is no time limit to make a late entry; however, the entry should be made as soon as reasonably possible. Late entries are to include the date and time the late entry was made and the date for the late entry. Late entries should be made as soon as practicably possible. Avoid using the phrase late entry Example: 05/05/02 1400 entry for 05/03/02 1000. b. During a review of Resident A's Morse Fall Scale assessment forms, dated 11/20/19, 12/10/19, 12/12/19, 12/30/19 and 1/10/2020, there was no score or category on the form. The form itself indicated the score and category will appear in the header of the assessment. During a telephone interview and following a review on the computer of Resident A clinical record with the DON on 2/25/25 at 10:56, he stated the computer system assigns a score in the header of the assessment, however, when the assessment is printed the score does not appear on the form. According to the DON's review of the the assessment from the computer the resident's scores were as follow: On 11-20-19 the score was 75, on 12-10-19 the score was 50, on 12-12-19 the score was 55, on 12-30-19 the score was 65, and on 1-10-20 the score was 75. A score of 45 or higher indicate a high risk.