STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055531	A. BUILDING _____ B. WING _____	**03/31/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BEACHSIDE POST ACUTE	**22520 MAPLE AVENUE TORRANCE, CA 90505**

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 0658 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow its policy and evaluate changes in level of consciousness ((LOC) identify how awake, alert, and aware of the surroundings) for two of three sampled residents (Residents 1 and 2) after an unwitnessed fall. This deficient practice had the potential to result in Residents 1 and 2 suffering internal bleeding, injuries such as broken bones, and/or death. Findings: a. A review of Resident 2's Admission Records indicated Resident 2 was admitted to the facility on [DATE] and re-admitted on [DATE]. Resident 2's [DIAGNOSES REDACTED]. A review of Resident 2's History and Physical (H/P), dated 6/14/19, indicated Resident 2 had a history of [REDACTED]. A review of Resident 2's Medication Administration Record [REDACTED]. The MAR indicated [REDACTED]. A review of Resident 2's Progress Note, dated 11/16/19, indicated Resident 2 reported to the staff she fell the day before. The note indicated Resident 1 stated she was on her knees, screamed for help, and a certified nursing assistant (CNA) helped her get up. A review of Resident 2's Change of Condition Evaluation ((COC) an internal communication tool), dated 11/16/19, indicated Resident 2 reported to a CNA she fell in the bathroom on 11/15/19. The COC indicated Resident 2's physician recommended neurological checks for 72 hours. A review of Resident 2's Minimum Data Set ((MDS) a standardized assessment and care screening tool), dated 12/13/20, indicated Resident 2 had the ability to understand and make herself understood. The MDS indicated Resident 2 required a one-person physical assistance for toilet use and transferring from the bed to the wheelchair. A review of Resident 2's Fall Risk Assessment, dated 12/24/19, indicated Resident 2 was a high risk for falls. During an interview with Resident 2, on 2/25/20, at 7:25 a.m., the resident stated she had a fall in the facility last year. Resident 2 stated she fell in the bathroom and a CNA helped her get up. Resident 2 stated she was not monitored for changes in LOC. Resident 2 stated she had a history of [REDACTED]. LVN 2 stated for unwitnessed falls, the neuro-check form was completed to assess for changes in the LOC such as alertness, pupil reaction, change of mentation, and hallucinations (seeing things that are not there). During an interview with the Director of Nursing (DON) on 2/25/20, at 3:5 p.m. the DON stated when residents had a fall they were assessed for injury, the doctor and responsible party were notified, and the COC form was completed. During an interview and concurrent record review with Registered Nurse 1 (RN 1) on 2/28/20, at 9:24 a.m., RN 1 stated they were to document any incident, conduct an investigation, and monitor the resident for any change of condition. RN 1 stated Resident 2 notified her on 11/16/19 that she had a fall on 11/15/19. RN 1 stated she assessed Resident 2 and completed the COC on 11/16/20. RN 1 stated she was not notified that Resident 2 had a fall. RN 1 stated she reviewed the documentation for 11/15/19 and could not find any documentation that Resident 2 had a fall. RN 1 stated Resident 2 had [MEDICAL CONDITION] (disorder characterized by low bone mass) and could suffer an injury such as a fracture. RN 1 stated Resident 1 should have had a neuro- check to check for changes in LOC. RN 1 reviewed Resident 2's chart and was unable to find any documentation Resident 2 was monitored for changes in LOC. During an interview on 2/28/19, at 1:31 p.m., RN 1 stated she was working on 11/15/19 and CNA 4 did not report Resident 2's fall because CNA 4 assumed it was not a fall. RN 1 stated CNA 4 did not think it was a fall because Resident 2 was not all way on the floor. b. A review of Resident 1's Admission Record indicated the resident was admitted to the facility on [DATE]. Resident 1's [DIAGNOSES REDACTED]. A review of Resident 1's undated Admission history and physical examination [REDACTED]. A review of Resident 1's Nursing Admission Assessment, dated 10/18/19, indicated Resident 1 had poor safety judgement. The assessment indicated Resident 1 was at risk for fall due to impaired balance and unsteady gait. A review of Resident 1's At Risk for Falls Care Plan dated 10/20/19, indicated Resident 1 had interventions that included assessment of the need for assistive supportive device and keep environment free of clutter and safety hazards. A review of Resident 1's Physical Therapist (PT) Evaluation and Treatment dated 10/20/19, indicated Resident 1 was a fall risk. A review of Resident 1's Physician's Progress Note dated 10/25/19, indicated Resident 1 had a [DIAGNOSES REDACTED]. The MDS indicated Resident 1 required a one-person assist to move on and off the unit and used a walker and wheelchair for mobility. A review of Resident 1's Progress Notes dated 12/8/19, at 10:15 a.m., indicated Resident 1 was found on the floor next to the exit door. The note indicated Resident 1 stated he slid and his cane was next to him. A review of Resident 1's COC dated 12/9/19, indicated Resident 1 had a fall on 12/8/19. A review of Resident 1's Progress Note dated 12/9/19, indicated staff saw Resident 1 on the floor in front of the back-exit door in a sitting position. The note indicated Resident 1 stated he was using his cane to go outside for a smoke break and his cane tripped at the edge of the floor mat and he fell from losing balance. During an interview with RN 1, on 12/25/20, at 1:59 p.m., RN 1 stated Resident 1 told her he lost his balance while smoking outside and fell . During an interview and concurrent record review with RN 1 on 2/28/20, at 9:24 a.m., RN 1 stated any incident were documented on the COC, an investigation was to be conducted, and the resident was to monitored for any change of condition. RN 1 reviewed Resident 1's chart and was unable to find any documentation Resident 1 was monitored for changes in LOC. RN 1 stated Resident 1 should have had a neuro- check to monitor changes in LOC. RN 1 stated Resident 1 could have had internal bleeding and a fracture that could have gotten worse. A review of the facility's policy titled, Fall Prevention Program, dated 12/16, indicated all residents would be assessed following a fall incident. The policy indicated care plan interventions should include close observation and increased supervision. A review of the facility's policy titled, Post Fall Management Program, dated 12/16, indicated the resident's evaluation and assessment after a fall incident would be documented and included on the nurses' documentation record every shift 72 hours thereafter the fall event. The policy indicated the staff would monitor and document each resident's response to interventions intended to reduce falling or the risk of falling. All precautions would be implemented to protect the resident from a repeated fall. The policy indicated nursing should assess the resident after a fall for injuries, obtain and record sitting/standing vital signs, assess for change in range of motion, alert the physician, assess and document resident monitoring for at least 72 hours post fall, assess neurological status using neurological assessment form for residents with unobserved fall and with observed falls involving hitting the head and neck, document circumstance in the medical records, notify all team members of resident fall. A review of the facility's undated policy titled, Neuro Check, indicated the facility would ensure that each resident's neurologic assessment after an unwitnessed fall. The purpose of the policy was to assess the resident's level of consciousness through evaluation of their response and document the findings in neuro checks form.
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 supervise one of three sampled residents (Resident 1) who had a history of [REDACTED]. The deficient practice resulted in Resident 1 having a fall during an unsupervised smoke break and had the potential to result in injury such as a fracture (broken bone). Findings: A review of Resident 1's Admission Record indicated the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 1's undated

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 -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) Admission history and physical examination [REDACTED]. A review of Resident 1's Fall Risk assessment dated [DATE], indicated Resident 1 was a low risk for falls. A review of Resident 1's Nursing Admission assessment dated [DATE], indicated Resident 1 had poor safety judgement. The assessment indicated resident 1 was at risk for fall due to impaired balance and unsteady gait. A review of Resident 1's At Risk for Falls Care Plan dated 10/20/19, indicated Resident 1 had interventions that included assessment of the need for assistive supportive devices and to keep the environment free of clutter and safety hazards. A review of Resident 1's Physical Therapist (PT) Evaluation and Treatment dated 10/20/19, indicated Resident 1 was a fall risk. A review of Resident 1's Occupational Therapist (OT) Evaluation and Treatment dated 10/20/19, indicated Resident 1 was a fall risk. A review of Resident 1's Physician's Progress Note dated 10/25/19, indicated Resident 1 had a [DIAGNOSES REDACTED]. The MDS indicated Resident 1 required a one-person assist to move on and off the unit and used a walker and wheelchair for mobility. The MDS indicated Resident 1 was a current tobacco user. A review of Resident 1's Progress Notes dated 12/8/19, at 10:15 a.m., indicated Resident 1 was found on the floor next to the exit door. The note indicated Resident 1 stated he slid with his cane next to him. A review of Resident 1's Change of Condition dated 12/9/19, indicated Resident 1 had a fall on 12/8/19 in the morning. A review of Resident 1's Progress Notes dated 12/9/19, indicated staff heard a noise and saw Resident 1 on the floor in front of the back-exit door in a sitting position. The note indicated Resident 1 stated he was using his cane to go outside for a smoke break and his cane tripped at the edge of the floor mat and he fell off balance. During an interview with Registered Nurse (RN 1), on 2/25/20, at 1:59 p.m., she stated Resident 1 was a smoker and was non-compliant with the smoking schedule. RN 1 stated resident 1 told her he lost balance while smoking outside and felt. During an interview with Occupational Therapist 1 (OT 1) on 2/25/20, at 2:28 p.m., OT 1 stated Resident 1 was unsafe to walk around the facility by himself. OT 1 stated Resident 1 was not compliant with safety awareness and required supervision while walking. During an interview with Activity Assistant 2 (AA 2), on 2/25/20, at 3:41 p.m., AA 2 stated residents who smoked had to be supervised. During an interview with RN 1, on 2/25/20, at 3:50 p.m., RN 1 stated Resident 1 did not notify staff he was going outside to smoke on 12/8/19. During an interview and concurrent record review with RN 1 on 2/28/20, at 9:24 a.m., RN 1 stated the rehab department assessed the residents on their level of assistance. RN 1 stated she could not find a smoking assessment for Resident 1 and stated smoking assessments identified the proper precaution and supervision for the residents. The facility's policy titled Fall Prevention Program dated 12/16, indicated the facility would identify interventions related to the resident's specific risk and causes to try to prevent the resident from falling and to try to minimize complications from falling. All residents would be assessed following an incident fall. The policy indicated care plan interventions should include closed observation and increased supervision. A review of the facility's policy titled, Smoking Policy, dated 4/18, indicated the facility should establish and maintain safe resident's smoking practices. The policy indicated the staff should consult with the attending physician and the Director of Nursing (DON) services to determine any restrictions on the resident's smoking privilege and any smoking-related privileges, restrictions, and concerns (for example need for close monitoring) shall be noted in the care plan, and all personnel caring for the resident should be alerted to theses issues. Any resident with restricted smoking privileges that required monitoring should have the direct supervision at all times while smoking.