STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055350	A. BUILDING _____ B. WING _____	**10/13/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CULVER WEST HEALTH CENTER	**4035 GRANDVIEW BLVD. LOS ANGELES, CA 90066**

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 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow physician's orders to assess, monitor, and document a neurological check list (used to assess an individual's level of consciousness in order to determine whether or not the individual is functioning properly and reacting appropriately to the tests being performing) after an unwitnessed fall for one of three sampled residents (Resident 1). This failed practice had the potential to cause altered level of consciousness, and impede progress to wellness for Resident 1. Findings: On 9/16/2020 at 1:45 p.m. an unannounced visit was made to the facility to investigate an entity-reported incident related to Resident Safety/Falls. A review of Resident 1's Minimum Data Set (MDS- an assessment and care planning tool) dated 5/31/2020, indicated Resident 1 had clear speech, limited ability to making concrete request, and responds adequately to simple, direct communication only. The MDS further assessed Resident 1 requiring extensive assistance with dressing, walking in room, personal hygiene. A review of Resident 1's Morse fall score (MFS-is a rapid and simple method of assessing a patient's likelihood of falling) dated 6/2/2020 indicated a high risk score of 65, due to a history of falling, impaired gait, and mental status. A review of Resident 1's Change of Condition form dated 7/10/2020 at 11:08 a.m., indicated Resident 1 had an unwitnessed fall and was found on the floor in the hallway laying on her left side. A review of the Physician's Order dated 7/10/2020, at 11:15 a.m., indicated to do neuro checks for 72 hours. Further review of the Physician 's Orders dated 7/10/2020 at 12:17 p.m., indicated to transfer Resident 1 to the General Acute Care Hospital (GACH) for further evaluation due to the unwitnessed fall. A review of Resident 1's Progress Notes dated 7/10/2020, at 1 p.m., indicated a neuro-check was initiated, blood pressure 154/68, heart rate 102, respiratory rate 20 per minute, oxygen saturation 95% on room air, left and right pupils were reactive to light, and left and right hand grip strength was good. The progress note indicated Resident 1 left the facility at 12:40 p.m. The initial neuro check was documented but it failed to indicate the time it was initiated and any further assessments of Resident 1's neuro status. A review of Resident 1's Admission Record indicated Resident 1 was re-admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. During an interview and a concurrent record review on 9/16/2020, at 2:55 p.m., the Director of Nursing (DON), was unable to provide a documented neuro-check list, or an assessment for the remaining time of one and a half hours Resident 1 spent in the facility waiting on the ambulance. The DON further stated Resident 1 may have experienced an altered level of consciousness (is a measurement of a person's arousability and responsiveness to stimuli from the environment), or neurological changes. A review of the facility's neuro checklist assessment form, undated, indicated neuro checks should be assessed and documented every 30 minutes for the first hour and then every two hours thereafter. A review of Resident 1's care plan indicated a high risk for falls, pathological fractures (a broken bone that's caused by a disease, rather than an injury) and other injuries related to impaired cognition, history of falls with fracture and Osteopenia (a condition that begins as you lose bone mass and your bones get weaker). Nursing interventions included to place a bed alarm while in bed, provide non-skid socks when not wearing footwear, and maintain bed in the lowest position with floor mats. The facility policy and procedures titled, Neurological Assessment, with revised date of October 2010, indicated the purpose of this procedure was to provide guidelines for a neurological assessment 1) upon physician order; 2) when following an unwitnessed fall to a fall with suspected head injury; or 4) when indicated by resident condition; 3) subsequent to a fall with a suspected head injury. The policy further indicated the date and time the procedure was performed should be documented in the resident's medical record. And all assessment data obtained during the procedure.

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.