STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555004	A. BUILDING _____ B. WING _____	**03/10/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PLAYA DEL REY CENTER	**7716 MANCHESTER AVENUE PLAYA DEL REY, CA 90293**

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 observation, interview, and record review, the facility failed to ensure one of four sampled residents (Resident 1) was safely secured in the facility's transport van during transportation from an appointment. Resident 1's wheelchair tipped over inside the facility's transport van while being transported back to the facility from an appointment. The facility's driver stopped the facility's van, found Resident 1 on the floor of the van, and assisted the resident back to her wheelchair. This deficient practice resulted in Resident 1 falling and sustaining a compression fracture (occurs when the bones in the spine collapses, making them shorter in height) to the lower back spine and she required a transfer to a general acute care hospital (GACH) for evaluation and treatment with pain medication. Findings: A review of Resident 1's Face Sheet (admission record) indicated the facility admitted the resident on 12/22/18, and last readmitted her on 5/15/19. Resident 1's [DIAGNOSES REDACTED]. A review of Resident 1's Minimum Data Set (MDS), an assessment and care-screening tool, dated 10/25/19 indicated Resident 1 had moderately impaired cognition (thought process) and required limited assistance with transfer and walking, and an extensive assistance (staff provide weight bearing support) with dressing and toilet use. A review of Resident 1's care plan titled, Fall Risk Prevention and Management, dated 4/18/19, indicated to encourage Resident 1 to use assistive devices, such as a wheelchair (W/C) or a front wheel walker (FWW) for transfer and ambulation (walking). A review of Resident 1's Nurses Progress Note, dated 11/14/19 and timed at 18:42 (6:42 p.m.) indicated Resident 1 fell from her wheelchair during transport back to the facility from [MEDICAL TREATMENT] (treatment to filter waste and water from the blood of a person whose kidneys are not working normally). The note indicated Resident 1 vomited and complained of mild pain in the lower back. According to the note, Resident 1's physician ordered a transfer to a general acute care hospital (GACH) for further evaluation. A review of Resident 1's computed tomography scan ((CT) an x-ray that allows doctors to see inside the body) of the lumbar spine (lower back), dated 11/14/19 and timed at 9:41 p.m., indicated an acute (sudden) compression [MEDICAL CONDITION] endplate (referring to the spine) of the L1 vertebral body (lower back). A review of Resident 1's GACH progress note, dated 11/14/19, indicated Resident 1 had an acute compression [MEDICAL CONDITION] endplate of the L1 vertebrae (lower back) as a result of a fall incident (on 11/14/19). The note indicated Resident 1 continued to complain of pain, especially on the left side of the lumbar area (lower part of the back). A review of Resident 1's GACH After Visit Summary, dated 11/14/19, indicated Resident 1 was treated with [MEDICATION NAME] ((Tylenol) pain reliever) for pain. A review of Resident 1's nursing progress note, dated 11/15/19 and timed at 1:48 a.m., indicated the facility readmitted Resident 1. On 11/19/19 at 1:35 p.m., during an interview, Licensed Vocational Nurse (LVN) 1 stated, If safety precautions are not properly implemented and secured during the transportation, it can potentially hurt the resident. LVN 1 stated the maintenance personnel should maintain the equipment with regards to latches, straps, seats, W/C or anything involved with the safety of residents riding in the facility's van to prevent accidents. LVN 1 stated the maintenance supervisor should maintain the equipment in good working condition. LVN 1 stated in-service trainings should have been provided when it comes to safety precautions when handling all residents. On 11/19/19 at 1:58 p.m., during an interview, the Maintenance Supervisor (MS) stated his primary responsibility was to maintain the facility's equipment and building in good working condition. The MS stated that the facility's transportation van should be properly checked on a regular basis and as needed before and after use to help prevent accidents. On 11/19/19 at 2:13 p.m., during an interview, Certified Nursing Assistant (CNA) 1 stated Resident 1 was alert, responsive, able to make her needs known, and could recall events. CNA 1 stated Resident 1 could walk with a one-person assist, but she could not keep her balance without assistance, which could lead to falls/accidents if safety measures were not properly implemented. On 11/19/19 at 2:24 p.m., during an interview, the Social Services Director (SSD) stated during the time of Resident 1's fall incident (on 11/14/19), the facility's van was used because the regular transportation was not available to transport Resident 1 from the facility to the [MEDICAL TREATMENT] (treatment that replaces kidney function by removing waste products and excess fluid from the body) treatment center and back. The SSD stated if safety precautions were not in place, accidents could happen that could lead to injuries. On 11/19/19 at 2:35 p.m., during an observation, the MS demonstrated how to properly secure a resident in a W/C inside the facility's van. The demonstration showed that when the W/C was properly strapped and secured, it did not shift nor move. On 11/19/19 at 2:50 p.m., during an interview, Registered Nurse (RN) Supervisor 1 stated, If resident's W/C was not strapped or secured properly during the transportation using the facility's van, the W/C can potentially shift from its original position, either front or back, and that can lead to accident and injury. On 11/19/19 at 3:10 p.m., during an interview, the Director of Nursing (DON) stated, If a resident's W/C is not properly strapped and secured during transportation it is considered a safety issues that can lead to accidents, injuries and even death. On 11/19/19 at 3:45 p.m., during an interview, LVN 2 stated, Safety precautions needs to be implemented before transporting any resident to prevent accidents and injuries. During the huddles (quick meeting to share and discuss information), safety issues are always being discussed to make sure charge nurses talk among licensed nurses, CNAs, and the rehabilitation department. On 11/20/29 at 9:35 a.m., during an interview, Resident 1 stated the W/C tipped over backwards and she had to scream loud for the facility's driver (Driver 1) to stop. Resident 1 stated Driver 1 pulled over and helped her back in the W/C and continued to transport her back to the facility. Resident 1 stated her W/C was not properly strapped/secured and that was why it tipped over. Resident 1 stated she continued to have pain because of the accident, especially on the left lower back area. On 11/20/19 am at 10:16 a.m., during a telephone interview, Resident 1's family member (FM 1) stated she was not happy regarding Resident 1's incident. FM 1 stated the facility should train them (the facility's staff or driver) on how to properly transport residents safely. On 11/21/19 at 9:24 a.m., Driver 1 stated it was already dark outside and she kept asking Resident 1 if she was okay during the bumpy ride. Driver 1 stated Resident 1 did not answer back so she pulled over to check Resident 1 and saw Resident 1 on the floor of the van and the W/C was halfway to the floor. Driver 1 stated she helped Resident 1 back in her W/C and continued to transport the resident back to the facility. Driver 1 stated she did not see exactly what really happened for Resident 1 to fall, but she strapped the resident well to secure the ride based on her recollection. A review of the facility's policy titled, revised on 7/1/19 and Transportation and Escort: Patient, indicated staff may escort patients if needed but will not use their own vehicles to transport patients. The purpose of the policy is to assure patients safety.

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.