STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555686	A. BUILDING _____ B. WING _____	**03/09/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
STUDIO CITY REHABILITATION CENTER	**11429 VENTURA BLVD STUDIO CITY, CA 91604**

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 -** 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 prevent an accident by failing to implement the Fall Care Plan for one of four sampled residents (Resident 1). This deficient practice resulted in Resident 1 suffering a fall with complaints of severe pain and being transferred to the General Acute Care Hospital 1 (GACH 1). Findings: A review of Resident 1's Admission Record indicated the facility readmitted Resident 1 on 9/20/19 with [DIAGNOSES REDACTED]. A review of Resident 1's Minimum Data Set (MDS - a standardized assessment and care planning tool) dated 7/10/19 indicated Resident 1's cognition (ability to think, understand and reason) was severely impaired. The MDS also indicated Resident 1 required extensive assistance from staff with bed mobility and is dependent with staff on transfers, dressing, toilet use and personal hygiene. A review of Resident 1's Fall Risk assessment dated [DATE] indicated Resident 1 had a fall risk score of 24. Total score of 18 or above represented high fall risk. The Fall Risk Assessement further indicated for the facility staff to assess for environmental hazards and implement useful interventions. A review of Resident 1's Change of Condition Form dated 1/7/20 indicated at 1:30 a.m., the facility staff heard a tab alarm (device used to alert caregivers to address high fall risk residents from getting up unassisted) ringing, and Resident 1 was yelling Help, I broke my legs! Resident 1 was found lying on her right side on the floormat with her head by the foot of the bed. The Change of Condition Form also indicated Resident 1's bed was observed to be at an unusually high position. Resident 1 complained of eight out of ten (ten being the highest) bilateral (both sides) lower extremity pain. A review of Resident 1's Physician and Telephone Orders Form dated 1/7/20 indicated to transfer Resident 1 to GACH 1 via 911 (emergency services) secondary to being found on the floor and complaints of severe pain. On 1/22/20 at 3:30 p.m., during an observation and interview with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated on 1/7/20 at around 1:30 a.m., LVN 1 confirmed Resident 1's room was observed as one of the furthest room from the nursing station. A review of Resident 1's Fall Care Plan with a revision date of 10/7/18 indicated Resident 1 had history of falls. The interventions included were to provide frequent visual monitoring and place resident close to nursing station for close observation. On 12/13/20 at 12:48 p.m., during an interview and concurrent record review with the Director of Nursing (DON), she confirmed Resident 1's room was not close to the nursing station on the day of the fall incident (1/7/20). The DON stated the facility staff should have implemented Resident 1's Fall Care Plan. The DON stated Resident 1, who was identified as high risk for falls should have been placed near the nursing station for close monitoring to prevent accidents. A review of the facility's policy and procedure titled Accident/Incident Policy undated, indicated it is the facility's policy to ensure systems are in place to prevent, monitor, and record accidents and incidents.

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.