STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055870	A. BUILDING _____ B. WING _____	**03/26/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SUNRAY HEALTHCARE CENTER	**3210 W PICO BLVD LOS ANGELES, CA 90019**

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 0558 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Reasonably accommodate the needs and preferences of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the nursing staff failed to address a request for leg brace (a device attached to the leg in order to strengthen or support it) for one of two sampled residents (Resident 2). This failure resulted in Resident 2 not receiving any update for approximately one month regarding his request for a leg brace. Findings include: A review of the Admission Record, dated 3/5/20, indicated facility admitted Resident 2 on 6/18/2019, with [DIAGNOSES REDACTED]. A review of Resident 2's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 2/25/2019, indicated walk in room and in corridor activities did not occur. The MDS indicated Resident 2 needed extensive assistance for locomotion (movement) on and off unit. A review of History and Physical record, dated 6/20/2019, indicated Resident 2's concern was that he wants to get stronger and get back to life. The record indicated Resident 2 was oriented to person, place, and time. During an interview on 3/5/2020 at 1:10 p.m., Resident 2, who was observed lying in bed and with wheelchair near bedside, stated he was told by therapist about six months prior regarding a leg brace that may help him walk better, but has not received any update since then. Resident 2 was requesting an update on the discussion with the therapist as he would like to use it as soon as possible to help improve his ambulation (walking). Leg brace was not observed on the resident or in the resident's room at the time of interview. During an interview on 3/5/2020 at 1:40 p.m., and concurrent record review, the Director of Rehabilitation (DOR) stated Resident 2 requested for approximately one month already the potential need of a leg brace to assist with walking. DOR stated Resident 2 may need a brace for leg support and requested for a quote from Central Supply and Dietary Assistant (CSDA) to submit for insurance review and was waiting for a reply. DOR stated there was no update regarding the requested quote as of 3/5/2020. DOR stated there was no documented evidence that there was a discussion with Resident 2 about any update on the request for a leg brace. During an interview on 3/6/2020 at 8:53 a.m., and concurrent record review, the CSDA stated there was no request for leg brace quote from DOR. CSDA stated there was no documentation or log for any quote requests from staff. CSDA stated there was no documented evidence a leg brace was ordered for Resident 2. During an interview on 3/6/2020 at 1:30 p.m., and concurrent record review, the Director of Nursing (DON) stated that not giving any response for approximately one month to Resident 2 regarding his request for a leg brace was a long time. DON stated there was no therapy evaluation completed for the leg brace as of 3/6/2020. DON stated Resident 2 may benefit from an Interdisciplinary Team (IDT - a group of health care professionals from diverse fields who work in a coordinated fashion toward a common goal for the resident) meeting to discuss with Resident 2 his request for leg brace for potential need for evaluation prior to ordering and providing leg brace. A review of the facility's policy and procedure titled, Quality of Life - Accommodation of Needs, revised on (NAME)2009, indicated The resident's individual needs and preferences shall be accommodated to the extent possible, except when the health and safety of the individual or other residents would be endangered. The resident's individual needs and preferences, including the need for adaptive devices and modifications to the physical environment, shall be evaluated upon admission and reviewed on an ongoing basis.
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the revised care plan for fall for one of two sampled residents (Resident 1) who had an actual fall was resident-centered. Resident 1 fell from a geri-chair (or geriatric chair which is a large padded chair with wheeled bases and is designed to assist seniors with limited mobility) and this was not addressed in the revised care plan. This deficient practice had the potential to place Resident 1 at risk for recurrent falls. Findings: A review of the Admission Record, dated 3/5/20, indicated the facility readmitted Resident 1 on 1/23/2013 with [DIAGNOSES REDACTED]. to perform everyday activities), and age-related [MEDICAL CONDITION] (causes bones to become weak and brittle). A review of the Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 2/7/2020, indicated Resident 1 had severe impairment in cognition (thought process). The MDS indicated Resident 1 needed total dependence (full staff performance every time during entire 7-day period) for transfer, locomotion (movement) on, and locomotion off unit. The MDS indicated Resident 1 needed extensive assistance (resident involved in activity, staff provide weight-bearing support) for bed mobility. A review of the physician's orders [REDACTED]. A review of the Change in Condition evaluation, dated 1/25/20 at 1:38 p.m., indicated Resident 1 had a fall on 1/25/20 with right upper eyebrow laceration (measuring 2 x 2 x 0.2) requiring sutures. A Review of the POS [REDACTED]. The review indicated Resident 1 was sitting in a geri-chair before the fall. During an interview on 3/5/2020 at 1:25 p.m., the Certified Nursing Assistant (CNA) 1 stated Resident 1 required total assistance with activities of daily living, bathing, and eating. CNA 1 stated Resident 1 required assistance with transfers from bed to wheelchair, and back to bed. CNA stated, Resident 1 had a history of [REDACTED]. During an interview on 3/6/2020 at 1:45 p.m., and concurrent record review, the Licensed Vocational Nurse (LVN) 2 stated the care plan on Fall risk which was initiated on 1/31/20 and was last revised on 2/3/20 was not resident specific. LVN 2 stated the care plan did not include the potential need for further monitoring when resident was not on the bed and resident was on a chair. During an interview on 3/6/2020 at 3:48 p.m., and concurrent record review, the Director of Nursing (DON) stated Resident 1's care plan for fall prevention did not include recommendations from the Interdisciplinary Team (IDT - a group of health care professionals from diverse fields who work in a coordinated fashion toward a common goal for the resident). IDT recommendations included don't leave resident unattended. DON stated Resident 1's care plan for fall prevention did not include safety precautions when resident was off the bed or in a chair. A review of the facility's policy and procedure titled, Care Plans, Comprehensive Person-Centered, revised on December 2016, indicated A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident Identifying problem areas and their causes, and developing interventions that are targeted and meaningful to the resident Care plan interventions are chosen only after careful data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.

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.