STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055748	A. BUILDING _____ B. WING _____	**05/29/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SANTA MONICA CONV CTR II	**2250 29TH STREET SANTA MONICA, CA 90405**

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 observation, interview, and record review, the facility failed to properly monitor, and connect a tab alarm (a device which will produce sounds to alert staff when resident's tries to stand up and walk) to resident's clothes for one of three sampled residents, (Resident 2). This deficient practice had the potential to result in falls. Findings: On 11/19/2019 at 11:45 am, an unannounced visit was made to the facility to investigate an Entity Reported incident regarding Resident Safety/Falls. During a observation on 11/19/2019 at 12:15 p.m., in the dining room, Resident 2 was observed sitting in a wheelchair with a tab alarm attached to the chair was not connected to her clothes. During an interview on 11/19/2019 at 3 p.m., Registered Nurse Supervisor (RNS) stated Resident 2's tab alarm was not connected properly and would not go off if the resident stood up. A review of Resident 2's admission record indicated Resident 2 was re-admitted on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 2's physician's orders [REDACTED]. A review of Resident 2's Care Plan titled Alarm dated 09/26/2019, indicated Resident 2 required a tab alarm while in bed and up in wheelchair to alert staff of the resident's mobility or any unassisted transfer/standing. The interventions included monitoring the tab alarm placement and well functioning. A review of Resident 2's Minimum Data Set (MDS- standardized assessment and care-planning tool) dated 10/03/2019, indicated Resident 2 had memory problems and required extensive assistance with transfers. A review of the facility's undated policy on Devices and Physical Restraints, indicated position change alarms are alerting devices intended to monitor a resident's movement. The devices emit an audible signal when the resident moves in certain ways.

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.