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CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055360	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/20/2013
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NAME OF PROVIDER OR SUPPLIER Oakpark Healthcare Center	STREET ADDRESS, CITY, STATE, ZIP CODE 9166 Tujunga Canyon Blvd, Tujunga, CA 91042-3462 LOS ANGELES COUNTY
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	<p>The following reflects the findings of the Department of Public Health during a Complaint Investigation visit:</p> <p>CLASS AA CITATION – PATIENT CARE 92-1676-0011543-F Complaint(s): CA00344878, CA00344878</p> <p>Representing the Department of Public Health: Surveyor ID # 17135, HFEN</p> <p>The inspection was limited to the specific facility event investigated and does not represent the findings of a full inspection of the facility.</p> <p>483.25 Quality of Care Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>On 3/7/13, at 1:30 p.m., an unannounced visit was made to the facility to investigate a complaint regarding quality of care.</p> <p>Based on interview and record review, the facility failed to provide Resident 1 with the necessary care and services in accordance with the comprehensive assessment, plan of care and physician's orders by failing to:</p> <p>1. Ensure licensed nurses monitored the condition of a left heel wound for signs and symptoms of infection (such as odor, presence of fluid or drainage, and increased temperature of the area).</p>		<p>Oakpark Healthcare Center submits this response & Plan of Correction as part of the requirements under state & federal law. The plan of correction is submitted with specific regulatory requirements. It shall not be construed as an admission of any alleged deficiency cited or any other liability. Provider submits this plan of correction with the intention that it is inadmissible by any third party in any civil or criminal action or proceedings against Provider or its employees, agents, officers, directors or shareholders. Provider reserves the right to challenge the cited findings if at any time Provider determines that the disputed findings are relied upon in a manner adverse to the interests of Provider either by the governmental agencies or third party.</p> <p>483.25 1. It is the policy of this facility & the goal of this community to minimize the development of skin breakdown & to heal &/or decrease the further deterioration of existing skin/wound conditions when appropriate. Some medical conditions may cause some unavoidable skin breakdown. For these residents, management will focus on decreasing the risk of infection. Treatment requires a comprehensive approach, including debridement when necessary, managing infections, managing systematic issues (edema, venous insufficiency, etc.), maximizing the potential for healing, & pain control. Pain management will also be incorporated in our wound care treatment plans, as some, but not all residents may experience discomfort from the wounds or during the treatment process.</p> <p>To ensure licensed nursing staff (LNS) monitor the condition of wounds for signs & symptoms of infection (such as odor, presence of fluid or drainage, & increased temperature of the area), response to treatment, changes in size & color, & presence of pain, the LNS conduct assessments & document skin/wound types on a weekly</p>	9/17/15
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Anna Lance* TITLE ADMINISTRATOR (X6) DATE 9/17/15

By signing this document, I am acknowledging receipt of the entire citation packet. *Page(s) 1 thru 11*

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. Except for nursing homes, the findings 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.

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	<p>response to treatment, changes in size and color, and presence of pain.</p> <p>2. Follow the physician's order to obtain a wound consultation in a timely manner.</p> <p>3. Implement the recommendation by the wound consultant physician to have a follow up evaluation a week after the initial evaluation.</p> <p>4. Implement pain management interventions when the resident manifested pain to the affected left leg/foot and had increased behavioral manifestations of crying and continuous yelling for help.</p> <p>On 1/16/13, Resident 1's left heel was evaluated by a wound consultant physician who diagnosed infected gangrene (dead tissue caused by an infection or lack of blood flow) on the left heel. On the same day, Resident 1 was transferred to a general acute care hospital (GACH) where she was diagnosed and treated for severe pain to the left heel, gas gangrene [potentially deadly form of tissue death caused by a bacteria. Gas gangrene causes very painful swelling, foul smelling discharge, and when the swollen area is pressed, gas can be felt as a crackly sensation (crepitus)] with foul smelling drainage, creamy-yellowish in color and, osteomyelitis (infection of a bone) of the left heel, urinary tract infection, and septicemia (blood poisoning, a life-threatening complication of an infection), which caused Resident 1's death on 1/27/13 at the GACH.</p>		<p>skin/wound QI log that is submitted to the DON every week for review & follow up as needed.</p> <p>The Director of Nursing (DON) conducts weekly rounds with the Wound Consultant & LNS to ensure compliance & progress of the wound. The recommendations of the Wound MD & treatment orders are carried out by the LNS. Findings are further discussed at monthly QA meetings for effectiveness; recommendations are made by QA Committee accordingly.</p> <p>An In-service regarding Pressure Ulcer Prevention, Diagnosis & Treatment was conducted by a wound specialist on 2/4/15 to the LNS.</p> <p>2. Physician's orders shall be obtained prior to the initiation of any medication or treatment from a person lawfully authorized to prescribe & treat human illness. The LNS are responsible for transcribing & carrying out physician orders. In treating pressure ulcer/wounds, the physician's orders shall be obtained at the time the initial observation is made. The attending physician shall be notified within the specified duration of the treatment order or in two weeks of the treatment program, if not otherwise specified. The care plan objectives are to be re-evaluated for other alternative interventions. There is to be a continuous assessment to evaluate the care plan objectives. When the pressure ulcer heals, the attending physician shall be notified & an order shall be obtained to discontinue the treatment. The care plan shall be updated to include the potential risk factors & the necessary preventative care.</p> <p>The DON provided an In-service to LNS on 7/30/13 on the topic of proper follow up with wound consultants for diabetic, arterial, venous ulcers & decubitus ulcers of stage II or greater.</p> <p>The DON conducted weekly QA audits semi-monthly for three months following the incident to assure wound care specialist/consultant orders were followed up in a timely manner. No negative trends found during the review with the QA Committee &</p>	

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	<p>A review of the clinical record indicated the Resident 1 had been initially admitted to the facility on 5/11/12 and was transferred to GACH seven times, with the last readmission dated 11/12/12. Resident 1's diagnoses included chronic kidney disease Stage 4 (advanced kidney damage), diabetes mellitus (high blood sugar levels), anemia (deficiency of red blood cells), and dementia (a group of thinking and social symptoms that interferes with daily functioning). The admission nursing assessment documented the resident was readmitted with a Stage 2 (skin is broken) wound to the left heel measuring three centimeters (cm) by two (cm).</p> <p>The Minimum Data Set (MDS -standardized assessment and care planning tool) dated 11/25/12, indicated the resident had memory problems, was able to communicate verbally, had daily behavioral symptoms not directed toward others, required extensive assistance with transfer, dressing, and walking, and required total assistance with toilet use, personal hygiene, and bathing.</p> <p>A review of the readmission physician's orders included monitoring pain every shift, treatment to the left heel with Vitamin A & D ointment twice a day, and acetaminophen (pain medication) 325 milligrams (mg) orally one tablet as needed (PRN) for mild pain. The psychoactive (mind altering) medications ordered on readmission were Remeron 15 mg orally for depression manifested by poor</p>		<p>recommendations thereof have been adhered to. The HID will continue to monitor the wound care orders monthly during weekly audits to verify that all wound care specialists/consultant orders are followed up in a timely manner. HID will report findings to the DON to ensure compliance & follow up.</p> <p>An in-service was provided on 9/17/15 to the LNS by the Wound Specialist to the LNS on regarding Pressure Ulcers, Staging, Wound, Pain Management, Debridement, Treatment, Documentation, Gangrene, the Importance of timely wound consult referrals, & Wound Assessment Compliance.</p> <p>An in-service regarding Resident Health Records & QA/CQI Audit System Guidelines was given by Administrator on 9/17/15 to HID, DON, & Mgrs.</p> <p>The DON will report audit findings to QA Committee monthly for further review & recommendations.</p> <p>3. It is the policy of this facility that LNS & physician will assess & document an individual's significant risk factors for developing pressure sores; for example, immobility, recent weight loss, & a history of pressure ulcers. The physician will help identify factors contributing or predisposing residents to skin breakdown. The physician will also help clarify relevant medical issues.</p> <p>In treating & managing wounds, the physician will authorize pertinent orders related to wound treatments, including pressure reduction surfaces, wound cleansing & debridement approaches, dressings, & application of topical agents. The physician will help identify medical interventions related to wound management.</p> <p>Under the protocol guidelines set forth between the facility & the Wound Consultant, weekly wound rounds are conducted in accordance to the following: 1) Preparing for the rounds by having a list of patients to be seen with relevant information; 2) For new patients, the LNS are to obtain a written order for wound consult from physician & the LNS</p>	

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	<p>appetite, Xanax 0.25 mg every six hours PRN for anxiety manifested by crying out, "Help me," and Haldol 0.5 mg orally at night for dementia with psychosis (mental disorder characterized by a disconnection with reality) manifested by continuous yelling out, "Help me."</p> <p>The plan of care developed upon readmission on 11/12/12, included the resident's problem of potential for leg pain and edema due to peripheral neuropathy (pain from nerve damage) due to diabetes. The approaches included assess when the resident complained of pain and check extremities for pulses, color, coolness, and swelling.</p> <p>The plan of care addressing the resident's psychoactive medications for behavioral manifestations included in the approaches to listen attentively and attempt to resolve or discuss area of upset. The approaches did not include determining if the behaviors were the result of pain.</p> <p>On 11/13/12, the treatment order to the left heel was changed to cleansing the left heel wound with normal saline solution (treated salty water, free from germs), apply triple antibiotic and cover with a dry dressing twice a day for 30 days.</p> <p>On 11/26/12, the psychiatrist evaluated the resident and ordered to increase the Haldol to twice a day and added Trazadone (antidepressant) 50 mg for depression manifested by crying and tearfulness. On 12/5/12, Haldol was increased to three times a day. On 1/10/13, the psychiatrist discontinued</p>		<p>provide to the wound consultant a face sheet with diagnosis list, height & weight of the patient, & any supporting documentation that may be pertinent to the care; 3) During rounds, treatment nurses accompany the wound surgeon to minimize documentation discrepancy & promote continuity of care, provide dressing changes when needed; 4) All orders can be written & carried out by wound surgeon's treatment nurse.</p> <p>The DON & LNS meet, & make rounds with the Wound MD on a weekly basis to review findings, follow up, & monitor the progress of wounds. The DON reviews findings monthly with the QA Committee for further recommendations.</p> <p>An in-service was provided by the Wound Specialist to the LNS on 9/17/15 regarding Pressure Ulcers, Staging, Wound Treatment, Pain Management, Documentation, Gangrene, Debridement, the Importance of timely wound consult referrals, & Wound Assessment Compliance.</p> <p>4. It is the policy & procedure of this facility to assess residents for pain & to provide pain management as indicated in order for the resident to maintain their highest practicable level of function. The facility will use a scale of 1 to 10 for residents who are able to verbalize & describe pain & the PAINAD for residents with cognitive impairment:</p> <p>0 = No Pain; 1-3 = Mild Pain; 4-6 = Moderate Pain; 7-10 = Severe Pain.</p> <p>Pain shall be assessed every shift & documented on the MAR using a scale of 1-10. Residents who receive PRN pain medications shall have them recorded on a pain flow sheet, including effectiveness.</p> <p>Further, when implementing pain management interventions to a resident who manifests pain to an affected area & has increased behavioral manifestations, the licensed staff & managers review resident records for completeness &</p>	

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	<p>Haldol (not effective) and ordered Depakote Sprinkles (mood stabilizer) 125 mg twice a day for continuous yelling for help.</p> <p>On 12/19/12, a telephone physician's order was obtained to change the left heel wound treatment to cleanse the wound with normal saline solution, apply Santyl ointment (debridement agent that removes dead tissue from wounds) twice a day and cover with a dry dressing for 21 days due to non-healing wound. The physician also ordered to have a wound care consultation which was not done until 1/1/13, 13 days after it was ordered on 12/19/12. The reason for the licensed nurse to call the physician and obtain new orders related to the wound was not documented in the clinical record. From readmission to 12/19/12, there was no documentation of the progress of the left heel wound; there was no description of the wound condition such as size, depth, pain, color, swelling, temperature, drainage, and response to the treatment. There was no documentation the wound had deteriorated from a Stage 2 (superficial) to having presence of dead tissue [Stage 3, 4 or undetermined (UTD - the base of the sore cannot be seen due to dead tissue)]</p> <p>On 1/1/13, Wound Consultant 1 documented on 1/1/13, the left heel wound measured 6 cm in length, 3 cm in width and UTD depth; 100 percent black necrotic (dead) tissue; no evidence of active infection; no drainage; pulses were not present (blood flow was not detected though pulse sensation). Wound Consultant 1 documented there</p>		<p>evaluation of items including: 1) How the resident typically communicates physical needs such as pain, discomfort, hunger, or thirst, as well as emotional & psychological needs such as frustration or boredom or a desire to do or to express something that he or she cannot articulate; 2) Residents usual & current cognitive patterns, mood & behavior, & whether these present a risk to the resident or others; 3) How the resident typically displays personal distress such as anxiety or fatigue.</p> <p>This & other information enables an understanding of the individual & provides a basis for cause identification & individualized interventions. If resident expresses distress, the LNS are to specifically describe the behavior (including potential underlying causes, duration, intensity, precipitating events/environmental triggers, on-set, etc) & related factors in the medical records with enough detail of the actual situation to permit cause identification & individualized interventions.</p> <p>An in-service was conducted by the Pharmacist Consultant on 3/19/15 to the LNS addressing the facility's policy & procedure for the psychotropic medicine use of the elderly with a focus on physical needs such as pain, discomfort, hunger or thirst, versus the emotional & psychological needs such as frustration or boredom or a desire to express something that he/she cannot articulate.</p> <p>The HID conducts monthly audits to ensure accuracy & completeness of the pain flow sheet & MAR. Results of the audits are reviewed by the DON for follow up. Trends & findings are further reviewed monthly with the QA Committee & recommendations are made accordingly.</p> <p>5. When identifying the condition of a wound, facility protocol states that, to be effective, the first step in skin wound assessment & treatment, is to complete a thorough assessment of the skin/wound. Using the Wound/Skin Assessment Form, this assessment would include the following: 1) size of the wound: length, width, depth along with</p>	

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	<p>was no need of debridement (removal of dead tissue) at the time, recommended vascular study on the left lower extremity, and to monitor the wound for visible or expressible liquid drainage or other signs of infection under or around the eschar (dead tissue) which would require debridement. Wound Consultant 1 documented to arrange another wound consultation for the following week, which was not done until 15 days later, on 1/16/13.</p> <p>Between 1/1/13 and 1/16/13, there was no documented evidence the licensed nurses monitored the condition of the wound for presence of drainage, presence of pain to the wound or other signs of infections as recommended by Wound Consultant 1.</p> <p>On 1/16/13, Wound Consultant 2 documented the left heel wound measured 9 cm in length, 10 cm in width and UTD depth (the wound increased in size since 1/1/13); had 100 percent black necrotic; foul odor and diagnosed infected gangrene.</p> <p>According to the licensed nursing noted dated 1/16/13, timed at 3 p.m., Resident was screaming and yelling without apparent reason. At 3:30 p.m., another nurse documented the resident continued to yell repeatedly and complaining of severe pain to the left heel, pain medication not effective, and the attending physician (Physician 1) was called. At 4 p.m., the same nurse documented Physician 1 ordered to transfer the resident to a GACH due to uncontrollable pain. At 4:30 p.m., the same nurse documented the family was at Resident 1's bedside trying to control the resident.</p> <p>Resident 1 was transferred to a GACH on the same</p>		<p>with undermining & tunneling; 2) specific location of the wound using anatomical positions; 3) type of wound: pressure, venous, arterial, diabetic &/or neuropathic; 4) stage of the pressure wound: stage 1-4, presence of eschar or slough; 5) additional assessments: presence of exudate, edema, or pain, condition of wound bed, & signs & symptoms of infection.</p> <p>In addition, LNS are to notify the physician if the wound is exhibiting signs & symptoms of local or systemic infection or deterioration. The physician will help clarify whether there is a soft tissue infection or just wound colonization, whether the wound has necrotic tissue, the impact of comorbid conditions on wound healing, etc. The physician will authorize pertinent orders related to wound treatment, including pressure reduction surfaces, wound cleansing & debridement approaches, dressings, & application of topical agents. The LNS will request wound consult referrals for multiple stage II, stage III, stage IV, DTI.</p> <p>The Wound/Skin Assessment forms are completed by the LNS on a weekly basis. The completed forms are submitted to the DON for review & follow up. Findings are further reviewed with the QA Committee monthly & recommendations are made by the QA Committee accordingly.</p> <p>An in-service was provided to the LNS on 9/17/2015 by the wound specialist for Pressure Ulcers, Staging, Treatments, Pain Management, Documentation, Gangrene, Debridement, the Importance of timely wound consult referrals, & Wound Assessment Compliance.</p> <p>6. The facility's IDT team shall evaluate the resident who lacks decision making capacity & who has no surrogate decision maker or any interested party, when the resident's physician determines a medical intervention is necessary that requires prior informed consent. This shall be included on the designated assessment form (physical restraint, psychotropic medications/chemical restraint, or prolonged device use form).</p>	

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	<p>day 1/16/13, at 5:30 p.m., where according to the GACH clinical record review, the resident arrived in severe pain and was given Morphine Sulfate intravenous (IV), was diagnosed with gas gangrene on the left heel, and the wound was described as having foul smelling drainage, creamy-yellowish in color. The resident was admitted to the GACH and was further diagnosed with osteomyelitis (infection of a bone) of the left heel, urinary tract infection, and septicemia. The resident underwent surgical debridement of the left heel wound on 1/20/13. Resident 1 expired on 1/27/13 at the GACH.</p> <p>Since Resident 1's admission to the facility on 11/12/12 to the date of transfer on 1/16/13, the weekly licensed nursing notes lacked documentation of the progress of the left heel wound and a description of its condition; presence or absence of pain to the wound area was not addressed. There was no documentation pain management related to the wound was provided. There was no new order for pain medication since admission. On 1/11/13 Tylenol #3 (acetaminophen and codeine, a narcotic pain medication) one tablet orally twice a day PRN was ordered for severe pain. On 1/14/13, the physician added Tylenol # 3 three times a day routinely for pain management.</p> <p>A review of the Medication Administration Record (MAR) since the month of 12/2012 until 1/16/13 indicated for the pain monitoring every shift the resident had no pain, 0/10 (in a pain scale from zero to ten, zero indicating no pain and 10 the worst possible pain). However, the MAR also had documentation the nurses administered Tylenol 325</p>		<p>In accordance to facility policy & procedure, residents will only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated & effective. The attending physician & other staff will gather & document information to clarify a resident's behavior, mood, function, medical condition, symptoms, & risks. Based on assessing the resident's symptoms & overall situation, the physician will determine whether to continue, adjust, or stop existing anti-psychotic medication.</p> <p>Further, antipsychotic medications will not be used if the only symptoms are one or more of the following: wearing, poor self care, restlessness, impaired memory, mild anxiety, insomnia, unsociability, inattention to surroundings, fidgeting, nervousness, & uncooperativeness, verbal expressions or behaviors that do not represent a danger to the resident or others. Pertinent non-pharmacological interventions must be attempted, unless contraindicated, & documented following the resolution of the acute psychiatric situation.</p> <p>Medication regimen review consists of a review & an analysis of prescribed medication therapy & medication use review, including nursing documentation of medication ordering & administration. The consultant pharmacist reviews the medication regimen of each resident at least monthly. Findings & recommendations are reported to the Administrator, DON, the responsible physician, & the Medical Director, where appropriate.</p> <p>The DON provided the LNS with an in-service on 2/20/15 pertaining to the purpose of monthly Pharmacist drug regimen review & identifying areas of focus. The Pharmacist Consultant will continue to review all residents for unnecessary drugs & make recommendations that will be followed up by the licensed staff.</p> <p>On 3/19/15 the Pharmacist Consultant in-serviced the LNS on the policy & procedure of psychotropic medications focusing on documentation of non-</p>		

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	<p>mg 11 times during the month on 12/2012 for pain rated 3/10-4/10 on the head or the back; three times from 1/1/13 to 1/8/13 for leg pain rated 5/10; Tylenol #3 ten times from 1/11/13 to 1/16/13 for left heel pain rated 7/10-8/10.</p> <p>Since Resident 1's admission to the facility on 11/12/12, to the date of transfer on 1/16/13, there was no documentation the interdisciplinary team (IDT) including the psychiatrist and the attending physician, addressed as possible causative factors for the resident's increased behavior manifestations the deterioration of the wound to the left heel and possible presence of pain. Since admission, the resident was given routinely the antipsychotic medication Haldol for crying out for help. The behavior increased despite increased of the Haldol dosage. Haldol was changed to the mood stabilizer Depakote on 1/10/13. The antidepressant Remeron was given every night since admission for poor appetite. The anti-anxiety medication Xanax (Alprazolam) was given PRN crying out for help during the month of 11/2012 a total of four times, during the month of 12/2012 a total of 25 times, and from 1/1/13 to 1/16/13, Xanax was given 11 times. The antidepressant Trazadone for crying out for help and tearfulness was added to the medication regimen on 11/26/12. The IDT did not rule out the behaviors were related to pain from the left heel wound which was not responding to treatment.</p> <p>On 3/7/13, at 1:30 p.m., during an interview, the</p>		<p>pharmacological interventions. LNS will receive ongoing education by the DON, Staff Educator &/or Consultant/Specialist with regards to psychotropic medications & non-pharmacological interventions.</p> <p>7. Care plans shall be developed for residents at risk for & with pain. The care plan shall include the nonpharmacological interventions as well as medications & approaches used in determining if behaviors are a result of pain. Residents shall be educated regarding their pain & the methods employed to relieve pain. Care plans are conducted with the IDT members & patients/responsible party/family member(s) routinely & as needed &/or as requested.</p> <p>As part of the initial assessment, the staff & physician will identify individuals with a history of impaired cognition (for example, dementia or mental retardation), problematic behavior, or mental illness. The staff will identify, document, & inform the Physician about an individual's mental status, behavior, & cognition. This will include details about any problematic behavior such as onset, frequency, & precipitating factors. Nursing staff will document the nature, duration, & associated features of any changes over time in behavior, cognition, or mood. In addition, the nurse shall assess & document/report items including, but not limited to, vital signs, neurological assessment, changes in level of consciousness, pain assessment, general appearance of selected body systems, & full description of behavior compared to usual behavior.</p> <p>The Physician will help verify that previously identified diagnoses are correct & seek causes of new or previously unidentified cognitive deficits, mood disturbances, & problematic behavior, or explain why the Individual should not be tested or evaluated or why identifying causes would not change the management. The Physician will also help identify medications, or medication combinations, that may be causing or contributing to impaired cognition, delirium, mood disturbances, or problematic behavior.</p>	

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DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055360	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/20/2013
NAME OF PROVIDER OR SUPPLIER Oakpark Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 9166 Tujunga Canyon Blvd, Tujunga, CA 91042-3462 LOS ANGELES COUNTY		
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	<p>director of nursing (DON) stated the resident needed multiple transfers to the GACH and had several skin break down during the different admissions.</p> <p>On 3/7/13, at 3:40 p.m., during another interview, the DON stated on 1/1/13, Wound Consultant 1 explained to Responsible Party 1 the condition of the wound and it was not gangrenous. The DON stated the facility did not learn Resident 1 had gangrene until Wound Consultant 2 evaluated the resident on 1/16/13.</p> <p>On 6/20/13, at 10:30 a.m., during another interview, the DON explained the delay in obtaining the wound consultations was related to the fact the provider of wound consultants did not have enough physicians to visit residents and the facility had to change providers. The DON could not explain the lack of documentation by the licensed nursing staff regarding the progress of the wound and pain management.</p> <p>The facility failed to provide Resident 1 with the necessary care and services in accordance with the comprehensive assessment, plan of care and physician's orders by failing to:</p> <p>1. Ensure licensed nurses monitored the condition of a left heel wound for signs and symptoms of infection (such as odor, presence of fluid or drainage, and increased temperature of the area), response to treatment, changes in size and color, and presence of pain.</p>		<p>In conjunction, psychotropic medications are reviewed monthly with the IDT members, Psychiatrist, & DON to determine appropriateness of medications. Findings are documented & further reviewed monthly for trends & possible dose reduction.</p> <p>The HID conducts monthly psychotropic audits & care plan/assessment audits to confirm that facility policy & procedure is being adhered to by all responsible team members. HID is responsible for reporting results of the audits to the DON for follow up & the DON further reports findings to the QA Committee monthly for review & recommendations.</p> <p>An in-service was also provided by the DON to the LNS on 9/17/15 regarding Assessments, Monitoring Pain every Shift, etc. An in-service was also provided by the MDS/Care Plan Coordinator to the LNS on 9/17/15 regarding Behavior Manifestations, Causation of Behavior, & Non-Pharmacological Interventions in Managing Behavior.</p> <p>8. Debridement is the removal of nonviable tissue, reduce bioburden, & promote healing. Debridement should be performed with the intention of removing the vitalized tissue, promoting a healthy, minimally bleeding wound edge. Standard surgical techniques when debriding while keeping the patient's safety & comfort as the utmost priority. This procedure should be discontinued if the patient experiences pain, in the event of instrument failure, field compromise, uncontrolled bleeding, or patient's request.</p> <p>In Pressure Ulcer Treatments (stages 1-4, DTI, necrotic tissue or gangrene), it is the policy & procedure of this facility to debride slough/escar using the following guidelines: a) select the method of debridement most appropriate to the resident's condition & goals (note: this is a physician task); b) sharp, mechanical, enzymatic, &/or autolytic debridement techniques may be used when there is no urgent clinical need for drainage or removal of devitalized tissue; c) if there is urgent need for</p>	

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NAME OF PROVIDER OR SUPPLIER Oakpark Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 9166 Tujunga Canyon Blvd, Tujunga, CA 91042-3462 LOS ANGELES COUNTY		
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	<p>2. Follow the physician's order to obtain a wound consultation in a timely manner.</p> <p>3. Implement the recommendation by the wound consultant physician to have a follow up evaluation a week after the initial evaluation.</p> <p>4. Implement pain management interventions when the resident manifested pain to the affected left/foot and had increased behavioral manifestations of crying and continuous yelling for help.</p> <p>On 1/16/13, Resident 1's left heel was evaluated by a wound consultant physician who diagnosed infected gangrene (dead tissue caused by an infection or lack of blood flow) on the left heel. On the same day, Resident 1 was transferred to a general acute care hospital (GACH) where she was diagnosed and treated for severe pain to the left heel, gas gangrene [potentially deadly form of tissue death caused by a bacteria. Gas gangrene causes very painful swelling, foul smelling discharge, and when the swollen area is pressed, gas can be felt as a crackly sensation (crepitus)] with foul smelling drainage, creamy-yellowish in color and, osteomyelitis (infection of a bone) of the left heel, urinary tract infection, and septicemia (blood poisoning, a life-threatening complication of an infection) which caused Resident 1's death on 1/27/13 at the GACH.</p> <p>The above violation presented either imminent danger that death or serious harm would result or a</p>		<p>debridement, as with advancing cellulites or sepsis, sharp debridement should be used.</p> <p>Effective 1/16/13, the facility terminated the Wound Consultant who failed to provide timely wound consults as ordered & outlined in the CMS 2567 dated 6/20/13. Under the new contract, the Wound Specialist consistently & in accordance to the protocol provided by the service agreement, conducts weekly, & as needed, wound consultant visits & treatments.</p> <p>The DON meets with the Wound Consultant on a weekly basis to review findings, follow up, & monitor the progress of wounds. The DON will review findings monthly with QA Committee for further recommendations.</p> <p>An in-service was provided by the Wound Specialist to the LNS on 9/17/15 regarding Pressure Ulcers, Staging, Wound Treatment, Pain Management, Documentation, Gangrene, Debridement, the Importance of timely wound consult referrals, & Wound Assessment Compliance.</p> <p>9. It is the intent of this facility to maintain complete, accurate & timely documentation in the resident's health record in accordance with state & federal regulations, & professional practice standards. The Quality Assurance (QA)/Continuous Quality Improvement (CQI) audit system has been developed to provide concurrent monitoring of the documentation performed by the various members of the health care team. This process assists staff to more readily identify problem records/documentation that does not meet regulatory requirements, thus allowing the responsive staff the opportunity to recall the event & accurately complete/correct the inconsistency. Timeliness is a key factor to ensure the integrity of the record, as well as, be able to provide an accurate copy of the resident's record when requested. It is understood that some deficiencies may not be correctable & this information is to be used for QA purposes.</p> <p>The HID is to conduct concurrent health record reviews in accordance with the subjects & schedule</p>	

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NAME OF PROVIDER OR SUPPLIER Oakpark Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 9186 Tujunga Canyon Blvd, Tujunga, CA 91042-3462 LOS ANGELES COUNTY		
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	substantial probability that death or serious physical harm would result and was a direct proximate cause of Resident 1's death.		<p>approved by the QA Committee for quality assurance purposes. These QA/CQI audit records are considered confidential & qualify as privileged records & shall not be accessible to state & federal regulators, unless it has been approved by the Administrator &/or facility's legal counsel.</p> <p>Each member of the Interdisciplinary Team (IDT) shall be responsible for completing his/her own deficiency in a timely manner & in accordance with professional practice standards. The Audit System process to communicate the results is important in order to organize & track the forms for follow-up & for maintaining privacy of the recorded health information.</p> <p>The Administrator & DON (DON) shall ensure that the QA/CQI audit process is enforced & the necessary corrections are made ethically & in accordance with regulatory requirements.</p> <p>The results of the medical records audits are reported to & reviewed with the QA Committee for trends & further recommendations.</p> <p>An in-service regarding Resident Health Records & QA/CQI Audit Systems/Guidelines was given by the Administrator on 9/17/15 to the HID, DON, & Department Managers.</p> <p>10. In accordance to the facility's policy & procedure regarding Skin/Wound Assessment & Treatment, the documentation by the LNS evidencing the monitoring of wounds & the conditions thereof, the following documentation procedure is to be followed:</p> <p>Weekly Skin/Wound Assessments & Weekly QI Logs are conducted by the LNS & submitted to the DON for review for compliance & follow up. The CNAs perform body assessments each shift & submit the assessments to the LNS before the end of their shift. The LNS review the body assessment sheet provided by the CNA & further assess resident as needed. The LNS notify the physician for any changes in skin condition.</p>	

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			<p>The DON reviews the submitted weekly wound/skin assessments & QI logs for compliance. Findings are reviewed monthly with the QA Committee for further recommendations.</p> <p>An in-service was provided by a wound care specialist regarding Pressure Ulcer, Staging, Treatment, & Documentation on 2/4/15 to LNS.</p> <p>A Body Assessment in-service was provided by DSD to the LNS & CNAs on 3/15/15.</p> <p>An in-service was also provided by the DON to the LNS on 9/17/15, regarding Completion of Weekly QI Logs, Weekly Skin Assessments, Monitoring Pain every Shift, Transcribing Treatment Orders, & the Importance of Timely Wound Consultant Visits.</p> <p>11. It is the policy of this facility that weekly progress notes are to be written on each resident regardless of the amount of daily entries recorded. These progress notes shall include the following: 1) Resident's response & progress towards goals established on his/her care plan; 2) Summary of the events or condition changes since the last weekly summary; 3) Any pertinent information to reflect an overall profile of the resident.</p> <p>When a licensed nurse is writing a weekly summary, certain documentation, including but not limited to, care plans, treatment records, weight, physician orders, MAR for PRN administered, & licensed nursing notes from the previous week should be reviewed.</p> <p>HID conducted an in-service to the LNS on 9/17/15 regarding the documentation completion of the LNS weekly summaries.</p> <p>HID conducts weekly summary audits to ensure compliance of documentation. Findings are reviewed with the DON for follow up as needed.</p> <p>12. The purpose of hydration is to increase resident fluid intake & to prevent dehydration. The key issues to be considered to develop care plan</p>	

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			<p>may include skin turgor, weight, need for assistive devices, resident food preferences, need for dietary & fluid restrictions, swallowing status, the condition of the oral mucosa, food allergies, reason for refusal, & h& dexterity.</p> <p>Fluids are offered by nursing personnel to residents frequently as tolerated. Meal & fluid intakes are recorded by RNAs daily & monitored by the LNS. Findings are given to the DON for review & follow up.</p> <p>The Registered Dietician (RD) reviews residents on fluid-restrictions weekly &, together with the DON, evaluates to ensure that residents are receiving the amount indicated per physicians order.</p> <p>The RD provided an in-service to the LNS on the topic of Hydration for Residents with Controlled Fluids on 7/13/2013, with emphasis on physician notification. The RD provided another in-service to the LNS on 7/24/2015.</p>	

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