DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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By 34180 12/4/16
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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555719	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IMPERIAL CREST HEALTH CARE CENTER	11834 INGLEWOOD AVENUE HAWTHORNE, CA 90250

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the Department of Public Health during an Entity Reported Incident (ERI) during an Abbreviated survey. ERI Number: CA00501723 - Substantiated with regulatory violation. Representing the Department of Public Health: Surveyor ID: 35385, RN, HFEN. The inspection was limited to the specific ERI and does not represent a full inspection of the facility. One deficiency was written for ERI Number: CA00501723.	F 000	Imperial Crest Healthcare Center submits this Plan of Correction as the part of the requirements under state and federal law. The plan of correction is submitted in accordance with specific regulatory requirements. It shall not be construed as admission of any alleged deficiency cited or any liability. The provider submits this plan of correction with the intention that it is inadmissible by any third party in any civil, criminal action or proceedings against the provider or its employee, agents, officers, directors, or shareholders. The provider reserves the right to challenge the cited findings if at any time the provider determines that the disputed findings are relied upon in a manner adverse to the interests of the provider either by the governmental agencies or their party.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under	F 279	F279 Corrective action for residents found to have been affected by this deficiency: Immediately on 9/26/16 a care plan was done for Resident 1 and Resident 2 by the MDS Coordinator. Measures to Identify Potential affected residents Resident Care Plans were reviewed by IDT Members and all care plans were complete and updated. Corrective action for residents that maybe affected by this deficiency: No other residents were found to be out of compliance.	10/27/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	10/20/16

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days lowing 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 ys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation.

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F 279	Continued From page 1 §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop a plan of care that included an assessment and documentation of an incident for one of two sampled residents (Resident 1) after being struck accidentally on the shoulder by another resident (Resident 2). This deficient practice had the potential to place the resident at risk for lack in continuity of care. Findings: During an unannounced visit for an Entity Reported Incident (ERI) on September 26, 2016 at 10:15 a.m., it was reported to the Department that Resident 2 struck Resident 1's shoulder while agitated, which took place in front of Nurse's station 1. A review of the facility's incident investigation form indicated Resident 2 became very agitated, tried to leave the facility, and she began to strike out by swinging her arms. According to the investigation, Resident 2 accidentally made contact with Resident 1's shoulder. Resident 1 remained in the facility. Resident 2 was transferred to the acute care hospital for further evaluation. During an interview and record review with the Director of Nursing (DON), dated September 26,	F 279	**Measures that will be put into place to ensure that this deficiency does not recur:** Under the supervision of the DON, Licensed Nurses were in-serviced regarding facility policy for resident care plans and importance of nursing assessments and documentation which are to be done on care plans in a timely manner. Medical Records will audit on a daily basis for any change of conditions to ensure that care plans are all done and completed.	

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F 279	Continued From page 2 2016 at 2:56 p.m., indicated there was no injuries to either of the residents. However, Resident 1's care plans did not include documentation about the incident that took place between him, and Resident 2. The DON stated she did not initiate a care plan for Resident 1 after the incident because Resident 1 was okay. A review of the facility's undated policy titled "Reporting Accidents/Incidents" indicated incidents and accidents shall be reported to the charge nurse and documentation on the accident/incident report as soon as they occur. The charge nurse handling the report shall be responsible for the completeness and accuracy of the information contained in the report. Nursing assessment and documentation of incident shall be done on care plan entry.	F 279		