Accepted POC 36526
5/11/17 HFEN

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

PRINTED: 04/26/2017
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
	555099	A. BUILDING _____ B. WING _____	C 04/14/2017

2017 MAY 11 PM 3:30
RECEIVED

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD HEALTHCARE CENTER	12023 LAKEWOOD BLVD. DOWNEY, CA 90242

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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during the investigation of an entity reported incidents (ERI) during an Abbreviated Standard Survey. ERI number: CA00526991, -Substantiated with no regulatory violations Representing the Department of Public Health: Health Facilities Evaluator Nurse ID: 38526 The inspection was limited to the specific ERI investigation and does not represent the findings of a full inspection of the facility. One deficiency was issued for ERI CA00526991	F 000	**Preparation and/or execution of this Plan of Correction does not constitute admission by the Provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because it's required by the provisions of Health and Safety Code Section 1280 and 42 C.F.R. 483."** **This Plan of Correction constitutes Lakewood's Healthcare credible allegation of compliance for the alleged deficient practices.**	
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.	F 323	**F: 323 Free of Accident Hazards/ Supervision/ Devices** **Corrective actions for deficient practice:** Resident 1 and 2 were separated immediately by the facility staff. Resident 2 is no longer a resident in the facility. Resident 1 was re-assessed by a licensed nurse per facility's policy and procedure and there were no other incidents related to resident 1's wandering behavior.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 05/04/2017

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.

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F 323	Continued From page 1 (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to provide supervision for two of two residents (Resident 1 & 2). Resident 1 was assessed with wandering behaviors in the hallway and Resident 2 who was on 1:1 supervision was able to hit Resident 1. As a result of the facility's failure, Resident 1 wandered into Resident 2's room where Resident 1 was physically abused by Resident 2. Findings: A review of the Admission Record (face sheet) indicated that Resident 1 was admitted to the facility on 2/25/17. Resident 1's diagnoses included dementia (symptoms associated with a decline in memory). A review of Resident 1's Minimum Data Set (MDS), a resident assessment and care-screening tool dated 3/9/17, indicated that Resident 1 was moderately impaired in cognitive skills for activities of daily living. The MDS indicated that Resident 1 was unable to recall words after cueing. The MDS indicated that Resident 1 required extensive assistance from one staff for transferring between surfaces (bed,	F 323	**Identification of other residents with the potential of being affected by same practice and implemented corrective measures:** Licensed Nurses were in-serviced by Director of Nursing (DON) on 3/29/2017 regarding wandering and elopement and supervision of patients with wandering episodes. Residents with wandering behavior were identified by licensed nurses and wandering elopement assessments were updated per facility's policy and procedure on scheduled risk assessments. **Measures in place to ensure practice does not recur:** Residents identified by the facility staff with a behavior of going into other resident's room will be re-assessed by a licensed nurse. Licensed nurse will indicate the behavior management and provision of safe environment and to ensure that care plan is being followed.	

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F 323	Continued From page 2 chair, wheelchair, and standing position), dressing, toilet use and personal hygiene. Resident 1 used a wheelchair as a mobility device. A review of Resident 1's Wandering Assessment dated 3/1/17 indicated that Resident 1 wanders around the facility while using the wheelchair. A review of Resident 1's Care Plan dated 3/1/17 and titled, "Dementia/Alzheimer's" indicated that Resident 1 had wandering behavior and the resident was at risk for injury due to wandering and impaired judgement. The Care Plan indicated that the facility will perform frequent checks on Resident 1. During an interview on 3/30/17 at 7:00 a.m., Resident 1 was unable to respond to surveyor questions regarding the altercation that occurred between her and Resident 2. On 4/1/17 at 2:31 p.m., registered nurse supervisor (RNS 1) stated that Resident 2 swung at Resident 1 while under 1:1 supervision. A review of the Admission Record (face sheet) indicated Resident 2 was admitted to the facility on 6/29/16 and re-admitted on 3/15/17. Resident 2's diagnoses included schizoaffective disorder (condition in which a person experiences a combination of schizophrenia symptoms - such as hallucinations or delusions - and mood disorder symptoms, such as mania or depression). A review of Resident 2's Minimum Data Set (MDS), a resident assessment and care-screening tool dated 3/16/17, indicated that	F 323	**Monitoring system to make sure solutions are sustained.** This plan of correction will be integrated into our on-going quality assurance process. DON/ designee will report the findings to QAA committee on monthly basis for further recommendations. Completion Date- 05/18/2017	

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F 323	Continued From page 3 Resident 2 was moderately impaired in cognitive skills for activities of daily living. The MDS indicated that Resident 2 required extensive assistance from one staff when transferring between surfaces (bed, chair, wheelchair, and standing position), dressing, toilet use, and personal hygiene. Resident 2 used a wheelchair as a mobility device. During a telephone interview on 4/1/17 at 2:36 p.m., Sitter 1stated that Resident 1 came inside Resident 2's room. Sitter 1 stated that while he was trying to prevent Resident 1 from coming inside the room, Resident 2 walked behind Sitter 1 and swung at Resident 1's left cheek. Sitter 1 stated Resident 2 was under 1:1 supervision due to aggressive behaviors. During an interview on 4/14/17 at 3:18 p.m., the director of nursing (DON) stated that, the facility does not have a policy and procedures for 1:1 supervision. A review of the facility's revised policy titled, "Wandering & Elopement" and dated 1/11/16 indicated that the facility would take for a resident identified with wandering behaviors.	F 323		