POC Accepted 10-3-17 · 36356

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

PRINTED: 08/30/2017
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
	555004	A. BUILDING _____ B. WING _____	C 08/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAYA DEL REY CARE AND REHABILITATION CENTER	7716 MANCHESTER AVENUE PLAYA DEL REY, CA 90293

(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 a COMPLAINT investigation. Complaint Number:CA00536206 Substantiated with regulatory violations Representing the Department: Surveyor ID: 36356, RN, HFEN Surveyor ID: 36385, RN, HFEN The inspection was limited to the specific complaints investigated and does not represent the findings of a full inspection of the facility.	F 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Playa Del Rey Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."	
F 309 SS=G	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life _____ Quality of life is a fundamental principle that applies to all care and services provided to facility residents. 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, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in	F 309	F309 Quality of Care Resident #4 no longer resides in the facility Residents who have laboratory orders have the potential to be affected. Facility did audit on the past 7 days to verify that all physicians had been notified for any abnormal lab.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Trudy Strauss — Administrator — 9/14/17

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 309	Continued From page 1 accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to follow physician's orders and ensure necessary care and services were provided for two of six sampled residents (Residents 4 and 5). For Resident 4, the facility failed to report abnormal laboratory results twice to the physician and monitor the resident's change of condition (COC). For Resident 5, who was at risk for dehydration (deficit of total body water) and had an indwelling urinary catheter (soft rubber inserted in the bladder to drain urine), the facility failed to monitor the resident's urinary output and follow the physician's orders in obtaining a urinalysis ([UA] test to check urine for signs of disease and for clues about overall health).	F 309	Facility staff will be re-educated by the NPE (Nurse Process Educator) on the process for collecting laboratory specimens, and notification of provider regarding laboratory results with supporting documentation. An audit of residents with laboratory orders for collection and results will be conducted on 8/28/17 with all results collected and reported. An audit of MD orders for laboratory specimen collection and results will be reviewed in morning clinical meeting to verify documentation of physician notification. The CNE (Center Nurse Executive) and/or designee will monitor for compliance.	

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F 309	Continued From page 2 Theses failures of not monitoring, reporting, and following physician's orders for both Residents 4 and 5, resulted in changes in condition, requiring a transfer to a general acute care hospital (GACHs 1 and 2), receiving intravenous fluids ([IVF] into the vein), antibiotics (medication to fight infections), being intubated (placement of a flexible plastic tube into the trachea [windpipe]) to maintain an open airway for breathing, and admitted into intensive care (ICU). Findings: a. A review of Resident 5's Admission Record Face Sheet indicated the resident was admitted to the facility on 4/19/17. Resident 5's diagnoses included adult failure to thrive (a progressive deterioration of a loss of willingness to eat and drink), lack of coordination with generalized muscle weakness, dystonia (abnormal muscle tone resulting in muscular spasm and abnormal posture), and cerebrovascular accident ([CVA] stroke). A review of Resident 5's Minimum Data Set (MDS) a comprehensive assessment and care-screening tool, dated 4/26/17, indicated the resident had severe cognitive impairment (ability to think, reason, or remember) and required an extensive assistance from the staff with eating and drinking. A review of Resident 5's History and Physical (H&P), dated 4/17/17, indicated Resident 5's baseline blood creatinine ([SCr] kidney function	F 309	Audits will be done daily times three months then monthly until full compliance. Results of these audits will be reported by the CNE to the QAPI committee. The QAPI committee will evaluate the data and recommend when indicated. Compliance Date: September 13, 201 F309 483.25 Quality of Life Resident # 5 no longer reside in the facility. Resident with an MD order for an indwelling catheter have been identified to ensure that urinary output is being monitored and documented as indicated.	

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F 309	Continued From page 3 test) was elevated at 1.3 to 1.4 milligrams [mg] (normal reference range (NRR) is 0.6 to 1.2 mg). A review of an online article by BioMed Nephrology, titled "Elevation Serum Creatinine in Primary Care," indicated residents with elevated SCr had an increase in mortality (death). https;//www-ncbi-nlm-nih-gov.wgu.idm.oclc.org/pmc/articles/PMC4289548/ A review of Resident 5's "Activities of Daily Living form," ([ADL]-routine activities that people do every day) such as eating, bathing, dressing, toileting, transferring and walking), dated 4/20/17 and timed 3 p.m. to 11 p.m.; 4/21/17 and timed at 11 p.m. to 7 a.m., and 3 p.m. to 11 p.m., the entire day on 4/22/17 and 4/24/17 timed at 3 p.m. to 11 p.m., there was no documentation of Resident 5's urine output. A review of Resident 5's laboratory results, dated 4/24/17, and timed at 3:50 a.m., indicated Resident 5's blood creatinine level had increased to 1.51 mg. A review of a nurses' note, dated 4/26/17, and timed at 8:21 a.m., indicated Resident 5 was warm to touch, sweaty, and sleepy. The nurses' note further indicated Resident 5 was transferred to GACH 1 for an elevated body temperature of 101.4 degrees Fahrenheit [F] (NRR is 98.6°F), an elevated heart rate (HR) of 155 (NRR is 60 to 100 beats per minute) and an elevated blood sugar of 414 milligrams per deciliter ([mg/dl] NRR is 70-99 mg/dl).	F 309	An audit of residents with an MD order for a urinalysis in the last 30 days have been identified to ensure it was obtained and the MD was notified of results. Re-education will be conducted with the licensed nurse staff and CNA staff on monitoring and documenting of urinary output and following MD orders by the NPE by 9/13/17 The audits will be monitored by the CNE or her designee daily for one month. Results of these audits will be reported by the CNE to the QAPI committee. The QAPI committee will evaluate the data and act on the information as indicated, and determine continued need or resolution of auditing. Compliance Date: September 13, 2017 Addendum to the original POC	

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F 309	Continued From page 4	F 309		

A review of the facility's "Transfer Form," dated 4/26/17, and timed at 10:04 a.m., indicated Resident 5's blood pressure (BP) was recorded as 148/60 millimeters of mercury [mHg] (NRR is 120/80 mHg), HR was 88, respirations [breaths] was 18/min (NRR is 12-16 breaths per min), and the resident's temperature was 98.1 F.

A review of GACH's "Emergency Department (ED) Service Report," dated 4/26/17 and timed at 10:38 a.m., indicated Resident 5's vital signs (measurements of body temperature, blood pressure, pulse (heart rate), and respiratory rate) were: temperature 101.2 degrees F, BP 102/46 mmHg, HR 168, and respirations elevated at 30/min. According to the report, Resident 5 presented with an altered mental status ([AMS] a range from slight confusion to total memory loss), had dry mucus membranes (line many tracts and structures of the body, including the mouth, nose, eyelids, trachea [windpipe] and lungs etc.).

Resident 5's laboratory results were abnormal in the ED as follow:

a. Blood creatinine level was high at 3.36
b. Potassium was elevated high at 6.0 (NRR 3.5-5.0) melliquivalent (mEq/L).
c. White blood cells ([WBC] elevated in the presence of an infection) count was 30.72 (NRR 4,500 to 11,000).
d. Red cell distribution width ([RBC], NRR standard size of about 6-8 µm in diameter) was elevated at 50.5.
e. Neutrophils (type of WBC that ingests bacteria) count was elevated at 28.7 (NRR 1.5 to 8.0 [when

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F 309	Continued From page 5 elevated is indicative of an infection]. On 4/26/17, at 11:30 a.m., while in the ED, Resident 5 received 2,070 milliliters (ml) of sodium chloride (salt) 0.9 percent (%) intravenous bolus (relatively large volume of fluid or dose at one time). A review of Resident 5's GACH's H&P, dated 4/26/17, and timed at 6:12 p.m., indicated Resident 5's fluid intake was 3,412 ml, but the resident's urine output was ten (10) ml gross (total) per 24 hour. The H&P indicated Resident 5 was in septic shock (an infection that spreads throughout the blood and tissues that can result in organ failure). The urine in Resident 5's indwelling urinary catheter was purulence (pus) on admission and the H&P indicated the resident required critical care (ICU), intubation, and received vasoactive medications (to increase blood pressure due to septic shock) to treat or prevent life threatening deterioration of circulatory (the movement of blood through the body) failure and shock (sudden drop in blood flow through the body). A review of the facility's progress note, dated 5/2/17, and timed at 2:53 p.m., indicated Resident 5's family member (FM) contacted the facility and was very upset about the resident's condition of being extremely dehydrated and requiring an admission in the ICU. On 6/2/17, at 4:23 p.m., during an interview, Licensed Vocational Nurse 6 (LVN 6) stated on 4/26/17, Resident 5 had only 10 and 20 ml of	F 309		

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F 309	Continued From page 6 urine in the urinary indwelling catheter. During an interview on 6/2/17, at 4:43 p.m., Certified Nurse Assistant 1 (CNA 1) stated Resident 5 would not eat his food and only took sips of fluids throughout the day. CNA 5 stated she could not recall the color of Resident 5's urine, but stated the catheter did not have more than 300 ml of urine after eight hours. On 8/16/17, at 7:25 a.m., during a telephone interview, Resident 5's FM 1 stated the facility had contacted the resident's other family member and stated the resident was very sick, had a high fever, and was being transferred to the hospital. FM1 stated the ED physician informed the family that Resident 5 was severely dehydration and had an infection. FM1 stated Resident 5 had to received IVF upon admission to the ED. FM 1 stated Resident 5 was not able to hold a cup or a bottle to feed himself and on several occasions when she visited the resident at the facility, the resident's food tray would be at the bedside untouched. On 8/17/17 at 2:43 p.m., during a telephone interview and a concurrent record review, the Director of Nursing (DON) stated for the entire day on 4/22/17, there was no documentation to indicate Resident 5's meal/fluid intake and urine output were recorded and should have been. The DON stated Resident 5 had a physician's order for UA to be obtained, but was not collected on 4/25/17 nor 4/26/17. The DON stated on 4/26/17 at 8:21 a.m., LVN 6 discovered Resident 5's COC and notified the physician. The DON further stated Resident 5 did not have a care plan for a	F 309		

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F 309	Continued From page 7 failure to thrive or at risk for dehydration, but should have had a plan of care for the risk of dehydration. b. A review of Resident 4's Admission Record Face Sheet indicated the resident was admitted to the facility on 4/26/17. Resident 4's diagnoses included acute kidney failure (occurs when the kidneys are unable to filter waste products from the blood), acute respiratory failure (not enough oxygen passes from the lungs into the blood), pneumonia (lung infection), and dementia (decreased ability to think and remember). A review of Resident 4's physician's order, dated 4/26/17, and timed at 8:50 p.m., indicated an order for a complete blood count (CBC), to be done on May 1, 2017 for one time only, in the morning. The order was confirmed and noted by Registered Nurse 1 (RN 1). A review of Resident 4's H & P, dated 4/27/17, indicated the resident was non-ambulatory (unable to walk on his own), dependent on staff for activities of daily living (ADL) and was incontinent of bowel and bladder (unable to control urination and defecation). The resident was assessed not having the capacity to understand and make his own decisions due to dementia. A review Resident 4's physician's orders, dated 4/27/17, indicated an order for complete blood count (CBC), comprehensive metabolic panel (CMP), and vitamin D level to be done the following day (4/28/17). The order was noted and signed by RN 1 on 4/27/17 at 4:50 p.m.	F 309		

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F 309	Continued From page 8 A review of Resident 4's nurse's note, dated 5/8/17, and timed at 4:28 a.m., indicated the resident was very congested throughout the night. Another nurses' note, dated 5/8/17, and timed at 9 a.m., indicated the resident had an unplanned transfer to the hospital. The note did not indicate the reason for Resident 4's transfer or where the resident was being transferred to. However, a review of Resident 4's Nursing Home to Hospital Transfer form, dated 5/8/17, indicated Resident 4 was transferred to a GACH due to respiratory distress. A review of the facility's Prehospital Care Report Summary, dated 5/8/17, indicated that the Fire Department arrived at the facility at 8:26 a.m. on 5/8/17 for Resident 4. The assessment records for the resident when the paramedics arrived indicated the resident had rales (clicking, rattling, or crackling sounds in the lungs) and skin temperature was hot. The paramedics assessed the resident's heart via a 12-lead EKG (electrocardiogram used to monitor the electrical activity of the heart) to be in atrial fibrillation (an irregular and often rapid heart rate). Resident 4's vital signs taken at 8:34 a.m. on 5/8/17 by the paramedics were abnormal with a low blood pressure at 78/40 (NRR 120/80), and the pulse [heart rate] high at 123 beats per minute (bpm). The report further indicated the resident had shortness of breath with tripoding (position is a physical stance often assumed by people experiencing respiratory distress), while using accessory muscle (any of the muscles of the neck, back, and abdomen that may assist the diaphragm and the internal and external	F 309		

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F 309	Continued From page 9 intercostal muscles in breathing) and had a productive cough. A review of Resident 4's GACH Discharge Summary, dated 5/25/17, indicated the resident was brought to GACH (2) for acute respiratory distress and required intubation. The summary indicated the resident was febrile (elevated fever [body temperature] of 101.3 (NRR 98.6 F) had bilateral infiltrates (a substance denser than air, such as pus, blood, or protein, which lingers within the lungs [usually associated with pneumonia]) consistent with the diagnosis of bilateral pneumonia (both lungs); was dehydrated, in an acute renal failure with a BUN (blood, urea, and nitrogen [test used to evaluate kidney function]) of 39 (NRR 10 to 20 mg/dL) and an elevated creatinine level of 2.2 and sodium of 153 (NRR 135 and 145 mEq/liter). On 6/2/17 at 4:05 p.m., during an interview and a concurrent record review, LVN 6 verified that the printed laboratory results were not found in Resident 4's medical records. LVN 6 stated two (2) laboratory reports, one dated on 4/28/17, and the other, on 5/1/17 were observed in Resident 4's electronic medical records (EMR). LVN 6 verified that there was no documentation that indicated the results were received, noted, and communicated to the physician. A further review of Resident 4's EMRs indicated there were no entries on 4/28/17 and 5/1/17 to indicate the physician was informed about Resident 4's abnormal lab results. LVN 6 stated that when abnormal labs are received, nurses are supposed to call the physician, then document on EMR.	F 309		

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F 309	Continued From page 10 The laboratory results for Resident 4 were as follows on 4/28/17: a. White blood cell were elevated at 15.9 per micro liter (uL), higher than NRR of 4-10 uL b. Red blood cell (RBC, type of blood cell that delivers oxygen (O2) to the body tissues) was low at 4.0, lower than NRR of 4.63-6.08 c. Hemoglobin (the molecule in red blood cells that carries oxygen) was low at 11.5, lower than NRR of 13.7-17.5 d. Hematocrit (the volume percentage of red blood cells in the blood) was low at 39.7, lower than NRR of 40.1-51 e. Absolute Neutrophils (neutrophils are a type of white blood cell that fights against infection) was elevated at 13.4, higher than NRR of 1.56-6.13 f. BUN was elevated at 27 mg/dl higher than NRR of 7-25 mg/dl g. Albumin (human protein found in the blood) was low at 2.4 g/dl lower than NRR of 3.5-5.7 g/dl The laboratory results for Resident 4 on 5/1/17 were as follows: a. WBC was elevated at 20.13 per micro liter (uL), higher than NRR of 4-10 uL b. RBC was low at 4.07, lower than NRR of 4.63-6.08 c. Hemoglobin was 11.9, lower than NRR of	F 309		

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	555004	A. BUILDING _____ B. WING _____	C 08/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAYA DEL REY CARE AND REHABILITATION CENTER	7716 MANCHESTER AVENUE PLAYA DEL REY, CA 90293

(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 309	Continued From page 11 13.7-17.5 d. Hematocrit was 41.1, lower than NRR of 40.1-51 e. Absolute Neutrophils was 17.52, higher than NRR of 1.56-6.13 On 6/2/17, at 4:20 p.m., during an interview, LVN 7 stated that a WBC of 20.13 was "very high" and she would have called the physician immediately and ask if he wanted to transfer the resident out to the hospital. On 6/2/17, at 5:15 p.m., during an interview, LVN 9 confirmed working on 4/28/17, and was asked to verify Resident 4's lab results, dated 4/28/17; LVN 9 stated she could not find it in Resident 4's chart. LVN 9 further stated, "Sometimes we don't receive the labs." During a concurrent interview and record review with LVN 10 on 6/2/17 at 5:50 p.m., he stated that Resident 4 was confused, but verbally responsive. LVN 10 stated that on assessment, the resident "sounded congested" and was sent out to the hospital because he had a low blood pressure and decreased oxygen saturation (O2 sat). LVN 10 confirmed he worked on 5/1/17 and stated, "Honestly I cannot remember any labs on the days I worked." During further review of the resident's chart with LVN 10 indicated there was no progress notes were written on the lab results, dated 5/1/17. LVN 10 stated that no notes would probably mean that no one reported the abnormal	F 309		

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

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PLAYA DEL REY CARE AND REHABILITATION CENTER	7716 MANCHESTER AVENUE PLAYA DEL REY, CA 90293

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F 309	Continued From page 12 results to the physician. LVN 10 stated that if the labs were received, the nurse should document "reported to physician with a date and time." During an interview with the Registered Nurse Supervisor (RN 1) on 6/2/17 at 6:10 p.m., she verified that she reviewed and signed the physician's order, dated 4/27/17, to draw Resident 4's CBC and CMP the following morning. RN 1 stated that pending labs are endorsed to the next shift for follow-up. RN 1 verified she worked on 4/27/17 on the 3 p.m. -11 p.m. shift and that she verbally endorsed the physician's order to the next shift, but could not remember who she endorsed to. During an interview with the DON on 6/2/17 at 7:45 p.m., she stated that when a physician order was received for a lab draw, the nurse who received the order writes on the lab request form and when the order was carried out, the nurse writes on the communication book for the DON and the unit managers to monitor the labs. The DON stated that the nurses did not communicate with each other and failed to endorse with each other, which was the reason for failure to report the abnormal labs to the physician. A review of the facility's undated policy titled, "Change of Condition" indicated the facility must immediately inform the patient, consult with the patient's physician, and notify, consistent with his/her authority, the patient's Health Care Decision Maker (HCDM), where there is a significant change in the patient's physical, mental or psychosocial status in either	F 309		

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F 309	Continued From page 13 life-threatening conditions or clinical complications. A review of the facility's job description for licensed vocational nurses, revised on 10/22/12, indicated that the nurse was responsible for provision of direct care, which included to administer medications, perform treatment per physician's orders, communicate pertinent data to registered nurse or physician, and document accurately and thoroughly.	F 309		