136385 2

PRINTED: 01/18/20 FORM APPROVE OMB NO. 0938-031

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION		SURVEY PLETED
		555677	B. WNG			01/0	06/2019
1	PROVIDER OR SUPPLIER DRNE HEALTHCARE	& WELLNESS CENTRE, LP		11	REET ADDRESS, CITY, STATE, ZIP CODE 630 SOUTH GREVILLEA AVE. AWTHORNE, CA 90250		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	NTEMENT OF DEFIGIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCEO TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETII DATE
F 550 \$S=D	Department of Pub Recertification surveyor ID: 36356 Surveyor ID: 36356 Surveyor ID: 19096 Total Census: 78 Total Residents Sat Highest Severity at Resident Rights/E: CFR(s): 483.10(a) \$483.10(a) Resident has a self-determination access to persons outside the facility this section. §483.10(a)(1) A fawith respect and cresident in a many promotes mainter her quality of life, individuality. The promote the rights \$483.10(a)(2) The access to quality severity of conditionant establish an practices regarding	cts the findings of the lic Health during a rey. Department of Public Health: G. RN, HFEN G. RN, HFEN G. RN, HFEN Manual of Rights (1)(2)(b)(1)(2) Int Rights. In right to a dignified existence, and communication with and and services inside and, including those specified in an environment that the rand in an environment of his or recognizing each resident's facility must protect and so of the resident. In facility must provide equal care regardless of diagnosis, on, or payment source. A facility and maintain identical policies and the ransfer, discharge, and the		JAN 25 2019 U 659	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 so on the Statement of Deficience. This Plan of Correction is prepared and/or executed solely becausit's required by the provision Health and Safety Code Section 1280 and 42 C.F.R. 483. Please accept this POC as our credible allegation of compliance. F-550 I. Corrective Action/s: 1:1 education was given on 01/22/19 to CNA # 1 by the DSD in regards to Resident's Rights and the need to explain residents any procedure she remder. II. How to Identify Other Resident's were re-assessed on their skills/knowledge from 1/15/19-1/22/19 regarding ADL's And Resident's Rights and no other CNA's has been deficient with this pra	in to will	1/24/
LABORATO	RY DIRECTOR'S OF PRO	DERISUPPLIER REPRESENTATIVE'S S	IGNATURE	Ē	Arlministrate		(X8) DAT

Any deficiency statement ending with an esterisk (*) denotes a deficiency which the Institution may be excused from correcting providing it is determined to other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 or 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 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continue program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MED

		a MEDICAID SERVICES	,		(OMB NO	. 0938-039	
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		555677	B. WING			04	06/2019	
		& WELLNESS CENTRE, LP	STREET ADDRESS, CITY, STATE, 2IP CO 11630 SOUTH GREVILLEA AVE. HAWTHORNE, CA 90250			DE		
(X4) ID PREFIX TAG	(BACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCEO TO THE APPRO DEFICIENCY)	D BE	COMPLETION DATE	
F 550	§483.10(b) Exercise The resident has the rights as a resident or resident of the U §483.10(b)(1) The resident can exercise interference, coercifrom the facility. §483.10(b)(2) The free of interference reprisal from the facility. §483.10(b)(2) The free of interference reprisal from the facility. §483.10(b)(2) The free of interference reprisal from the facility. This REQUIREMED by: Based on observareview, the facility for sampled residents care, and have the This deficient practifor not being value rights to refuse care. Findings: During an incontinution of the particular of the particular for the particular for not being value rights to refuse care.	s under the State plan for all s of payment source. e of Rights. e right to exercise his or her of the facility and as a citizen nited States. facility must ensure that the se his or her rights without on, discrimination, or reprisal resident has the right to be a coercion, discrimination, and cility in exercising his or her apported by the facility in the er rights as required under this NT is not met as evidenced tion, interview and record ailed to ensure one of 18 (40), to be explained about the right to refuse the care. It can be a sident 40 at fish das an individual, and the		550	III. Systemic Changes: DSD in-serviced nursing staff on 1/22/19 regarding Resident's Rights a during resident care will explain procedure to pat and or RP and will honor resi refusal IV. Monitoring: This process will be monitored by the DSD by randomly checking CNA's during/ while performing ADL's. Any trend and or patterns of concerns identified will be shared with the QAA committee for further Recommendations for 3 mo	ients idents'		

					01.20.45 p.iii. 01.40 E	J.J	
		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	01/18/2019 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE S	
		555677	B. WING			01//	06/2019
NAME OF	PROVIDER OR SUPPLIER			ş	TREET ADDRESS, CITY, STATE, ZIP CODE		
HAWTH	ORNE HEALTHCARE	& WELLNESS CENTRE, LP			1630 SOUTH GREVILLEA AVE. AWTHORNE, CA 90250		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 550	Continued From pa	ge 2	F £	550			
	doing, prior to touch Resident 40 was ob pitched voice, "get of legs". CNA 1 ignore continued with her touch the facility activity outing. During an interview Development (DSD stated prior to admit explain the procedustated if the resider dementia (symptom memory or other the reduce a person's a activities) and was the resident alone fat another time. The indicated to stop a the staff should stouch the resident at another time.	the resident what she was being and turning the resident. It is served stating in a high off me, don't be hurting my and the resident's request and task. If a.m., in an attempt to divide Nurse (RN 1) stated CNA 1 ty, to escort a resident to an with the Director of Staff (a) on 1/06/19 at 11:39 a.m., instering care, staff should are to the resident. The DSD at was confused or had as associated with a decline in inking skills severe enough to ability to perform everyday agitated, the staff was to leave for a few minutes and try again to DSD stated when a resident task, that was their right and put the task. CNAs then should to the charge nurse (a		Organization and the second se			

SS=D CFR(s). 483.10(e)(2)

A review of the facility's policy titled "Residents Rights, Quality of Life" revised January 2012, indicated each resident shall be cared for in a manner that promotes and enhances the quality of life, dignity, respect, individuality and receives services in a person-centered manner, as well as those that support the resident in attaining or maintaining his/her highest practicable well-being.

F 557 Respect, Dignity/Right to have Prsnl Property

F 557

PKINTED: UTTOIZUTE FORM APPROVED OMB NO. 0938-0391

STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A BUILDING			E SURVEY IPLETED		
	_	555677	B. WING			01/	06/2019
	PROVIDER OR SUPPLIE ORNE HEALTHCAR!	R E & WELLNESS CENTRE, LP	-	11	REET ADDRESS, CITY, STATE, ZIP CODE 630 SOUTH GREVILLEA AVE. AWTHORNE, CA. 90250		00/2015
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETION DATE
F 557	and dignity, Include §483.10(e)(2) The possessions, includes space permits upon the rights or residents. This REQUIREM by: Based on observitive to the facility sampled resident and respect.	ect and Dignity. a right to be treated with respect		557	F-557 I. Corrective Action/s: 1:1 education was given to CNA # 1 on 1/22/19 by the DSD in regards to Dignity a Respect and the need to exto residents any procedure will render. II. How to Identify Other R CNA's were re-assessed on their skills/ knowledge from 1/15/19-1/22/19 regarding ADL's and Resident's Rights and no other CNA's has been deficient with this process.	nd kplain she kesidents:	
	1/05/19 at 9:14 a stating, "don't pullke that, don't do right side by Cer CNA 1 was obseresident what shituming the residuoserved to ignowith her task." On 1/05/19 at 9:	inent care observation on a.m., Resident 40 was observed ill it up like that, don't pull it up of it, you fool" when turned to the tified Nurse Assistant (CNA 1). erved to not explain to the e was doing prior to touching and ent. Resident 40 was was ored the resident and continued			III. Systemic Changes: DSD in-serviced nursing staff on 1/22/19 regarding Resident's Right during resident care will explain procedure to pand or RP and will honor refusal.	atients	
	take the gown of	19 a.m., CNA 1 was observed to ff Resident 40, without explaining what CNA 1 was doing prior to					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IPLE CONSTRUCTION NG	(X3) DA	TE SURVEY MPLETED		
		555677	B. WING		01	/06/2019		
	PROVIDER OR SUPPLIER DRNE HEALTHCARE	& WELLNESS CENTRE, LP		STREET ADDRESS, CITY, STATE, ZIP O 11630 SOUTH GREVILLEA AVE. HAWTHORNE, CA 90250		DOE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	COMPLETION DATE		
F 584	with the gown with task. On 01/06/19 at 10: Interview Registerd was out of the faci outing. During an interview Development (DSI stated prior to admexplain the proced stated if the resided dementia (symptomemory or other treduce a person's activities) and was the resident alone at another time. Treducated to stop at the staff should streport that incidenticensed nurse where the staff should streport strepo	k. CNA 1 assisted the resident out first explaining about the out first explaining about the A1 a.m., in an attempt to sed Nurse (RN 1) stated CNA 1 lity, to escort a resident activity with the Director of Staff D) on 1/05/19 at 11:39 a.m., ninistering care, staff should lure to the resident. The DSD ent was confused or had ms associated with a decline in hinking skills severe enough to ability to perform everyday a agitated, the staff was to leave for a few minutes and try again the DSD stated when a resident task, that was their right and op the task. CNAs should the to the charge nurse (a to oversees unlicensed staff). Stility's policy titled "Dementia ober 2017 indicated behavioral ndividualized approaches that art of a supportive physical and ronment, and are directed ding, preventing and relieving, as or to accommodate loss of ortable/Homelike Environment (1)-(7)		IV. Monitoring: This process will be monitored by the DSD by randomly checking CNA's during/ while performing ADL's. Any trend and or patter of concerns identified who be shared with the QA committee for furth recommendations for 3 months.	/ill			

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 01/18/2019 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING _ 555677 8 WING 01/06/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 11630 SOUTH GREVILLEA AVE. HAWTHORNE HEALTHCARE & WELLNESS CENTRE, LP HAWTHORNE, CA 90250 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE łΩ (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY F 584 Continued From page 5 F 5841 comfortable and homelike environment, including F-584 I. Corrective Action/s: but not limited to receiving treatment and Resident 55 room was immediately supports for daily living safely. cleaned by the housekeeping The facility must providestaff on 1/5/19. §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to II. How to Identify Other Residents: use his or her personal belongings to the extent On 1/5/19, Administrator possible. (I) This includes ensuring that the resident can and Maintenance Supervisor receive care and services safely and that the did rounds on the floor to check physical layout of the facility maximizes resident all rooms. No other independence and does not pose a safety risk. residents have been (ii) The facility shall exercise reasonable care for affected from this deficient finding. the protection of the resident's property from loss or theft. III. Systemic Changes: §483.10(i)(2) Housekeeping and maintenance a. An in-service was given to services necessary to maintain a sanitary, orderly, housekeeping staff on 1/22/19 and comfortable interior: by the Maintenance Supervisor regarding maintaining a safe, \$483.10(i)(3) Clean bed and bath Ilnens that are home-like and clean environment in good condition; for the residents. §483.10(i)(4) Private closet space in each resident room, as specified in \$483.90 (e)(2)(iv); b. Maintenance Supervisor will do

sound levels.

81°F; and

levels in all areas;

§483.10(i)(5) Adequate and comfortable lighting

§483.10(i)(6) Comfortable and safe temperature

levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to

§4,83.10(i)(7). For the maintenance of comfortable

This REQUIREMENT is not met as evidenced

random room and facility rounds

home-like and safe environment

daily (M-F) to provide a clean,

for the residents.

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(VP) IV U TIP			0938-039
	OF CORRECTION	IDENTIFICATION NUMBER:	1	E CONSTRUCTION	(X3) DATE	SURVEY
		555677	B. WING		01/0	6/2019
	PROVIDER OR SUPPLIER DRNE HEALTHCARE	& WELLNESS CENTRE, LP	1.	TREET ADDRESS, CITY, STATE, ZIP CODE 1630 SOUTH GREVILLEA AVE. AWTHORNE, CA 90250		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETIO DATE
F 584	review, the facility sampled residents clean, organized at The deficient pract environment for Residents safety hazards. Findings: During the initial to 5:30 PM., and through the face beard in corner webs in the far combehind the bags of the face sheet indicated and interest of other right femulates, rods and procedure that resplates, rods and puring an interview (DON) on 1/5/19 a had a lot of reside moving their items cluttered personal hazards for Residents.	tion, interview and record failed to ensure one of 18 (55) room was kept safe,		IV. Monitoring: Any negative findings will be reported and discussed by the Maintenance Supervisor during the monthly QAA meeting for trending and sustaining compliance for 3 months.	d Or	

DEPAR'	TMENT OF HEALTH	AND HUMAN SERVICES MEDICAID SERVICES		PRINTED: 01/18/20 FORM APPROVI OMB NO. 0938-03
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED
		555677	B. WING_	01/06/2019
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE
НАЖТНО		& WELLNESS CENTRE, LP		11530 SOUTH GREVILLEA AVE. HAWTHORNE, CA 90250
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE COMPLETIC CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
F 584	Continued From passafe environment.	age 7	F 58	84
	titled "Resident Ro revised 1/1/12, ind create a personalizattention to the foll ADL Care Provided CFR(s): 483.24(a)(for a cout activities of dais services to mainta personal and oral in This REQUIREME by: Based on interview failed to ensure on who was dependencare (a term that dinvoluntary loss of timely manner after back to the facility hospital (GACH). The deficient pracheing assigned a control sheet and two incomits with urine and bow	sident who is unable to carry by living receives the necessary in good nutrition, grooming, and hygiene; NT is not met as evidenced w and record review, the facility e of 18 sampled residents (44), nt on staff recieved incontinent escribes any accidental or unne or bowel functions) in a er the resident was transferred from general acute care tice resulted in Resident 44 not care giver, left laying on a fitted ontinent pads that were soaked wel movement, increasing the	F 67	care provided for dependent residents and that a resident who is unable to carry out activities of daily living receives the necessary services to maintain good grooming, nutrition and personal hygiene. b. 1:1 in- service was given to LVN # 3 regarding assessing any admission and/or readmission resident and informing CNA's for any additional or change in their assignment.
	out activities of dai services to mainta personal and oral in This REQUIREME by: Based on interview failed to ensure on who was depended care (a term that do involuntary loss of timely manner after back to the facility hospital (GACH). The deficient practice being assigned a contract sheet and two incoming and bow risks for skin brea	ly living receives the necessary in good nutrition, grooming, and hygiene; NT is not met as evidenced of and record review, the facility e of 18 sampled residents (44), at on staff recieved incontinent escribes any accidental or unne or bowel functions) in a crette resident was transferred from general acute care tice resulted in Resident 44 not care giver, left laying on a fitted ontinent pads that were soaked		and that a resident who is unable to carry out activities of daily living receives the necessary services to maintain good grooming, nutrition and personal hygiene. b. 1:1 in- service was given to LVN # 3 regarding assessing any admission and/or readmission resident and informing CNA's for any additional or change in

The Admission records indicated Resident 44

was readmitted to the facility on 1/25/18 with

Findings:

lift for transfer.

regarding the present plan of care of the resident and

the facility's recommendation on transferring the resident on 2 assist and/or using a hoyer

FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION		E SURVEY PLETED
		555677	B. WING		ON THE STATE OF TH	01/	06/2019
	PROVIDER OR SUPPLIER ORNE HEALTHCARE	& WELLNESS CENTRE, LP		11	TREET ADDRESS, CITY, STATE, ZIP CODE 1830 SOUTH GREVILLEA AVE. AWTHORNE, CA 90250		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 677	diagnoses not limite (stroke), abscess (abelow the skin's suithe right lower leg to thrive and contraction and hardening of milssue, often leading joints) of the right k. The minimum data assessment and cate of the resident was dependent on (such as dressing, use and surface transferred to the general facility falled to procare to Resident 44 clean her. RP 1 state transferred to the general form the facility falled to provide incontinent bowel movement. The turned from GAC but the facility falle resident till about 1 stated the resident till about 1 stated the resident till about 1 stated the resident stated the resident till about 1 stated the residen	ed to cerebrovascular accident a bump that appears within or rface that may be infected) to endon sheath, adult failure to ure (a condition of shortening nuscles, tendons, or other g to deformity and rigidity of nee and right ankle. set (MDS), a standardized are-screening tool, dated resident 44 had severe learn, understand, remember s) impairment. The same MDS and was unable to walk and staff for activities of daily living eating, personal hygiene, toilet insfers). interview on 1/05/19 at 4:07 Party (RP 1) complained the vide appropriate and timely 4. RP 1 stated "They don't ated Resident 44 was general acute care hospital 8 and the facility also failed to a care after the resident had a RP 1 stated the resident CH on 11/29/18 at 5:30 a.m., d to assign a CNA to the :00 p.m. on 11/29/18." RP 1		677	II. How to Identify Other Re A facility wide review of dep residents was conducted by DSD on 1/6/19. No other resident was affected by this practice. III. Systemic Changes: a. On 1/22/19, DSD and DON in-serviced nursing staff on A care provided for dependent who is unable to carry out ac daily living receives the necessary services to mainta good grooming, nutrition and personal hygiene. b. The facility has developed system and a form for accura of assignment and will be distributed to the nurses on floor. IV. Monitoring: Any negative findings will be reported and discusse by the DSD during the month QAA meeting for trending and sustaining compliance for 3 months.	endent the has DL residents tivities of in d accy the	1

provide incontinent care at GACH before a cast

2133312730

	13 FOR MEDICARE	& MEDICAID SERVICES	·		OWR NO	<u>. 0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION G		E SURVEY MPLETED
		555677	B. WING		01	/06/2019
NAME OF	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZI		
HAWTH	DRNE HEALTHCARE	& WELLNESS CENTRE, LP		11630 SOUTH GREVILLEA AVE. HAWTHORNE, CA 90250		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IOENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 677	stated the facility di 44 from 5:30 a.m. b the resident's leg a was an old blood st 2 stated "Resident incontinent pads ar unne and the incontook pictures as proasked RP 1 and 2 v before visiting the rwith 84 residents. Even here for three told me that I had to my mom." RP 2 stawas assigned to the 5:30 a.m. till 11:30 2 asked about, stat the resident. RP 2 Resident 44 was nowhen she came bastated one time as bed table, was too the resident needs stated in the past to the hospital and hastated "I said it to reposition the resident RP 1 demai assist with the resident even and or move to RP 2 "It is not the RP 2." It is not the	ge 9 resident's right leg. RP 2 d not provide care to Resident because cast debris were on and on the bed sheet, and there ain on the incontinent pad. RP 44 was lying in stool and urine, diffitted sheet was soaked with tinent pads had stool on it. I bof." RP 2 stated the DON why they did not call the facility esident, and DON was busy RP 2 stated "My mom has e years and the DON has never to call the facility before I visit ated no CNA attended and or e resident on 11/29/19 from a.m. because all the CNAs RP ated they were not assigned to stated "a CNA told me but served or fed breakfast tock from the hospital." RP 2 staff placed food on an over far for the resident to reach but help to eat the foods. RP 2 the resident was transferred to ad dried food on the face.	t	7		

CLIVIL	KO FOR WEDICARE	& MEDICAID SERVICES				OMR NO	. 0938-0391	
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMSER:	} ` `		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		555677	B. WING			01	/06/2019	
•	PROVIDER OR SUPPLIER ORNE HEALTHCARE	& WELLNESS CENTRE, LP		116:	EET ADDRESS, CITY, STATE, ZIP CODE 30 SOUTH GREVILLEA AVE. WITHORNE, CA 90250			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(XS) COMPLETION DATE	
F 677	stated Resident 44 11/29/18 during the was not originally o stated there are us 3:00 p.m. shift and called off and one o that CNA was not o stated CNAs are us changes the aroun morning the reside she was not on my (Resident 44) on m notify me. I got to k schedule when the time like 11 someti was upset the reside and licensed vocat to assist Resident in the shower room DSD and LVN 3 was room." CNA 3 state assisted the reside nine patients on th seven. I even com This assignment in assignment." During an interview stated on 11/29/18 GACH because of p.m. to 7:00 a.m. o registered nurse (I to toe assessment or returned from o night licensed nurs resident had a frace	ige 10 If on 1/6/19 at 2:59 p.m. CNA 3 If was her extra assignment on a morning shift but the resident in CNA 3's assignment. CNA 3 If was not resident in CNA 3's assignment. CNA 3 If was crossed out because incheduled to work. CNA 5 Is wally informed of assignment in the same of assignment in the returned from the hospital schedule. They put her in the returned from the hospital schedule but they did not know the resident was on my family came to visit at lunching in the morning. The family dent was not up in a chair." If the of staff development (DSD) in all nurse (LVN 3) for CNA 3 If CNA 3 further stated "I was in with another patient and the lanted me to go to the resident's ed CNA 6 and another CNA int. CNA 3 stated "I already had at day and other CNAs had plalned about my assignment. In the book is not the original of the book is not the original of the land of the RN) and charge LVN do a head when a resident was admitted a ACH. LVN 3 stated out going the reported to LVN 3 the charge reported to LVN 3 the char		377				

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

CENTE	TO FUR WEULDARE	& MEDICAID SERVICES			OIVID IV	. 0830-0381
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION		TE SURVEY MPLETED
		555677	B. WING	and the state of t	01	/06/2019
	PROVIDER OR SUPPLIER ORNE HEALTHCARE	& WELLNESS CENTRE, LP	1	STREET ADDRESS, CITY, STATE, ZIP COI 1630 SOUTH GREVILLEA AVE. HAWTHORNE, CA 90250		
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F 677	her in bed, I greete rounds, I went to the resident's condition "That is what we all the night LVN and I report at the reside pulled the blankets look at the fracture feet to the knee. I son the resident's leassessment during a visual assessment during a visual assessment family came in arouthe resident was st paged a CNA to as not permanently as CNA was in the shi who was busy, I as resident." LVN 3 st for the CNA assign state why LVN 3 co. During an interview stated "I was aske around 10:30 a.m. to help because the resident." CNA 6 s GACH gown and Further stated "whe saw a cast on the disposable incontinuous another on stuck 2 was taking pictur. "Before DSD or I get the sident of the transcription."	al round at 7:00 am. I saw in d her, I continued with my e station to endorse about the to the incoming night LVN. ways do." LVN 3 stated both LVN 3 conducted a hand off nt's bedside. LVN 3 stated "I from the foot of the bed to d leg exposing the resident's law a foot cradle, I saw a cast g, I did not do a complete body my eight hours shift. I only did not on the resident." LVN 3 hat on 11/29/18 Resident 44's and 10:00 a.m. and was upset lill in bed. LVN 3 stated "I sist the resident. That CNA is signed to the resident, The ower with another resident, liked CNA 6 to assist the lated the DSD was responsible ments. LVN 3 was not able to hald not assist Resident 44. If on 1/6/19 at 3:48 p.m. CNA 6 and to go help Resident 44 to 10:40 a.m. They asked me the CNA was busy with another thated Resident 44 was in a RP 2 was at the bedside. CNA 6 and I pulled back the blankets I night leg, two soaked ment pads, fitted sheets were and fresh stool. The stool was on the resident's skin" and RP res because CNA 6 witnessed as of the resident. CNA 6 stated to home we make sure e. We go home around 5:00				

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				MB NO.	0938-0391
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	PROVIDER OR SUPPLIER DRNE HEALTHCARE	& WELLNESS CENTRE, LP			STREET ADDRESS, CITY, STATE, ZIP CODE 11630 SOUTH GREVILLEA AVE. HAWTHORNE, CA 90250		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(XS) COMPLETION DATE
F 677	p.m." and the reside before DSD and Community and the DSD and Community and the DSD and Community and DSD and or Community and the community and the community and could readjust and could readjust and could readjust and could readjust stated "I did not involved the community and could readjust and could readjust and could readjust stated "I did not involved the community and could readjust and could readjust and could readjust stated "I did not involved the charge nurs 11:00 p.m. to 7:00. The DSD stated "I 11:00 a.m. on 11/2 a CNA. I was award unner and stool and the bed from the head from the	ent was transferred to GACH NA 6 went home on 11/28/18, NA 6 thought Resident 44 the facility. CNA 6 verified and is assigned to the resident on ated both the DSD and CNA 6 is morning at 8:30 a.m. and inds. CNA 6 stated "I saw the und 9:00 a.m., on 11/29/18 NA 6 needed to have assigned 44. CNA 6 verified and stated A 3 Resident 44 was added on ignment. We just mentioned to assignment was adjusted at 9/18 when the resident's family isit." CNA 6 stated charge CNAs assignment If DSD or		677			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				MB NO.	0938-0391
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NAME OF F	PROVIDER OR SUPPLIER	4		5	TREET ADDRESS, CITY, STATE, ZIP CODE		
наштно	DRNE HEALTHCARE	& WELLNESS CENTRE, LP			1530 SOUTH GREVILLEA AVE. NAWTHORNE, CA 90250		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
F 677	Continued From pa	ge 13	F6	577			
	document titled Pal	w on 1/6/19 the facility lient Care Plan dated 11/20/18 44 will be neat, clean, odor med, daily.					
	5:50 p.m. the DON early as 7:30 a.m. Resident 44 back f However RP 2 stat "the facility called c Resident 44 was b	exit conference on 1/6/19 at stated she was on duty as and RP 2 had accompanied from GACH on 11/29/18. ed on 1/6/2019 at 10:53 a.m. on phone at 5:30 am and said ack at the facility." The DON ery upset that no one had ant 44's needs.					
	a.m. RN 3 stated F facility from GACH services (EMS) on stated "I informed about Resident 44 one witnessed her 44's return back to remember what was the resident was."	e Interview on 1/7/19 at 7:35 Resident 44 returned to the via emergency medical 11/29/18 at 5:30 a.m. RN 3 the CNA assigned to that room was in bed. RN 3 stated no tell the CNA about Resident the facility. RN 3 stated "I can't as on the resident's bed or how RN 3 stated "I assessed the I to toe and the resident had a					
	a.m. ČNA 7 stated resident was trans hospital. When I recome back from the broken. The charged admission or read Resident 44 was cat 5:30 a.m. CNA	e interview on 1/7/19 at 10:43 "I can't remember the date the ferred to and returned from the eported to work she had alread ne hospital. I heard her foot was se always tells us if we have an mission." CNA 7 denied on his assignment on 11/29/18 7 stated the 11:00 p.m. to 7:00 y clock out at 7:00 a.m.					

	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	•	CONSTRUCTION	(X3) DATE SUR COMPLET	VEY		
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	ROMDER OR SUPPLIER	& WELLNESS CENTRE, LP	STREET ADDRESS, CITY, STATE, ZIP CODE 11630 SOUTH GREVILLEA AVE. HAWTHORNE, CA 90250					
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F 677	Continued From pa	age 14	F 677					
	Time Detail Indicate	ew the facility's document titled es CNA 7 electronically 3/19 at 10:53 p.m. and out on m.						
	CNA Dally Assignm	ew the facility document titled nents dated 11/28/18 11:00 to A 7 was assigned to Resident	, e					
	11:41 a.m. CNA 7 vitime card indicated at 10:53 p.m. and c CNA 7 was quiet for	elephone interview on 1/7/19 at was informed the electronic of CNA 7 clocked in on 11/28/19 out on 11/29/18 at 6:55 a.m. or a few seconds then stated "I me patient (Resident 44) when im the hospital."						
F 684	Rights, Quality of I indicated each res manner that promo of life, dignity, resp services in a perso those that support	llity's policy titled "Residents Life" revised January 2012, ident shall be cared for in a otes and enhances the quality pect, individuality and receives on-centered manner, as well as the resident in attaining or r highest practicable well-being.	F 684	F-684 I. Corrective Action/s: a. 1:1 in- service was given				
	GFR(s): 483.25 § 483.25 Quality of Quality of care is a applies to all treat facility residents. It assessment of a rethat residents recidence with process.	of care a fundamental principle that ment and care provided to Based on the comprehensive resident, the facility must ensure eive treatment and care in professional standards of prehensive person-centered		by the DSD to CNA #7 on 1/22/19 in regards to quality of care and residents receiving treatment and care in accorda with professional standards o practice, the comprehensive person-centered care plan an resident's choices.	f			

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		X3) DATE SURVEY. COMPLETED	
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NAME OF	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE	1 017	06/2019	
HAWTH	DRNE HEALTHCARE	& WELLNESS CENTRE, LP		1	630 SDUTH GREVILLEA AVE. AWTHORNE, CA 90250			
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F 684	This REQUIREME by: Based on interview failed to ensure on who needed assist comprehensive pe received assistanc that describes any of urine or bowel fu after the resident w facility from genera The deficient pract laying on fitted she soaked with urine Findings: The Admission rec was readmitted to diagnoses not limit (stroke), abscess below the skin's si the right lower leg thrive and contrac and hardening of tissue, often leadin joints) of the right The minimum dat assessment and of 12/7/18 indicated cognitive (ability to and make decisio indicated the resid	residents' choices. NT is not met as evidenced w and record review, the facility e of 18 sampled residents (44), ance from staff per reson centered care plan, e with incontinent care (a term accidental or involuntary loss unctions) in a timely manner vas transferred back to the all acute care hospital (GACH). lice resulted in Resident 44 left eet and two incontinent pads and bowel movement. cords indicated Resident 44 the facility on 1/25/18 with ted to cerebrovascular accident (a bump that appears within or urface that may be infected) to tendon sheath, adult failure to ture (a condition of shortening muscles, tendons, or other ing to deformity and rigidity of knee and right ankle. a set (MDS), a standardized care-screening tool, dated Resident 44 had severe to learn, understand, remember and impairment. The same MDS dent was unable to walk and a staff for activities of daily living the staff for activities of daily living the staff for activities of daily living		684	b. 1:1 in- service was given to LVN # 3 regarding assessing any admission and/or readmission resident and informing CNA's for any additional or change in their assignment. c. An IDT was conducted with the responsible party regarding the present plan of care of the resident and the facility's recommendation transferring the resident on 2 assist and/or using a halift for transfer. II. How to Identify Other Read facility wide review of depresidents was conducted by DSD on 1/6/19. No other resident is affected by this practice.	of on oyer esidents: pendent		

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нажтно	ORNE HEALTHCARE	& WELLNESS CENTRE, LP		1630 SOUTH GREVILLEA AVE. IAWTHORNE, CA. 90250		
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F 684	(such as dressing, use and surface transport of the p.m., Responsible facility failed to provide to Resident 44 clean her, RP 1 statement from the ground of	eating, personal hygiene, toilet insfers). interview on 1/05/19 at 4:07 Party (RP 1) complained the vide appropriate and timely 4. RP 1 stated "They don't ted Resident 44 was eneral acute care hospital 8 and the facility also failed to care after the resident had a RP 1 stated the resident H on 11/29/18 at 5:30 a.m., d to assign a CNA to the :00 p.m. on 11/29/18." RP 1		III. Systemic Changes: a. On 1/22/19, DSD and DON in-serviced nursing staff in regards to quality of care and ensuring that residents receive treatment and care in accord with professional standards of practice, the comprehensive person-centered care plan are resident's choices. b. The facility has developed system and a form for accurate assignment and will distributed to the nurses on floor. IV. Monitoring: Any negative findings will be reported and discussiby the DSD during the monting QAA meeting for trending and sustaining compliance for 3 months.	ve ance of ad be the	

was assigned to the resident on 11/29/19 from

STATEMENT OF		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUII	TIPLE CO	NSTRUCTION		E SURVEY
AND PLAN OF C		IDENTIFICATION NUMBER:	1		Natroction		APLETED
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HAWTHORN	NE HEALTHCARE	& WELLNESS CENTRE, LP			SOUTH GREVILLEA AVE. THORNE, CA 90250		
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5: 2 in the Rewistration of the State of the	asked about, state resident. RP 2 sesident 44 was not then she came bared table, was too the resident needs ated in the past the hospital and hat ated "I said it to my mom it could P 2 stated one CN aposition the resident with the residence and or move to the past of th	a.m. because all the CNAs RP ed they were not assigned to stated "a CNA told me at served or fed breakfast ck from the hospital." RP 2 taff placed food on an over far for the resident to reach but help to eat the foods. RP 2 are resident was transferred to did dried food on the face. RP 2 by self that if this is happening happen to another patient." NA would clean, turn, and sent before the fracture. RP 2 and dent's ADLs after the fracture and the foods of the face of the fracture and the foods. The fracture and the foods of the fracture and the foods of the fracture and the foods. The fracture are the fracture and the foods of the fracture and the fracture and the fracture and foods of the fracture and f		584			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED (X3) DATE SURVEY COMPLETED (X3) DATE SURVEY COMPLETED (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED (X4) DATE SURVEY COMPLETED (X5) DATE SURVEY COMPLETED (X4) DATE SURVEY COMPLETED (X5) DATE SURVEY COMPLETED (X6) DATE SURVEY COMPLETED (X7) DATE SURVEY COMPLETED (X8) DATE SURVEY COMPLETED (X9) DATE SURVEY COMPLETED	CENTE	KO FUR MEDICARE	& MEDICAID SERVICES	,		(<u>om amc</u>	<u> 0938-0391</u>
NAME OF PROVIDER OR SUPPLIER HAWTHORNE HEALTHCARE & WELLNESS CENTRE, LP SUMMARY STATEMENT OF DEFICIENCIES [EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 684 Continued From page 18 Was upset the resident was not up in a chair." CNA 3 stated director of staff development (DSD) and licensed vocational nurse (LVN 3) for CNA 3 to assist Resident 44, CNA 3 further stated "I was in the shower room with another patient and the DSD and LVN 3 wanted me to go to the resident's room." CNA 3 stated CNA 6 and another CNA assisted the resident. CNA 3 stated "I already had nine patients on that day and other CNAs had seven. I even complained about my assignment. This assignment in the book is not the original assignment." During an interview on 1/6/19 at 3:22 p.m. LVN 3 stated on 11/29/18 Resident 44 returned from GACH because of a right ankle fracture on 11:00 p.m. to 7:00 a.m. shift. LVN 3 stated the registered nurse (RN) and charge LVN do a head to toe assessment when a resident was admitted or returned from GACH. LVN 3 stated to treassessment when a resident was admitted or returned from GACH. LVN 3 stated to treassessment when a resident was admitted or returned from GACH. LVN 3 stated to make the resident on my inflital round at 7:00 a.m. is saw in the resident on my inflital round at 7:00 a.m. is saw in the resident on my inflital round at 7:00 a.m. is saw in the resident on my inflital round at 7:00 a.m. is saw in the resident on my inflital round at 7:00 a.m. is saw in the resident on my inflital round at 7:00 a.m. is saw in the resident on my inflital round at 7:00 a.m. is saw in the resident on my inflital round at 7:00 a.m. is saw in the resident on my inflital round at 7:00 a.m. is saw in the resident on my inflital round at 7:00 a.m. is saw in the resident on my inflital round at 7:00 a.m. is saw in the resident on my inflital round at 7:00 a.m. is saw in the resident on my inflital round at 7:00 a.m. is saw in the resident on my inflital round at 7:00 a.m. is saw i	STATEMENT AND PLAN (T OF DEFICIENCIES DF CORRECTION		(' '		E CONSTRUCTION	(X3) DAT	E SURVEY
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FREFIX REGULATORY OR LISC IDENTIFYING INFORMATION) F 684 Continued From page 18 was upset the resident was not up in a chair." CNA 3 stated director of staff development (DSD) and licensed vocational nurse (LVN 3) for CNA 3 to assist Resident 44. CNA 3 further stated "I was in the shower room with another patient and the DSD and LVN 3 wanted me to go to the resident's room." CNA 3 stated CNA 6 and another CNA assisted the resident. CNA 3 stated "I already had nine patients on that day and other CNAs had seven. I even complained about my assignment. This assignment in the book is not the original assignment." During an interview on 1/6/19 at 3:22 p.m. LVN 3 stated on 11/29/18 Resident 44 returned from GACH because of a right ankle fracture on 11:00 p.m. to 7:00 a.m. shift. LVN 3 stated the registered nurse (RN) and charge LVN do a head to toe assessment when a resident was admitted or returned from GACH. LVN 3 stated out going night licensed nurse reported to LVN 3 the resident had a fracture, needed two person assist and Hoyer lift to transfer. LVN 3 stated "I saw the resident on my initial round at 7:00 am. I saw the resident on my initial round at 7:00 am. I saw the	нажтно	ORNE HEALTHCARE	& WELLNESS CENTRE, LP		i			
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rounds, I went to the station to endorse about the resident's condition to the incoming night LVN. "That is what we always do." LVN 3 stated both the night LVN and LVN 3 conducted a hand off report at the resident's bedside. LVN 3 stated "I pulled the blankets from the foot of the bed to look at the fractured leg exposing the resident's feet to the knee. I saw a foot cradle, I saw a cast on the resident's leg, I did not do a complete body assessment during my eight hours shift. I only did a visual assessment on the resident." LVN 3 stated "I am sure that on 11/29/18 Resident 44's family came in around 10:00 a.m. and was upset the resident was still in bed. LVN 3 stated "I	F 684	was upset the reside CNA 3 stated direct and licensed vocation to assist Resident a in the shower room DSD and LVN 3 was room." CNA 3 stated assisted the resident patients on the seven. I even compart this assignment in assignment." During an interview stated on 11/29/18 GACH because of p.m. to 7:00 a.m. sergistered nurse (Fito toe assessment or returned from Gonight licensed nurse resident had a fract and Hoyer lift to trace identification of the resident of the resident of the pulled the blankets look at the fracture feet to the knee. If on the resident's leassessment during a visual assessment stated "I am sure the family came in architect."	ient was not up in a chair." tor of staff development (DSD) conal nurse (LVN 3) for CNA 3 44. CNA 3 further stated "I was with another patient and the inted me to go to the resident's rit. CNA 3 stated "I already had at day and other CNAs had clained about my assignment. The book is not the original of on 1/6/19 at 3:22 p.m. LVN 3 Resident 44 returned from a right ankle fracture on 11:00 hiff. LVN 3 stated the RN) and charge LVN do a head when a resident was admitted ACH. LVN 3 stated out going are reported to LVN 3 the ture, needed two person assist ansfer. LVN 3 stated "I saw the fall round at 7:00 am. I saw in active, needed two person assist ansfer. LVN 3 stated "I saw the fall round at 7:00 am. I saw in active, needed two person assist ansfer. LVN 3 stated "I saw the fall round at 7:00 am. I saw in active, needed two person assist actives a foot or and off cent's bedside. LVN 3 stated both LVN 3 conducted a hand off cent's bedside. LVN 3 stated "I as from the foot of the bed to cell leg exposing the resident's saw a foot cradle, I saw a cast cey, I did not do a complete body any eight hours shift. I only did ant on the resident." LVN 3 hat on 11/29/18 Resident 44's and 10:00 a.m. and was upset		684			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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NAME OF	PROVIDER OR SUPPLIER		^	}	REET ADDRESS, CITY, STATE, ZIP CODE		
HAWTHO	ORNE HEALTHCARE	& WELLNESS CENTRE, LP		}	630 SOUTH GREVILLEA AVE. AWTHORNE, CA 90250		
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F 684	not permanently as CNA was in the show who was busy, I as resident," LVN 3 stresident," LVN 3 stresident," LVN 3 control of the CNA assignate why LVN 3 control of the CNA assignate why LVN 3 control of the CNA 6 stresident." CNA 6 stresident." CNA 6 stresident." CNA 6 stresident of the resident of the control of the	ge 19 sist the resident. That CNA is signed to the resident, The ower with another resident, ked CNA 6 to assist the ated the DSD was responsible ments. LVN 3 was not able to uld not assist Resident 44. on 1/6/19 at 3:48 p.m. CNA 6 d to go help Resident 44 to 10:40 a.m. They asked meated Resident 44 was in a P 2 was at the bedside. CNA 6 n I pulled back the blankets I ight leg, two soaked ent pads, fitted sheets were not fresh stool. The stool was on the resident's skin" and RP es because CNA 6 witnessed to home we make sure who was transferred to GACH NA 6 went home on 11/28/18, CNA 6 thought Resident on the facility. CNA 6 verified and is assigned to the resident on the facility. CNA 6 verified and is assigned to have assigned to have assigned to have assigned 44. CNA 6 stated "I saw the bund 9:00 a.m., on 11/29/18 NA 6 needed to have assigned to the resident on the signment. We just mentioned to assignment was adjusted at 19/18 when the resident's family visit." CNA 6 stated charge		684			

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	ROVIDER OR SUPPLIER	& WELLNESS CENTRE, LP		11	REET ADDRESS, CITY, STATE, ZIP CODE 630 SOUTH GREVILLEA AVE. AWTHORNE, CA 90250		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 684	CNA 6 are not at the During an interview DSD stated Resides CNA assignment with transferred to GAC p.m. to 7:00 a.m. cliented and could readjust stated "I did not invor the charge nurse 11:00 p.m. to 7:00 a.m. on 11/23 a CNA. I was aware urine and stool and the bed from the hefamily came over froom. I was called was very upset because position I would be CNA 7 was assigned During record revised coument titled Paindicated Resident free, and well grood. During the survey endowners of the property of the proof	CNAs assignment if DSD or e facility. I on 1/6/19 at 4:16 p.m. the nt 44 was crossed out of the hen the resident was. H. The DSD stated the 11:00 harge nurse was responsible. CNAs assignment. The DSD estigate nor question the CNA assigned Resident 44 on the a.m. as to what happened." knew around 10:30 a.m. to 21/8 the resident did not have at the resident was soaked in particles from the cast was on oppital. I believe that day the or a meeting in the family if I understand why they were at I put myself in the family's very upset." The DSD stated at to Resident 44's room. When on 1/6/19 the facility then Care Plan dated 11/20/18 44 will be neat, clean, odor med, daily. Exit conference on 1/6/19 at stated she was on duty as and RP 2 had accompanied from GACH on 11/29/18. Red on 1/6/2019 at 10:53 a.m. on phone at 5:30 am and said ack at the facility." The DON ary upset that no one had		684			

	IND I OIL MEDICANCE	A MILLIONID OLIVIOLO				JIVID IVO.	1 600-0000
	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY PLETED
		555677	B. WING	i		01/	06/2019
	PROVIDER OR SUPPLIER ORNE HEALTHCARE	& WELLNESS CENTRE, LP		11	REET ADDRESS, CITY, STATE, ZIP CODE 630 SOUTH GREVILLEA AVE. AWTHORNE, CA 90250		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 684	During a telephone a.m. RN 3 stated R facility from GACH services (EMS) on stated "I informed the about Resident 44 one witnessed her 44's return back to remember what was the resident from head cast on one leg." During a telephone a.m. CNA 7 stated resident was transhospital. When I recome back from the broken. The charge admission or reading at 5:30 a.m. CNA a.m. CNAs usually During record reviction During record reviction During a second to 11:41 a.m. CNA 7 time card indicated at 10:53 p.m. and	esident 44 returned to the via emergency medical 11/29/18 at 5:30 a.m. RN 3 he CNA assigned to that room was in bed. RN 3 stated no tell the CNA about Resident the facility. RN 3 stated "I can't is on the resident's bed or how RN 3 stated "I assessed the to toe and the resident had a einterview on 1/7/19 at 10:43 "I can't remember the date the ferred to and returned from the exported to work she had already the hospital. I heard her foot was a always tells us if we have an mission." CNA 7 denied in his assignment on 11/29/18 stated the 11:00 p.m. to 7:00 clock out at 7:00 a.m. aw the facility's document titled tes CNA 7 electronically 8/19 at 10:53 p.m. and out on		684			

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CENTE	KO FUR MEDICARE	& MEDICAID SERVICES	·			OMB NO	<u>. 0938-039</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		555677	B. WINC	·		01	/06/2019
NAME OF	PROVIDER OR SUPPLIER			§	EET ADDRESS, CITY, STATE, ZIP CODE		
HAWTHO	ORNE HEALTHCARE	& WELLNESS CENTRE, LP		Į.	30 SOUTH GREVILLEA AVE. WTHORNE, CA 90250		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAC	'IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	COMPLETION DATE
E 684	0	200		CDA			
F 004	Continued From pa	· ·		684			
	she came back fro	ne patient (Resident 44) when my the hospital."					
	A review of the fac	llity's policy titled "Residents					
		Life" revised January 2012,					
	indicated each res	Ident shall be cared for in a					
		otes and enhances the quality		}			
		pect, individuality and receives on-centered manner, as well as		Ì			
		the resident in attaining or		İ			
		r highest practicable well-being			F-692		
		Status Maintenance	F	692	I. Corrective Action/s:		
SS≕E	CFR(s): 483.25(g)	(1)-(3)	Ì		Resident #72 and Residen	t	
	 8483-25(n) Assiste	ed nutrition and hydration.		į	#50 were immediately		
		stric and gastrostomy tubes,	1	j	provided water and that pitchers were within		
	percutaneous end	s endoscopic gastrostomy and oscopic jejunostomy, and used on a resident's			the residents reach on 1/5		
		ssessment, the facility must			Resident #72 and Residen	t	
	ensure that a resid	dent-		1	#50 were re-assessed by		i
	E483 25/a\/1\ Ma	intains acceptable parameters		!	the RN Supervisor. No		
		s, such as usual body weight o	or I	į	negative findings were no		
		eight range and electrolyte			upon the completion of th	e	Ì
		ne resident's clinical condition		İ	assessment.		
		t this is not possible or resident	t j	ļ	1.1 in convice was alves		
	preferences indic	ate utilei wise,			1:1 in- service was given by the DSD to CNA #1		}
	§483.25(g)(2) Is o	offered sufficient fluid intake to			on 1/22/19 regarding		
		ydration and health;	ļ		Nutrition/ Hydration		
	5400 DE/-VOV	area and a speciario alta alta ancida a	1		Maintenance and		
		offered a therapeutic diet when hal problem and the health care			that residents		
	provider orders a		=		are offered sufficient		
		ENT is not met as evidenced			fluid intake to maintain		
	by:				proper hydration and		
	Based on observ	ration, interview and record			health.		

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	SURVEY PLETED
		555677	B. WING			04//	06/2019
	PROVIDER OR SUPPLIE	R E & WELLNESS CENTRE, LP		11	TREET ADDRESS, CITY, STATE, ZIP CODE 630 SOUTH GREVILLEA AVE. AWTHORNE, CA 90250	1 01//	33/2015
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	IO PREFI TAG	ıx	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	DBE	COMPLETION DATE
F 692	offered for two of who required assiliving ([ADL] are accomplished eventhive). This deficient pra Resident 72, an 5 adequate fluids, proceeding to the much water as it. Findings: a. During the initiation water as it. Findings: a. During the initiation water as it. Findings: buring the initiation water as it. Juring the initiation was room, which was room, which was room, which was top of the nightstation of the nightstation was it. During the following the following the following the following trial was one of the inside of the was one of the was one of the full upside down. According to the was one of the following to the kidneys to your be kidneys to your be kidneys whice	ty failed to ensure fluids were 18 sampled residents (72, 50), istance with Activities of Daily basic tasks that must be ery day for an individual to ctice had the potential to put it at risk for not receiving blacing them at risk for in the body does not have as needs). ial tour of the facility on 1/4/19 at int 72 was observed sitting up in his bed. Resident 72's pitcher observed in the corner of the beyond the resident's reach, on		392	II. How to Identify Other Reside On 1/6/19, DSD and RN Supervisor made rounds on the to check water pitchers are within reach and that residents are offered sufficients intake to maintain proper hydra No other residents have been a from this finding. III. Systemic Changes: a. On 1/22/19, DSD and DON h in-serviced nursing staff in regards to Nutrition/ Hydra Maintenance and that residents are offered sufficient fluid intake to maintain proper hydration and health. b. The facility has developed a system and a form for accurate hydration monitorin and documentation. c. Ambassador rounds was re on 1/23/19 to reflect that wa pitchers are within reach of t residents. Any negative findin be discussed at the daily star meeting.	floor fluid ation. ffected as tion g	

and the province of the parties PRINTED: 01/18/2019 FORM APPROVED OMB NO. 0938-0391

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CONSTI	(X3) DATE SURVEY COMPLETED			
INU PLAN C	D PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDI	NG				
		555677	B. WING			01/06/2019		
	PROVIDER OR SUPPLIER DRNE HEALTHCARE	& WELLNESS CENTRE, LP		11630 SOL	ORESS, CITY, STATE, ZIP CODE ITH GREVILLEA AVE. IRNE, CA. 90250	P CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TEMENT OF CEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		PROVIDER'S PLAN OF CORRECT EACH CORRECTIVE ACTION SHOL OSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 692	unspecified demensocial symptoms the functions) without it functions) without it functions) without it functions) without it functions) without it functions a standard screening tool date resident was cognidally decision making activities. b. During the initial was observed lying television. Resident ([G-tube] a tube instant delivers nutritic pump (machine to running at 90 cubic of Diabetic Source observation, behing pitcher of fluid with On 1/5/19 at 10 and observation Reside up in a wheelchair 50's water pitcher behind him. During 50 was asked if he drink when they tu no one here ever to the source of the sever of the source of the sever of the source observation of the sever of the source of the sever of the sever of the source of the sever of the sever of the sever of the source of the sever of	age 24 ent of urinary device, and tia (a group of thinking and liat interferes with daily behavioral disturbances). Int 72's Minimum Data Set zed assessment and care did 12/19/18, indicated the tively impaired, unable to make ing and required extensive rming activities of daily. I tour of the facility Resident 50 in his bed, watching to 50's gastrostomy tube serted through the abdomen on directly to the stomach), deliver the nutrition) was a centimeter (cc) per hour (hr) (formula). During the lid Resident 50 there was a the top covering the pitcher. In, during an interview and ent 50 was in his room sitting watching television. Resident was on the bedside table an interview when Resident drank liquids stated, "I only me round enough to see me and offers me drinks unless when sty now. I want something to	*	iV. Hy wi by QA an	Monitoring: rdration monitoring II be reported and discuss the DSD during the mont AA meeting for trending d sustaining compliance r 3 months.			
	was originally adm and re-admitted to	dmlssion record, Resident 50 litted to the facility on 6/8/18, with facility on 8/24/18, with fuded Parkinson's disease (a						

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		555677	B. WING		the state of the s	01/0	06/2019
	PROVIDER OR SUPPLIER DRNE HEALTHCARE	& WELLNESS CENTRE, LP	· · · · · · · · · · · · · · · · · · ·	116	REET ADDRESS, CITY, STATE, ZIP CODE 530 SOUTH GREVILLEA AVE. WTHORNE, CA 90250	<u></u>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 692	uncontrollable shake and standing problemuscle weakness, swallowing), oral properties of Resider month of January 2 Diabetic Source at PM to 10 AM) to de 2160 calories in 24 flush with 200 cc of 50's re-cap order a finely chopped grote a one to one feede On 1/6/19 at 1 PM, certified nursing as water to drink when the ADL sheet on pmuch fluids Reside	s movement, often causing sing and tremors, with balance ems and stiffness of the limbs), dysphagia (difficulty nase, and G-tube placement. Int 50's re-cap ordered for the 2019, indicated to receive 90 cc/hr for 20 hrs (to run at 2 eliver 1800 cc which equals hours. The order indicated to f water every 8 hours. Resident Iso indicated mechanically soft und meat and thin liquids, and		592			
	on 1/6/19 at 2:24 P them water every h under percentage i percentage, Reside we usually get a st observation Reside his bed side table, and no straw on the asked how much fill 50 drink per shift, (cause they use per can monitor the ac-	tion and interview with CNA 2 M, stated, "I offer water to nour. I document it in the chart in the chart just the ent 50 can not drink by himself raw for him to drink." During ent 50's water pitcher was on filled with water with the top on e table or in the room. When find in ounces does Resident CNA 2 stated he did not know reentage system and no one tual amount of fluids.					

		E & MEDICAID SERVICES				OMB NO	<u>0.0938-039 </u>
STATEMENT AND PLAN C	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
	• .	555677	B. WING			04	10012040
NAME OF F	ROMDER OR SUPPLIER	4		STR	EET ADDRESS, CITY, STATE, ZIP COD		/06/2019
HAWTHO	RNE HEALTHCARE	& WELLNESS CENTRE, LP			30 SOUTH GREVILLEA AVE. WTHORNE, CA 90250		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(AX) COHPLETIO CATE
F 692	Continued From pa	age 26 t 2:55 PM., was asked how the	F' 8	392		:	
	facility knows how receiving on a daily	much fluid Resident 50 was / basis, stated the CNA's ctivities of dally Living sheet.				:	
	at 3:00 pm indicate not show the amou	L sheet with the DON on 1/6/19 and percentage per shift but did unt of fluid consumed by DON stated while reviewing					,
	how much fluids th	DL sheet, she could not lell te residents were receiving and me up with a more accurate	i i				
·	titled "Nutritional S revised June 2018 meet weekly, but r to identify resident swallowing proble diet.modification a benefit from adap	ellity's policy and procedure tatus Evaluation Committee" indicated the committee will must meet no less than monthly is with dysphasia (difficulty ms) for proper interventions and identify residents that tive devices, development of programs and utilizing adaptive it and positioning.					
	how staff monitor accurately per shi eliminate risks for	•					
	Physician Visits-F CFR(s): 483.30(c	requency/Timeliness/Alt NPP)(1)-(4)) F	712	F-712		
	§483.30(c)(1) The physician at least	ency of physician visits " a residents must be seen by a once every 30 days for the firs nission, and at least once every			I. Corrective Action/s: Resident 174 was seen and examined by MD on 1/5/19.		-

l .	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUFF, ER/CLIA IDENT/FICATION NUMBER	(X2) MUL A. BUILD	TIPLE CONSTRUCTION		DATE SURVEY COMPLETED	
		555677	B. WING			01/06/2019	
	PROVIDER OR SUPPLIER DRNE HEALTHCARE	& WELLNESS CENTRE, LP		STREET ADDRESS, CITY, 11630 SOUTH GREVILL HAWTHORNE, CA 9	, STATE, ZIP CODE LEA AVE.		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICENCES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFOR (ATION)	ID PREFI TAG	(EACH CORRECT CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE	
F 712	timely if it occurs not date the visit was result was r	ysician visit is considered of later than 10 days after the equired. But as provided in paragraphs is section, all required physician personally. But as provided in paragraphs is section, all required physician e by the physician personally. But as a provided in paragraphs is section, all required physician is personal visits by the physician is sician assistant, nutsectal nurse specialist in a rangraph (e) of this section. But is not met as evidenced and medical director (MD) conduct a face to face in prehensive assessment of the ission, in a timely mander for it residents (174) who was the facility. The facility also be MD obtained their formed psychotropic (medication that notions, and behavior) to administering them to tice had the potential of failure tress Resident 174's medical rins, and provided the russ, consent and continue	F 7	12			
	Findings:		i				
						1	1

CTATCHEN		E G MEDIO/ND DEI/MOLD				IVID IVO.	0900-00
AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		555677	B. WING	·		01/0	06/2019
NAME OF	PROVIDER OR SUPPLIER		L	57	TREET ADDRESS, CITY, STATE, ZIP CODE	0 111	7012010
				1	1630 SOUTH GREVILLEA AVE.		
HAWIH	DRNE HEALTHCARE	& WELLNESS CENTRE, LP		1	AWTHORNE, CA 90250		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)) BE	(X5) COMPLETION DATE
F 712	Continued From pa	nao 20	_	740			
1 / 12	1		} F	712	of the Augustic Other Book	o mitos	
		ords indicated Resident 174	ļ	1	II. How to Identify Other Resid		}
		e facility on 12/31/18 with		i	A physician visit review was do		-
		red to depression (low mood),	ļ	-	by the Medical Records Assista		}
	anxiety (nervousne	so) and post all.	l.	Ì	from 1/1/19 to 1/5/19. No other	er	
	The Minimum Data	Set (MDS), a standardized	! !		resident is affected by this prac	ctice.	}
		are screening tools, dated		Ì			
		esident 174 had no cognitive	1		III. Systemic Changes:		}
		nd, leam, remember, and	į	1	a. Administrator did an in-servi	ces to	ļ
	make decisions) in		}	ļ	Medical Record Staff on 1/22/1	19	}
	_				to assess that all residents will		
		v on 1/4/19 at 7:15 p.m.,	l	1	seen by their respective physic	ian	
		ed "I want to go back to Santa en here for one week."		İ	on a timely manner.		
		v on 1/5/19 at 12:30 p.m. the		 	b. Medical Records Director or		
		ssistant (MRA) stated Resident	1	1	Designee will conduct a Physici		ĺ
		ysician was out of town and the (ID) was aware to see the		(visit audit 1x/week. Findings fr		{
,		ed "no physician has seen the	1	Ì	audits will be brought up to the	e	
		81/18. On a concurrent record			Administrator during the morn	ing	
		d also three psychotropic			stand up meeting.		
		for Elavil (medication for nerve	}		,		
		on) 25 milligrams (mg),	}		IV. Monitoring:		
		ion for sleep) 15 mg and Ativan			Timeliness of Physician visit wi	ll be	
		trol anxiety) one (1) mg were			monitored by Medical Record		
	signed by the MD t	pecause the MD had obtained			Director or Designee		
	informed consent t	for the medications on 12/31/18					Ì
	the day the resider	nt was admitted to the facility.			and deficient practice will be		1
	During an internity				reported to Administrator.	1	!
		v on 1/5/19 at 12:45 p.m., the Supervisor (MR) stated the	}		Findings from these adults will	ı	
		text MR the MD will be in on			also be discussed during the		-
		It Resident 174. On a			Monthly QAA meeting for		
		review MR stated the hand			trending and any need of		
		med consents for Dalmane,			further education and disciplin	nary	
		ras the director of nurses	1		actions with staff to sustain		1
	(DON).		Ì		compliance for 3 months.		}

CT-75:-	OF DESIGNATION OF THE PERSON O	G WEDICAID SERVICES	T				0930-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		555677	B. WING	S		01/0	6/2019
	PROVIDER OR SUPPLIER DRNE HEALTHCARE	& WELLNESS CENTRE, LP		1.	TREET ADDRESS, CITY, STATE, ZIP CODE 1630 SOUTH GREVILLEA AVE. HAWTHORNE, CA 90250		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAC		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDER CROSS-REFERENCED TO THE A	DBE	(X5) COMPLETION DATE
F 712	Resident 174 states has come here to s phone and no doctor During an interview	on 1/5/19 at 1:00 p.m., d "to think about it, no doctor see me. When I fell, lost my or spoke to me on phone."	F	712			
	Resident 174, MD time to see the resident facility faxes paper	e MD's first time to visit stated "I am sure it is my first ident." The MD stated the sall the time and "I may have n." The MD stated "I will look					
	registered nurse (R an actual signature doctor had not bee consent can be ob- and documented c When any docume typed text message	on 1/5/19 at 1:51 p.m. RN 1) stated there was no way a can be on the forms if the in here to sign the forms. The tained face to face or on phone onsent obtained on phone, and was faxed in there will be a e indicating the date and sent. The occasionally it will a conginated from.					
	p.m., RN 3 stated	e interview on 1/5/19 at 2:27 "I worked on 12/31/18 from p.m., and I don't remember if					
	p.m., RN 4 stated from 3:00 p.m. to No I never saw hir further stated "I co	ne interview on 1/5/19 at 2:50 "I was on duty on 12/31/18 11:00 p.m., and I know the MD. In come in that night. RN 4 Intacted the admitting physician In orders" for Resident 174.					
	DON verified the h	w on 1/6/19 at 2:34 p.m., the nand writing on the three s for Ativan, Dalmane, and Elav	il				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		NSTRUCTION	(X3) DA	E SURVEY
		555677	B. WING			01	/06/2019
	PROVIDER OR SUPPLIER ORNE HEALTHCARE	& WELLNESS CENTRE, LP		11630	ET ADDRESS, CITY, STATE, ZIP CODE SOUTH GREVILLEA AVE. THORNE, CA 90250		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	×	PROVIDER'S PLAN OF CDRREC (EACH CDRRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 712	signature got on Reconsent forms." According to the fa	ed "I don't know how the MD's esident 174's psychotropic cility's policy and procedures pervision of Resident Care	F 7	12			
F 726 SS=E	physician services medical history and within 5 days befor admission. Competent Nursing		F 7	26	F-726 I. Corrective Action/s: a. Resident #44 primary M was called on 1/4/19 by th		
	the appropriate cor provide nursing an resident safety and practicable physica well-being of each	ervices ave sufficient nursing staff with appetencies and skills sets to d related services to assure attain or maintain the highest al, mental, and psychosocial resident, as determined by ents and individual plans of care			RN Supervisor and made a of the missed dosage. Res was on put on 72 hour monitoring there were no negative outcomes upon nursing evaluation.	iware ident	
	and considering the diagnoses of the factordance with the at §483.70(e).	e number, acuity and acility's resident population in e facility assessment required			b. 1:1 in service was given by the DON to RN #1 in re to Resident #44 recapitula order on 1/22/19.	gards	
	licensed nurses ha and skill sets nece needs, as identifie	facility must ensure that ave the specific competencies ssary to care for residents' d through resident described in the plan of care.			c. 1:1 in-service was given LVN #1 and LVN #4 by the DON on 1/9/19 and 1/17/19 respectively		
	limited to assessing	viding care includes but is not ig, evaluating, planning and dent care plans and responding s.			to have Licensed Nurse is sufficient, competent, and skilled wh administering medication		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTE	NO FUR WEULARI	& MEDICAID SERVICES	, <u>.</u>		OM	B NO.	093 8- 039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION ((X3) DATE : COMPI	
		555677	B. WING	3		01/0	6/2019
NAME OF	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
LI AMETHI	DNE HENITHONDE	& WELLNESS CENTRE, LP		11	630 SOUTH GREVILLEA AVE.		
I ATT I II	DANE HEALI HUARE	a Wellness Centre, LP		H	AWTHORNE, CA 90250		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC, IDENTIFYING INFORMATION)	PREF	1X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCEO TO THE APPROPRI	3E	(X5) COMPLETIO DATE
					DEFICIENCY)		
F 726	Continued From pa	age 31	=	726			
		ency of nurse aides.	'	/ 20			
	The facility must en	nsure that nurse aides are able)	
	to demonstrate cor	npetency in skills and		Ì	d. 1:1 in service and	}	
	techniques necess	ary to care for residents'		i			
	needs, as identified			ļ	skills competency was given b	У	
		described in the plan of care.		ļ	the DON to RN #3 on	. [
		NT is not met as evidenced	}	į	1/22/19 to check Licensed		
	by:			1	Nurse is sufficient,		
	Based on interview	v and record review the facility	ļ ,•	1	competent, and skilled when		
	falled to ensure sur	fficient, competent and skilled			administering medications.		
		rovided when administering		1	deminister in 8 me and a second		
		of 18 sampled residents (44,	ļ		e. The DSD contacted and		
	16) to ensure safe	medication administration and	ļ	i		_	i
	prior employments	references were contacted	1	1	documented results of the two	U	
	and documented to	safeguard the residents by:			reference listed on LVN #1,		
	: 	- " - 1 - 1 - 1 - 1 - 1 - 1 - 1			LVN #3, LVN #4 on 1/22/19.		}
	a. Resident 44's re	ecapitulate (summarize)		1			
		edication that reduces	İ		and the second second		
		r was not transferred on to a stration record ([MAR] a report		}	II. How to Identify Other Reside	ents:	
		record of the medications		İ	A facility wide review of the		}
,		patient at a facility by health	1		MAR and medication		Ì
), and nursing staff	1	1	recapitulation were conducted	by	
		nedication without prior			the Director of Nursing and)
	verification against		1	i	Medical Records Director on		
	J		1	1	1/5/19. No other		
	b. Resident 16's n	nedication was administered	ŀ	1	resident is affected by this		
	when the resident	was lying flat in bed, increasing	i i		practice.		}
	the risks for aspira	tion (inhale into the lungs)	į		practice.		
	which can lead to a	aspiration pneumonia (lung	İ	į			
	Infection).		ļ	ļ	The DSD was given 1:1 in-service		
			ĺ		on 1/7/19 by the Administrator		
		listed on application for	j		with regards to the process		
		were contacted and results	1		of two-reference check prior		
		to hiring licensed vocational	1		employment.		
		and 4) to ensure the staff were			, ,	,	
	safe and compete	nt to care for the residents.					
	These deficient as	antinge regulted in number stoff					
	i i nese delicient pri	actices resulted in nursing staff	1				i

Jrn

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 01/18/2019 FORM APPROVED DMB NO. 0938-0391

CENTE	RS FOR MEDICARI	E & MEDICAID SERVICES		0		0938-039
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ľ	E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		555677	B. WING		01//	06/2019
NAME OF	PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	10/2010
LI AVACT LIA	TONE HEALTHOADE	9 MELL MESS SEATERS LD	1	1630 SOUTH GREVILLEA AVE.		
DAVITA	DRNE REALITICARE	& WELLNESS CENTRE, LP	ļ ļ	AWTHORNE, CA 90250		
(X4) ID PREFIX TAG	EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION;	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEPICIENCY)	BE	(X5) COMPLETION DATE
F 726	administer seven of 44 without the MAI in medication adminedication to Resince increasing the risk potential to expose	age 32 doses of Naproxen to Resident R increasing the risks of error inistrations, administer dent 16 while lying flat in bed s of aspiration pneumonia, at the residents and staff to viedge on how to safeguard the	F 726		ce PI)	
	for Resident 44 on vocational nurse (I 250 milligrams (mg LVN 1 was then of LVN 1 stated "I wil not transcribed on record (MAR) and 11/30/18." On furth bubble packs for a naproxen missing through 1/4/19. LV no other MAR with sure it is not trans "when a bubble paindicated medication current intervies tated the medical transcribing medic LVN 1 stated regis recapitulates physical states of the pay observed transcribing MAR from the pay	ion administration observation 1/4/19 at 6:53 p.m. licensed LVN 1) dispensed Naproxen g) 1 tab oral (PO, by mouth). Diserved to stop and hesitate. I clarify with the book. It was the medication administration the medication was ordered on the medication Naproxen the medication Naproxen the medication Naproxen the medication Naproxen the medication Naproxen the medication Naproxen the medication Naproxen the medication Naproxen the medication Naproxen the medication Naproxen the medication Naproxen the medication Naproxen the indicated from MAR dated 12/29/18 IN 1 verified and stated "there is no Naproxen transcribed. I am the proxen transcribed. I am the proxen transcribed open it to no was administered." During a the director of nurses (DON) I records was responsible for the transcribed orders onto the MAR, therefore the market of the market orders onto the MAR, therefore the market order on a new visician order document. LVN 1 MAR Naproxen was scheduled		revisited and reinstated by the QAPI Committee on 1/9/16 and currently on going. c. Recap Nurse will include verification of orders from chart to MAR during Recap more on the last and first day of the result of the last and first day of the result of the indicate completion of two reference check. e. Medical Records Director or Designee will conduct a MAR audit 1x/week x 3 months. Findings from the audits will be given to the Director of Nursing and Administrator for follow through and completion.	nthly month.	

for 9:00 a.m. and 5:00 p.m.

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(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555677 WELLNESS CENTRE, LP TEMENT OF OEFICIENCIES MUST BE PRECEDED BY FULL	A BUILDING B. WING S	E CONSTRUCTION TREET ADDRESS, CITY, STATE, ZIP CODE	(X3) DATE S COMPLE 01/06	ETEO
WELLINESS CENTRE, LP	S* 11	TREET ADDRESS, CITY, STATE, ZIP CODE	01/06	
TEMENT OF DEFICIENCIES	11	TREET ADDRESS, CITY, STATE, ZIP CODE		/2019
	l H	1630 SOUTH GREVILLEA AVE. AWTHORNE, CA 90250		
SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	DBE C	(X5) COMPLETION DATE
ge 33 observation with the DON on the facility's information board surance performance [I] a system whereby a facility possess involved in health is ident quality of life) in reconciliation as a concern, failed to recapitulate Resident proxen from 1/1/19 till 1/4/19, in a concern, failed to recapitulate Resident proxen from 1/1/19 till 1/4/19, in a concern, failed to recapitulate Resident proxen from 1/1/19 till 1/4/19, in a concern, failed to recapitulate Resident and missed to the concern from 1/1/19 at 9:29 a.m. Note 1/6/19 at 9:29 a.m. Note 1/6/19 at 9:30 a.m.		DON. Findings from these aduits will also be discus during the Monthly QAA meet for trending and any need of further education with staff to sustain compliance x 3 months. A reference check log will be maintained by the DSD at the office for reference. Any issue presented during the Monthly Committee meeting by the	sed ing s. DSD s will be	
	ge 33 observation with the DON on the facility's information board surance performance [7] a system whereby a facility beesses involved in health isident quality of life) in reconciliation as a concern, failed to recapitulate Resident proxen from 1/1/19 till 1/4/19, are currently working on lation." on 1/6/19 at 9:29 a.m. N 1) stated he was apitulation and missed to non to Resident 44's MAR for are stated there was potential and Resident 44 subjected to be not on Resident 44 subjected to be not stated there was no MAR. RN and nurses have one hour administer scheduled to medication pass times were at medication pass times were at medication pass times were at medication pass times were for the further stated "I know the oxen and I know it is wrong in the MAR and administered I LVN 4 stated the five rights to stration included the right, right dose, right time and right is the MAR to ensure all strent.	ge 33 Observation with the DON on the facility's information board surance performance ell a system whereby a facility beesses involved in health sident quality of life) in reconciliation as a concern, failed to recapitulate Resident proxen from 1/1/19 till 1/4/19, et are currently working on lation." On 1/6/19 at 9:29 a.m. N 1) stated he was apitulation and missed to non to Resident 44's MAR for ear stated there was potential and Resident 44 subjected to be nown if there was no MAR. RN and nurses have one hour administer scheduled to medication pass times were at, 11:30 a.m., 5:00 p.m., and for 1/6/19 at 9:30 a.m. LVN 4 tered Naproxen twice to a further stated "I know the oxen and I know it is wrong in the MAR and administered I LVN 4 stated the five rights to stration included the right, right dose, right time and right is sed nurse must reconcile st the MAR to ensure all irrent.	MUST BE PRECEDED BY PULL TAG GEACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROV DEFICIENCY) IV. Monitoring: Completion of the MAR audit form will be monitored be DON. Findings from these aduits will also be discus during the Monthly QAA meet for trending and any need of further education with staff to sustain compliance x 3 months and Resident 44's MAR for are stated there was potential and Resident 44 subjected to consect nurse must not ions if there was no MAR. RN identication pass times were a., 11:30 a.m., 5:00 p.m., and To no 1/6/19 at 9:30 a.m. LVN 4 tered Naproxen twice to further stated "I know the oxen and I know it is wrong in the MAR and administered I LVN 4 stated the five rights to stration included the right rag IV. Monitoring: Completion of the MAR audit form will be monitored b DON. Findings from these aduits will also be discus during the Monthly QAA meet for trending and any need of further education with staff to sustain compliance x 3 months of fice for reference. Any issue presented during the Monthly Committee meeting by the DSD for discussion, tracking a trending for 3 months.	MUST BE PRECEDED BY PULL TAG ge 33 ge 33 ge 33 ge 33 ge 33 ge 34 ge 35 ge 36 ge 37 ge 37 ge 38 ge 38 ge 38 ge 38 ge 38 ge 38 ge 38 ge 39 ge 39 ge 39 ge 39 ge 39 ge 39 ge 39 ge 39 ge 39 ge 39 ge 30 ge 40

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		555677	B. WING			01/0	6/2019
. · –	PROVIDER OR SUPPLIER DRNE HEALTHCARE	& WELLNESS CENTRE, LP		11	TREET ADDRESS, CITY, STATE, ZIP CODE 1630 SOUTH GREVILLEA AVE. AWTHORNE, CA 90250		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 726	1/1/2012 indicated the drug, time adminame with each mane with each mane and Medication Administration observed mixing Control stomach administered it to poserved in supine the head of bed (Head to Hobbert and the Hobbert	Administration" revised the licensed nurse will chart inistered and initial his/her edication administration and title on each page of the stration Record (MAR). It is not pass observation on 1/5/19 stered Nurse (RN 3) was omeprazole DR (medication to oldity) in apple sauce and Resident 16. Resident 16 was a (lay on the back) position with 10B) flat. RN 1 failed to raise diministering the medication. It won 1/06/19 at 1:40 p.m. the velopment (DSD) stated a tensure, the resident was able and it the resident up to at least vent aspiration (inhale into the ead to aspiration pneumonia	F	726			
	review on 1/6/19 a	ssed employee file record at 10:48 a.m., the director of (DSD) verified and stated the					
	1. LVN 1's date of	hire (DOH) was on 7/11/12.					
1	2. LVN 3 DOH wa	s on 5/22/18.					
	3. LVN 4 DOH wa	s on 1/17/18.					
	documentation to references were	ledged there was no show LVN 1, 3 and 4 work contacted prior to hire. The DSD m supposed to document on the					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	[' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		555677	B. WING		01/06/2019
	PROVIDER OR SUPPLIER DRNE HEALTHCARE	& WELLNESS CENTRE, LP	11	REET ADDRESS, CITY, STATE, ZIP CODE 630 SOUTH GREVILLEA AVE. AWTHORNE, CA 90250	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 726	potential employee references paint a employee work per reference check was before the hire. DS assist the facility to employee was fit for not documented it background search complete and that abuse or violent his further stated "If the violence we do not we work with elder vulnerable and sor According to the fatilied "Abuse, Prev Program" indicated background check The facility obtains from previous or c	age 35 ation form when I speak to references." The DSD stated picture of the potential formance and attitude, and as supposed to be completed D stated reference checks will determine If a potential or hire. The DSD stated "when is not done." The DSD stated it was important to rule out story in the past. The DSD ere is any report on abuse or recommend hiring because ly population who are ne of them can't speak up." collity's policy and procedures ention, Screening, and Training of the facility conducts criminal as of applicants prior to hire. In at least two reference checks urrent employees of applicants	F 726		
F 755 SS=E	S483.45 (a) §483.45 Pharmacy The facility must p drugs and biologic them under an agr §483.70(g). The f personnel to admi permits, but only to a licensed nurse. §483.45(a) Proces			F-755 I. Corrective Action/s: a. Resident #44 primary MD was called on 1/4/19 by the RN Supervisor and made awa of the missed dosage. Reside was on put on 72 hour monitoring there were no negative outcomes upon nursing evaluation.	ì

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				MB NO.	0938-0391
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	•		E CONSTRUCTION	(X3) DATE	
	• . 	555677	B. WING			01/0	6/2019
NAME OF	PROVIDER OR SUPPLIER	·		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HAWTHO	ORNE HEALTHCARE	& WELLNESS CENTRE, LP		1	1630 SOUTH GREVILLEA AVE. HAWTHORNE, CA. 90250		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE !	(X5) COMPLETION DATE
F 755	Continued From pa	nge 36	F.	755	h 1.1 in convice was given		
		rurate acquiring, receiving,	'	, 00	D. 1.1 111 0C1 1100 1100 B11 011		
		ministering of all drugs and			by the DON to RN #1 in regards to Resident #44 recapitulation	'	
		t the needs of each resident.			order on 1/22/19.		
		Consultation. The facility					
		tain the services of a licensed			c. 1:1 in-service was given to		
	pharmacist who-				LVN #1 and LVN #4 by the		
	 P400 45/5/4/ 0				DON on 1/9/19 and		
		ides consultation on all fision of pharmacy services in			1/17/19 respectively		
	the facility.	ision or pharmacy services in			for competency, and skills		
	1		!		when administering medication	ns.	
		blishes a system of records of tion of all controlled drugs in enable an accurate			d. 1:1 in service and skills competency was given by the DON to RN #3 on	у	
			İ		****	4	
		rmines that drug records are in			1/22/19 to check that License	u	
		ecount of all controlled drugs			nurse is sufficient, competent, and skilled when		
	This REQUIREME	periodically reconciled. NT is not met as evidenced			administering medications.		
	review, the facility sampled residents (Including procedu acquiring, receiving	tion, interview, and record falled to provide one of 18 (18), pharmaceutical services res that assure the accurate a, dispensing, and I drugs and biologicals) to meet			e. The DSD contacted and documented results of the two reference listed on LVN #1, LVN #3, LVN #4 on 1/22/19.	o O	
,	the needs.	. u.ugo unu biologibale/ to fileet			f. A recapitulation of orders in-service was given by the Me	adical	
	recapitulate (sumn Naproxen (to treat medication admini	o thoroughly and completely narize) a physician order for fever and pain) by utilizing the stration record ([MAR] a report record of the modications.			Records Consultant to the medical records director and assistant on 1/7/19.	<u>-</u> uicai	
	administered to a	record of the medications patient at a facility by health) before administering the			e		

PRINTED: 01/18/20 FORM APPROVI OMB NO. 0938-03

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G		TE SURVEY MPLETED
		555677	B. WING_		01	/06/2019
	PROVIDER OR SUPPLIER DRNE HEALTHCARE	& WELLNESS CENTRE, LP		STREET ADDRESS, CITY, STATE, ZIP CODE 11630 SOUTH GREVILLEA AVE. HAWTHORNE, CA 90250		
(X4) ID PREFIX TAG	EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETI DATE
F 755	The deficient practinot transcribed on licensed vocational 7 doses of Naproxe against the MAR. Findings: The Admission recreadmitted to the fadiagnoses not limit (stroke), abscess to sheath, failure to the maintain weight) of shortening and for other tissue, often	ord indicated Resident 44 was acility on 1/25/18 with ed to cerebrovascular accident to the right lower leg tendon and contracture (a condition hardening of muscles, tendons, en leading to deformity and the right knee and right ankle.	F 75	il. How to identify Other Real A facility wide review of the MAR and medication recapitulation were conducted the Director of Nursing and Medical Records Director of 1/5/19. No other resident is affected by this practice. The DSD was given 1:1 inson 1/7/19 by the Administr with regards to the process of two-reference check priemployment to check the sare safe and competent to care for the residents.	erted by n ervice ator or	
	assessment and ci 12/7/18 indicated in cognitive (ability to and make decision indicated the reside dependent on nurse (dressing, eating, a surface transfers). During medication 1/4/19 at 6:53 p.m. (LVN 1) dispensed 1 tab oral (PO, by observed to stop a clarify with the book MAR but the medication	a Set (MDS), a standardized are-screening tooi, dated Resident 44 had severe learn, understand, remember is) impairment. The same MDS ent was unable to walk and is ses for activities of daily living personal hygiene, toilet use and administration observation on licensed vocational nurse in Naproxen 250 milligrams (mg) mouth). LVN 1 was then and hesitate. LVN 1 stated "I will ok, it was not transcribed on the cation was ordered on ner observation Naproxen		III. Systemic Changes: a. Licensed Nurses in-service given by the DON on 1/22/to demonstrate competents skills and techniques necess to care for residents medicand needs. b. The facility's Quality Ass Performance Improvement on Medication Recapitulating revisited and reinstated by QAPI Committee on 1/9/16 currently on going.	ty in sary ations urance t (QAPI) fon was the	

bubble packs for a.m., and p.m., indicated

02:03:22 p.m. 01-18-2019

DEPARTM.	ENT O	F HEALT	HAN.	D HUMAN	SERVICES
CENTERS	FOR N	MEDICAR	E & 1	MEDICAID	SERVICES

STATEMENT OF DEFICIENCIES (I AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		555677	B. WING_		01/	06/2019	
	PROVIDER OR SUPPLIER DRNE HEALTHCARE	& WELLNESS CENTRE, LP		STREET ADDRESS, CITY, STATE, ZIP CODE 11630 SOUTH GREVILLEA AVE. HAWTHORNE, CA 90250		2012010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETI DATE	
F 755	LVN 1 verified and with Naproxen transcribed anywhole bubble pack has be medication was ad concurrent intervies stated the medical transcribing medical transcribing medical transcribing medical transcribing medical transcribing medical transcribing medical transcribing medical transcribing medicated on the Mark from the physical for 9:00 puring an observation of 9:17 a.m. the facilitation that quality assurated ([QAPI] a system vimprove processes delivery and reside medication reconcities facility failed to scheduled Naproxe	from 12/29/18 through 1/4/19. stated "there is no other MAR scribed. I am sure it is not ere." LVN 1 stated "when a een popped open it indicates ministered." During a w the director of nurses (DON) records was responsible for ation orders onto the MAR.	F 75	c. Recap Nurse will include verification of orders from chart to MAR during Recap ron the last and first day of the d. DSD will utilize an update to indicate completion of two reference check. e. Medical Records Director Designee will conduct a MA audit 1x/week x 3 months. Findings from the audits will be given to the Director of Nursing and Administrator for follow through and completion. IV. Monitoring: Completion of the MAR audit form will be monitored DON. Findings from these aduits will also be disc	d form or R		
	medication recapit Infection Preventio CFR(s): 483.80(a)	ulation." n & Control	F 88	during the Monthly QAA me for trending and any need of further education with staff sustain compliance x 3 mont	to		
	Infection prevention designed to providuce comfortable environments.	stablish and maintain an n and control program e a safe, sanitary and nment and to help prevent the ransmission of communicable		A reference check log will be maintained by the DSD at the office for reference. Any issurpresented during the Month Committee meeting by the DSD for discussion, tracking Trending x 3 months.	e DSD es will be ly QAA		

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

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	,			TE SURVEY MPLETED
	555677	B. WING _		01	/06/2019
SUMMARY ST. (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL		11630 SOUTH GREVILLEA AVE. HAWTHORNE, CA 90250 PROVIDER'S PLAN OF (EACH CORRECTIVE ACT	CORRECTION ON SHOULD BE	(XS) COMPLETIO DATE
3.80(a) Infection gram. Infection gram.	stabilish an infection prevention in (IPCP) that must include, at lowing elements: stem for preventing, identifying, ting, and controlling infections diseases for all residents, sitors, and other individuals under a contractual disponsible facility assessmenting to §483.70(e) and following standards; sen standards, policies, and program, which must include to reliance designed to Identify table diseases or legical contractions are presented to other sity; nom possible incidents of the ease or infections should be reassmission-based precautions revent spread of infections; isolation should be used for a but not ilmited to: uration of the isolation, e infectious agent or organism that the isolation should be the		F- 880 I. Corrective Action/s a. CNA #1 was given a 1:1 in-service by the I 1/5/19 in ensuring the the residents are bein provided a safe, sanit comfortable environn and preventing the development and trai of infection. b. A competency skills was done by the Nurs Consultant on 1/11/1 with TX #1 with regar facility's protocol and policy on Infection Co c. RN #3 was given a 1:1 in-service by the I 1/9/19 in checking th the residents are bein provided a safe, sanit comfortable environn and preventing the	control. CON on lat grant and secheck sing grant	
	SUMMARY STA (EACH DEFICIENC' REGULATORY OR L Intinued From pa (3.80(a) Infection gram. It facility must est (control program (inimum, the following services) (inimum, the following services) (inimum, the following services) (inimum, the following services) (inimum, the following services) (inimum)	SSS677 DER OR SUPPLIER E HEALTHCARE & WELLNESS CENTRE, LP SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Intinued From page 39 33.80(a) Infection prevention and control gram. Intinued From page 39 33.80(a) Infection prevention and control gram. Intinued From page 39 33.80(a) Infection prevention and control gram. Intinued From page 39 33.80(a) Infection prevention and control gram. Intinued From page 39 33.80(a) Infection prevention and control gram. Intinued From page 39 33.80(a) Infection prevention and control gram. Intinued From page 39 33.80(a) Infection prevention and control gram. Intinued From page 39 33.80(a) Infection prevention and control gram. Intinued From page 39 33.80(a) Infection prevention and control gram. Intinued From page 39 33.80(a) Infection preventing, identifying, orting, investigating, and controlling infections widing services under a contractual resident, include according to §483.70(e) and following epted national standards; 33.80(a) (2) Written standards, policies, and codures for the program, which must include, are not ilmited to: 33.80(a) (2) Written standards, policies, and codures for the program, which must include, are not ilmited to: 33.80(a) (2) Written standards, policies, and codures for the program, which must include, are not ilmited to: 33.80(a) (2) Written standards, policies, and codures for the program, which must include, are not ilmited to: 33.80(a) (2) Written standards, policies, and codures for the program, which must include, are not ilmited to other sons in the facility; When and to whom possible incidents of infections; When and how isolation should be used for a dent; including but not limited to: The type and duration of the isolation, bending upon the infectious agent or organism olived, and A requirement that the isolation should be the strestrictive possible for the resident under the umstances.	DERTIFICATION NUMBER: 555677 B. WING DER OR SUPPLIER E HEALTHCARE & WELLNESS CENTRE, LP SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Attituded From page 39 G. 80(a) Infection prevention and control gram. Infinity for information prevention and control gram. Infinity for information prevention and control program (IPCP) that must include, at altimum, the following elements: 3.80(a)(1) A system for preventing, identifying, porting, investigating, and controlling infections communicable diseases for all residents, for volunteers, visitors, and other individuals viding services under a contractual suggement based upon the facility assessment ducted according to §483.70(e) and following epted national standards; 3.80(a)(2) Written standards, policies, and cedures for the program, which must include, are not limited to: A system of surveillance designed to Identify sible communicable diseases or citions before they can spread to other sons in the facility; When and to whom possible incidents of municable disease or infections should be corted; Standard and transmission-based precautions are followed to prevent spread of infections; When and how isolation should be used for a dent; including but not limited to: The type and duration of the isolation, ending upon the infectious agent or organism olived, and A requirement that the isolation should be the strestrictive possible for the resident under the	DER OR SUPPLIER E HEALTHCARE & WELLNESS CENTRE, LP SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES (CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES (CACH DEFOCIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG F 880 F 880 I. Corrective Action/s a. CNA #1 was given a 1:1 in-service by the E 1/5/19 in ensuring the the residents are bein provided a safe, sanit comfortable diseases for all residents, rivolunteers, visitors, and other individuals widing services under a contractual ungement based upon the facility assessment ducted according to §483.70(e) and following epted national standards; 3.80(a)(2) Written standards, policies, and cedures for the program, which must include, are not limited to: system of surveillance designed to Identify sible communicable diseases or citions before they can spread to other sons in the facility; When and to whom possible incidents of trununicable disease or infections should be orted; When and tow whom possible incidents of trununicable disease or infections should be orted; When and how isolation should be used for a dent; including but not limited to: The type and duration of the isolation, tending upon the infectious agent or organism blved, and A requirement that the isolation should be the st restrictive possible for the resident under the	DER OR SUPPLIER E HEALTHCARE & WELLNESS CENTRE, LP SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFOLENCY MUST BE PRECEDED BY PILL REGULATORY OR LSC IDENTIFYING INFORMATION) Taking and control gram. S.3.80(a) Infection prevention and control gram. S.3.80(a) Infection prevention and control gram. S.3.80(a) (1) A system for preventing, identifying, ortining, investigating, and controlling infections communicable diseases for all residents, f, volunteers, visitors, and other individuals viding services under a contractual ingement based upon the facility assessment ducted according to \$483.70(e) and following epited national standards; 3.80(a)(2) Written standards, policies, and coedures for the program, which must include, are not limited to: system of surveillance designed to identify sible communicable diseases or citions before they can spread to other sons in the facility; When and to whom possible incidents of municable diseases or infections should be used for a dent; including but not limited to: The type and duration of the isolation, ending upon the infectious agent or organism blved, and A requirement that the isolation should be the it restrictive possible for the resident under the unstances.

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	LE CONSTRUCTION		TE SURVEY MPLETED
		555877	B. WING		01	/06/2019
	PROVIDER OR SUPPLIER ORNE HEALTHCARE	& WELLNESS CENTRE, LP		STREET ADDRESS, CITY, STATE, ZII 11630 SOUTH GREVILLEA AVE HAWTHORNE, CA 90250		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO TO DEFICIENCY	on should be heappropriate	COMPLETIC DATE
F 880	contact will transm (vi)The hand hygie by staff involved in §483.80(a)(4) A sylidentified under the corrective actions if \$483.80(e) Linens. Personnel must ha transport linens so infection. §483.80(f) Annual The facility will con IPCP and update to This REQUIREME by: Based on observative, the facility implemented stand preventions for two 35, 2). This deficient practical involves the standard preventions for two 35, 2).	ints or their food, if direct it the disease; and one procedures to be followed direct resident contact. stem for recording incidents of facility's IPCP and the taken by the facility. Indie, store, process, and as to prevent the spread of	F 880	II. How to Identify Oth DSD and Infection continuade facility rounds on 1/6/19. No other rewere affected from the III. Systemic Changes: a. Infection Control In was given to Nursing SDON and DSD on 1/22 with regards to facility's protocol and policy on Infection Corpractices during woun or patient treatment. b. DSD/Infection Contiviil do random Infection Rounds practices during procedure or patient to 2x/week. Findings will be discussed with the immediately during rowill be brought up dur Morning Clinical Meet	esident ese findings. Service taff by the /19 ntrol d procedure rol Nurse on Control ng wound creatment Staff involved unds and ring the	
		ntinent care observation for 05/19 at 9:14 a.m., Certified		IV. Monitoring: Monthly Infection Conwill be conducted by Infection Control Nurse/DSD. Findiscussed during the Monitorian Control Nurse/DSD.	nfection ndings will be Monthly QAA	
	Nurse Assistant (C urine soaked incor diaper into a ball, s	NA 1) took off the resident's atinent pad (diaper), rolled the set it on the foot of the bed, er, without changing gloves		Committee by DSD for tracking and trending		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	PLE CONSTRUCTION G		E SURVEY PLETED
		555677	B. WING _		01/	06/2019
	PROVIDER OR SUPPLIER	& WELLNESS CENTRE, LP		STREET ADDRESS, CITY, STATE, ZIP CODE 11630 SOUTH GREVILLEA AVE. HAWTHORNE, CA 90250		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETION DATE
F 880	1 was observed to top of the bedside On 01/06/19 at 10: interview Registers was out of the faci outing. During an interview Development (DSI stated the procedusing two wash ba another for soapy should wash their with the resident a after handling soile stated there was a dirty glove spreadi contaminate clean. A review of the fact Control" revised Japolicies and proce and sanitary environments admitted to the diagnoses not limituicer (wounds as in A review of the his	the dirty and clean diaper. CNA use one basin with water on table. 41 a.m., in an attempt to ad Nurse (RN 1) stated CNA 1 lity, to escort a resident activity with the Director of Staff D) on 1/06/19 at 11:39 a.m., are for incontinent care included sins, one for clean water and water. The DSD stated staff hands before and after contact and when they changed gloves ad pads or linens. The DSD apossibility of bacteria from a nig to other surface, which can surfaces. Allity's policy titled "Infection anuary 2012, indicated the dures are required for a safe poment. The cord indicated Resident 35 in a facility on 8/21/18 with ted to right and left foot arterial result of artery insufficiency). Attory and physical dated 8/23/18 it 35 had the capacity to	F 88	· · · · · · · · · · · · · · · · · · ·		
	a.m., treatment nu solution inside one	e observation on 1/6/19 at 11:21 irse (TX 1) poured saline e clear plastic cup. TX 1 wore a es, removed Resident 35's left	ļ			

DPH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
			555677	B. WING	S	01	/06/2019
		PROVIDER OR SUPPLIER DRNE HEALTHCARE	& WELLNESS CENTRE, LP	<u> </u>	STREET ADDRESS, CITY, STAT 11630 SOUTH GREVILLEA A HAWTHORNE, CA 90250	E, ZIP CODE VE.	
	(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	FIX (EACH CORRECTIVE CROSS-REFERENCED	OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETION DATE
	F 880	yellow stains. TX 1 dipped it in the sal stuck on the reside gloves. TX 1 chan and used the samplastic cup to clear wound. TX 1 remorgauze dressing stapicked up a clean saline solution and resident left foot with changed gloves, with same saline solution clean Resident 35 failed to discard the contamination. During an interview of should have changed of infessaline solution correct. The admission was admitted to the saline solution correct.	age 42 Ig that was stained with brown I picked up clean gauze and ine solution and wet a dressing ent left foot with the same ged the gloves, washed hands e saline solution in the clear in Resident 35's left inner ankle eved Resident 35's right foot ained with brown yellow stains, gauze and dipped it in the di wet a dressing stuck on the rith the same gloves. TX 1 evashed hands and used the on in the clear plastic cup to design solution with each whom 1/6/19 at 2:11 p.m., stated inged the saline solution after crevent cross contamination ction. Next time I will use two intainers during wound care." record indicated Resident 2 ine facility on 3/29/12 with ifed to diabetes (abnormal blood		880		
		bugar levels). During medication 1/5/19 at 6:55 a.m. administered insulabnormal blood susyinge and admir placed the same salcohol wipes, a wand returned the tRN 3 failed to clear	a administration observation on a registered nurse (RN 3) lin (medication to control ugar levels) into an insulin histered it to Resident 2. RN 3 syringe in a tray with unused that it is to be a tray with unused that is to be a tray inside the medication cart. In or sanitize the contaminated essure machine or discard the				

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

	FOF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	S	COMPLETED
		\$ 55677	B. WING		01/06/2019
	PROVIDER OR SUPPLIER DRNE HEALTHCARE	& WELLNESS CENTRE, LP		STREET ADDRESS, CITY, STATE, ZIP COD! 11530 SOUTH GREVILLEA AVE. HAWTHORNE, CA 90250	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE COMPLET
F 883	must develop policithat- (i) Before offering immunization, eac representative recibenefits and potentimunization; (ii) Each resident in immunization, unle medically contrained already been immunization, unle medically contrained immunization that the opportunity documentation that following: (A) That the resident side immunization; and potential side immunization; and (B) That the reside pneumococcal impunication or This REQUIREME by; Based on observative, the facility sampled residents either the influenzation, and sometimunication or the pneumococcal impunication or the pneumococcal im	umococcal disease. The facility sies and procedures to ensure the pneumococcal harmonic resident or the resident's elves education regarding the tial side effects of the soffered a pneumococcal ess the immunization is dicated or the resident has unized; the resident's representative to refuse immunization; and medical record includes at indicates, at a minimum, the ent or resident's representative eation regarding the benefits effects of pneumococcal ent either received the munization or did not receive immunization due to medical refusal. ENT is not met as evidenced eation, interview and record failed to ensure two of 18 (42, 224) were provided with a ([flu] a respiratory illness a viruses that infects the nose, mes the lungs) and/or the	F 88	III. Systemic Changes: a. 1:1 in-service was given to Infection Preventionist Nurse DSD by the DON on 1/15/19 regards to Influenza and Pneumococcal Immunizations to check that the medical record inclu documentation that will be secured at the residents chards. b. Medical Records Director of Designee will conduct a immunication audit 1x/week x 3 months. Findings from the audits will be given to the Director of Nursing for follow through and completion. IV. Monitoring: Completion of the immunization audits will be monitored by Medical Record Director or D and deficient practice will be reported to the Infection Pre Nurse. Findings from these aduits will also be discutduring the Monthly QAA meet for trending and any need of further education to sustain compliance for 3 months.	e and in des t. Or unization tion esignee ventionist t ussed eting

02:04:39 p.m. 01-18-2019

PRINTED: 01/18/2019 FORM APPROVED

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

DPH

OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY APLETED	
		555677	B. WING			01	/06/2019
	PRDVIDER OR SUPPLIER DRNE HEALTHCARE	& WELLNESS CENTRE, LP		116	REET ADDRESS, CITY, STATE, ZIP CODE 30 SOUTH GREVILLEA AVE. WTHORNE, CA 90250		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
. F 883	Continued From pa causing disease.	age 45	 F	883			
	Findings:						
	prevent communic Residents 42 and 2	view and review of ocess of receiving vaccines to able disease) records for 224 with Registered Nurse (RN 5 a.m., the records indicated					
		, the resident's immunization nd in the resident's medical					
	indicated the resid on 11/28/18 with distage renal diseas function) and deperatment to filte blood, when the kinormally), diabetes	ent 42's admission record ent was admitted to the facility lagnoses that included end e (advanced loss of kidney endence on renal hemodialysis er wastes and water from the dneys are no longer functioning mellitus type 2 (abnormal hypertension (high blood					
	a.m., stated he chemodialysis clinic any vaccines to Reinfluenza and pneimportant because immunocompromi	w with RN 1 on 1/06/19 at 10:08 ecked with the resident's and they had not administered esident 42. RN 1 stated both umococcal vaccines were the resident was sed (a person with weakened and was susceptible to the flu					
	b. During a review	of Resident 224, the resident's	S				

02:04:49 p.m. 01-18-2019

61 /65

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY APLETED
		555677	B. WING		01	/06/2019
	PROVIDER OR SUPPLIER DRNE HEALTHCARE	& WELLNESS CENTRE, LP		STREET ADDRESS, CITY, STATE, Z 11630 SOUTH GREVILLEA AVE. HAWTHORNE, CA 90250		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 883	the resident's medicated the resided indicated the resided on 2/15/12 and resided on 2/15/12 and resided indicated the resided on 2/15/12 and resided indicated the resided on 2/15/12 and resided in a constructive displays the state of the prostate (a composite of the prostate (a composite of the prostate of the prostate of the prostate of the prostate of the prostate of the prostate of the state of the flu and pneuto the flu and pneuto the flu and pneuto the flu and pneuto the flu and pneuto the flu and pneuto the flu and pneuto the flu and pneuto the flu and pneuto the flu and pneuto the flu and pneuto the flu and pneuto the flu and pneuto the flu and pneuto the flu and pneuto the flu and pneuto the flu and pneuto the flu and pneuto flu and pneu	cine record was not found in cal record (chart). Int 224's admission record ent was admitted to the facility admitted on 12/31/18 with uded atherosclerotic heart and narrowing of the llation (abnormal heart beat), pulmonary disease (a chronic disease that causes obstructed gs) and malignant neoplasm ancerous tumor, or abnormal with RN 1 on 1/06/19 at 10:08 filuenza and pneumococcal ortant because the resident ordised (a person with esystem) and was susceptible monia. Sease Control and Prevention gency that conducts and ormotion, prevention and inties in the United States) beople get a flu vaccine by the 18). Ility's policy titled sease Prevention" revised July the Advisory Committee tices (ACIP) of the CDC,		383		
	received pneumoc previous vaccination receive a dose of F conjugate vaccine	older who have not previously occal vaccine or whose on status is unknown should PCV 13 (pneumococcal , followed by a dose of coccal polysacharride vaccine)				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	S55677		B. WING		01/06/2019	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	·	
HAWTHO	ORNE HEALTHCARE	& WELLNESS CENTRE, LP	1	11630 SOUTH GREVILLEA AVE.		
				HAWTHORNE, CA 90250		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROV DEFICIENCY)	D BE	COMPLETION DATE
F 883	Continued From pa		F 883	3		
	six to 12 months la					
	925 Maintains Effective Pest Control Program		F 925	F- 925		
SS≐E	CFR(s): 483.90(l)(4	·)		I. Corrective Action/s:		
	§483.90(i)(4) Maint	ain an effective pest control		a. Resident 12, 17, 31, and		
	program so that the	facility is free of pests and		68 rooms were deep cleaned as	า d	
İ	rodents.			pest control company was calle		
•	this requirements	NT is not met as evidenced		and treated the rooms on 1/7/2	19.	
	Based on observat	ion, interview and record				
	review, the facility fa	alled to ensure an effective		b. Housekeeping #2 is no longe	r	
	measures to eradic	ate pests for four of 18		working at the facility.		
	southier resinguity ((12, 17, 58, 18) rooms.		c. Rooms 33, 25, 26, 27 and 28		
	The deficient practic	ce resulted in Resident 12, 17,		were deep cleaned on 1/7/19.		
i	58, and 18, not bein	ng provided with a homelike		Were deep creamed on 2,7,20.		
		there was live and dead nts, and dried material on the		II. How to Identify Other Resid	ents:	
}	floor that could hart			Maintenance Supervisor and		
				Administrator made facility rou	ınds	
į	Cladinan			on 1/6/19. No other residents	were	
÷	Findings:			affected from these findings.		
	at 9:40 a.m. Reside insects and roaches fly swatter to hit the the weather change Resident 31 stated. During an observati House Keeping (HK mop to clean Reside concurrent interview under bed A (Reside	ent council meeting at 1/5/19 ints 12 and 17 stated they saw s. Resident 17 state "I have a m." Resident 12 stated "when is we see them come out." "I've seen ants." on on 1/5/19 at 8:37 a.m. (2) was observed use a dust ent 17's room. During a v HK 2 stated "I did not clean ent 17) because he was old him I would be back."				

2133512756

PRINTED: 01/18/201

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

FORM APPROVE OMB NO. 0938-039

NAME OF PROVIDER OR SUPPLIER HAWTHORNE HEALTHCARE & WELLINESS CENTRE, LP (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE	NAME OF PROVIDER OR SUPPLIER			(X2) MULTIPLE CONSTRUCTION A BUILDING			COMPLETED	
NAME OF PROVIDER OR SUPPLIER HAWTHORNE HEALTHCARE & WELLNESS CENTRE, LP (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE			B. WING			01/06/2019		
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE			STREET ADDRESS, CITY, STATE, ZIP CODE 11630 SOUTH GREVILLEA AVE.					
DEFICIENCY)	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		HOULD BE	BE COMPLETE	
F 925 Continued From page 48 During an observation on 1/5/19 at 10:20 a.m. maintenance supervisor (MS) pulled out Resident 12's night stand from a comer and the director of nurses (DON). MS observed three live cockroaches, nest/egg like and dry tiny small materials on the floor. MS stated "we are not supposed to have roaches in the facility." Resident 12 was observed very upset shook his head and then stated "give my shoes. I want to get out of here. This is very upseting." The MS and the writer further observed several tiny dry particles under Resident 12's bed and benind head of bed on the floor. During an interview translated by MS on 1/5/19 at 10:42 a.m., HK 2 states "I am always assigned the resident (Resident 12). He likes for his bed area be cleaned a flar lunch and I move the over bed table, wheel chair, chest of drawers, raise the bed, I use a disinfectant." HX 2 further stated "I don't remember the last time I moved the bedside table and chest of drawers because it is heavy. I am supposed to ask for help." HX 2 stated "we do deep cleaning every month. It's not good for me to be around naches because of infection." HX 2 stated she was having trouble with Resident 12 and never reported to MS. During a concurrent interview the MS stated "we have a deep cleaning schedule but not a log to indicate that deep cleaning was completed." HX 2 further stated "I never went back to the clean the room," if she went back to lean Resident 12's room, HK 2 stated housekeeping must move tables and night stands when cleaning the residents' rooms. HK 2 further stated it was important to clean under the residents beds to prevent pests infestation and spread of diseases. b. During a withessed random residents room. Blike systemic Changes: a. Maintenance Supervisor will do random room and facility rounds 2x/week (M-F) to monitor and check a safe/ clean and home like environment to rother residents. b. Ambassador rounds vere revised to reflective pest control program. Department Managers will include monitoring a safe/ c		During an observat maintenance super 12's night stand fro nurses (DON), MS cockroaches, nest/materials on the flo supposed to have resident 12 was obtained and then state get out of here. This and the writer further particles under Resident of bed on the During an interview 10:42 a.m., HK 2 sidere a be cleaned affixed bed; I use a disinference be around roach table and chest of am supposed to as deep cleaning ever to be around roach stated she was have and never reported interview the MS stachedule but not a cleaning was compnever went back to clean stated housekeepir stands when cleanifurther stated it was residents beds to p spread of diseases	visor (MS) pulled out Resident m a comer and the director of observed three live egg like and dry tiny small for MS stated "we are not roaches in the facility." oserved very upset shook his ed "give my shoes. I want to se is very upsetting." The MS er observed several tiny dry sident 12's bed and behind floor. It translated by MS on 1/5/19 at tates "I am always assigned ent 12). He likes for his bed er lunch and I move the over rair, chest of drawers, raise the ctant." HK 2 further stated "I e tast time I moved the bedside drawers because it is heavy. I k for help." HK 2 stated "we do y month. It's not good for me es because of infection." HK 2 for help. "HK 2 further stated "I to MS. During a concurrent ated "we have a deep cleaning log to indicate that deep sleted." HK 2 further stated "I the clean the room," if she Resident 12's room, HK 2 arg must move tables and night ing the residents' rooms. HK 2 important to clean under the revent pests infestation and	F 92	a. Maintenance Supervisor random room and facility random room and facility random room and facility random room and facility random rounds clean and home like environment for the reside b. Ambassador rounds were to reflect that the facility ran effective pest control propartment Managers will monitoring a safe/ clean and homelike environment on rounds 5x/week (M-F). And will be discussed during the Stand Up meeting for following the Stand Up meeting for following the Administration of the facility maintains an effective pest control program. d. A deep cleaning schedulog was developed by the on 1/6/9 to measure, eract pests and to provide a hor	ents. The revised maintains rogram. I include and their room y issues through. To the include and their room y issues through. The to the include and facility licate		

		F DEFICIENCIES (X1) PROVIDER/SUPPLIER/GLIA CORRECTION UMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			
		555677	B. WING	B. WING			
	PROVIDER OR SUPPLIER ORNE HEALTHCARE	& WELLNESS CENTRE, LP		STREET ADDRESS, CITY, STATE, ZIP CO 11630 SOUTH GREVILLEA AVE. HAWTHORNE, CA 90250		<u>/06/2019</u>	
(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 CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	D BE COMPLE	
F 925	1. A live spider, spi white/gray dust like chest of drawers. 2. Rooms 33, 25, 2 material under the stands. c. During a tour of p.m., Resident 68 s cockroach problem seen small and me room on several oche had reported the but had received ar issue was being ad A review of Resider (MDS), a comprehe dated 12/30/18 indicognitive impairme and make daily decided Janitor (JR) insmultiple dead insection the resident housekeeper stated	9 at 11:00 a.m., the medical MRA) observed: der webs and a pile of material behind Resident 8 6, 27, 28 observed with dried bed and under the night the facility on 1/04/19 at 6:06 stated the facility had a . Resident 68 stated he had dium sized cockroaches in his casions. The resident stated a Issue to the charge nurses by feedback as to how the dressed. at 68's minimum data set ensive care and screening tool cated the resident had no not (ability to think, understand)	F 92		i deep I nonthly hrough as		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

02:05:33 p.m. 01-18-2019

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PRINTED: 01/18/2019 FORM APPROVED

CENTER	S FOR MEDICARE	& MEDICAID SERVICES				<u>MB NO. (</u>	938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555677			'		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		B. WING			01/06/2019			
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE			
HAWTHORNE HEALTHCARE & WELLNESS CENTRE, LP			11630 SOUTH GREVILLEA AVE. HAWTHORNE, CA 90250					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDERICIENCY)	DBE	(X5) COMPLETION DATE	
F 925	on 1/05/19 at 2:07 the Maintenance Si there was a pest co once a month and a and spiders but the their drawers and n MS stated the hous responsible for clea living areas. A review of the faci Rooms and Enviro 2012 indicated the residents a safe, cl environment.	oom 18. The Housekeeper	F	925				