P.O.C Accepted on 2.3.2023 By 46445

PRINTED: 01/27/2023
FORM APPROVED

California Department of Public Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 9200011 | A. BUILDING: _____ B. WING _____ | C 01/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOLDEN LEGACY CARE CENTER | 12260 FOOTHILL BLVD SYLMAR, CA 91342 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| C 000 | Initial Comments<br><br>The following reflects the findings of the California Department of Public Health during the investigations of state complaint and Facility Reported Incident (FRI).<br><br>Complaint Number: CA00817498<br><br>Facility Reported Incident Number: CA00817680<br><br>Representing the Department:<br><br>Health Facilities Evaluator Nurse: 46445<br><br>The inspection was limited to the specific state complaint and Facility Reported Incident investigated and does not represent the findings of a full inspection of the facility.<br><br>Two state deficiencies were identified for intake numbers CA00817498 and CA00817680. | C 000 | | |
| C4130 | T22 DIV5 CH3 ART5-72523(a) Patient Care Policies and Procedures<br><br>(a) Written patient care policies and procedures shall be established and implemented to ensure that patient related goals and facility objectives are achieved.<br><br>This Statute is not met as evidenced by:<br>Based on interview and record review, the facility failed to follow its policy and procedure on abuse to report an allegation of staff to resident abuse to the State Survey Agency (SSA) for one of the three sampled residents (Resident 1) within two hours. On 12/18/2022 at 5:45 p.m., Resident 1 got the X-ray (a type of radiation that can go through many solid substances, allowing hidden objects such as bones and organs in the body to | C4130 | | |

Licensing and Certification Division

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

admin 1/30/2

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| C4130 | Continued From page 1<br>through many solid substances, allowing hidden objects such as bones and organs in the body to be photographed) result which indicated a left knee fracture (a break or rapture in the bone) reported an allegation of abuse that a facility staff pushed Resident 1 off the bed and slammed into the floor. The facility reported it on 12/19/2022 at 5:01 p.m.<br><br>This deficient practice had the potential to result in unidentified abuse in the facility and failure to protect other residents from abuse.<br><br>Findings:<br><br>A review of Resident 1 ' s Admission Record indicated the facility admitted the resident on 8/18/2022 with diagnoses that included hemiplegia (paralysis of the muscles of the lower face, arm, and leg on one side of the body) and hemiparesis (weakness or the inability to move on one side of the body, making it hard to perform everyday activities like eating and dressing), osteoporosis (a decrease in the amount and thickness of bone tissue), and osteoarthritis (inflammation or swelling of one or more joints).<br><br>A review of Resident 1 ' s Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 11/25/2022, indicated the resident was moderately impaired in cognition (involving conscious intellectual activity such as thinking, reasoning, or remembering) skills for daily decision making. The MDS indicated Resident 1 required extensive assistance on bed mobility and total dependence on transfers, toilet use, and personal hygiene. | C4130 | | |

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| C4130 | Continued From page 2<br><br>A review of the nurse progress notes, dated 12/18/2022, indicated Resident 1 complained of left knee pain and swelling. An X-ray of the left knee was done with findings of impacted slightly displaced transverse fracture of the knee. The nurse progress notes indicated Resident 1 was informed of the results of the X-ray and Resident 1 reported a facility staff pushed Resident 1 off the bed and slammed into the floor but unable to recall the details.<br><br>During an interview on 1/11/2023 at 2:35 p.m., the Assistant Director of Nursing (ADON) defined a serious bodily injury as "any incident that may impact the resident which may have been caused by a fall or accident." The ADON stated that Resident 1 ' s injury is considered a serious bodily injury since there was a fracture. A concurrent record review of the nurses progress note, dated 12/18/2022 indicted that the facility was aware of the allegation of abuse.<br><br>A concurrent review of the facility ' s submitted State of California (SOC) 341 form (report of suspected dependent adult/elder abuse) indicated the facility called the SSA to report the allegation on 12/19/2022 at 5:01 p.m.<br><br>During an interview on 1/11/2023 at 3:05 p.m. with the Director of Nursing (DON), the DON stated that any abuse or allegation of abuse needs to be reported to the SSA within 2 hours of the knowledge of the incident per facility policy and procedure.<br><br>A review of the facility ' s policy and procedure titled, "Abuse and Neglect Prohibition Policy", dated 6/2022, indicated that upon receiving information concerning a report of suspected or alleged abuse, mistreatment, neglect, or | C4130 | | |

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| C4130 | Continued From page 3<br>exploitation the Administrator or designee will ... report immediately but not later than two hours if the alleged violation involves abuse or results in serious bodily injury. | C4130 | | |
| C6100 | T22 DIV5 CH3 ART6-72631(a) Signal Systems<br><br>(a) A nurses' signal system shall be maintained in operating order as required by Section E702-30 of Title 24.<br><br>This Statute is not met as evidenced by:<br>Surveyor: 46445<br>Based on observation, interview, and record review, the facility failed to provide reasonable accommodations for resident needs and preference to two of the three sampled residents (Resident 2 and Resident 3) by<br>a. failing to ensure a working call light is available for Resident 2.<br>b. failing to ensure the call light is within reach.<br><br>This deficient practice had the potential for harm to Residents 2 and 3 who are not able to call for help in case of emergency.<br><br>Findings:<br><br>a. A review of Resident 2 ' s Admission Record indicated that the facility admitted the resident on 12/7/2022 with diagnoses including cerebral infarction (result of disrupted blood flow to the brain due to problems with the blood vessels that supply it), chronic kidney disease (a condition in which the kidneys are damaged and cannot filter blood as well as they should), and hypertension (a condition in which the blood vessels have | C6100 | | |

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| C6100 | Continued From page 4<br>persistently raised pressure).<br><br>A review of Resident 2 ' s Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 12/14/2022, indicated the resident was severely impaired in cognition (involving conscious intellectual activity such as thinking, reasoning, or remembering) skills for daily decision making and required extensive assistance on Activities of Daily Living (ADL - the tasks of everyday life).<br><br>A review of Resident 2 ' s care plan, dated 12/14/2022, indicated the resident was at risk for falls. The care plan intervention indicated Resident 2 ' s call light is within reach and encourage the resident to use it for assistance as needed.<br><br>During an observation on 12/27/2022 at 8:50 a.m., Resident 2 was in bed without a call light button. The call light panel had a plug in it. A concurrent interview with Admission Personnel (AP) confirmed Resident 2 did not have a call light button. AP stated that Resident 2 would not be able to call for help and could fall.<br><br>During a concurrent observation and interview on 12/27/2022 at 8:55 a.m., Certified Nurse Assistant 1 (CNA 1) stated Resident 2 did not have a call light button. CNA 1 stated the importance of having a working call light was for residents to be able to get help when requested. CNA stated that without the call light, the residents can fall and have injury.<br><br>During an interview on 12/27/2022 at 8:59 a.m., the Assistant Maintenance Supervisor (AMS) stated that he removed Resident 2 ' s call light button because it was broken and placed a plug | C6100 | | |

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| C6100 | Continued From page 5 | C6100 | | |

on the panel so it will not ring in the station while he gets the replacement call light button. The AMS stated he was also fixing Resident 1 ' s TV and decided to fix the TV first before replacing Resident 2 ' s call light button. The AMS stated that providing a working call light was more important for resident safety.

During an interview on 1/11/2023 at 3:05 p.m., the Director of Nursing (DON) stated the call lights must be in working condition and within the resident ' s reach. The DON stated that residents would not be able to get help from the staff if the call light is not working or not within reach of the resident.

b. A review of Resident 3 ' s Admission Record indicated that the facility admitted the resident on 1/7/2022 with diagnoses including gastro-esophageal reflux disease (occurs when stomach acid repeatedly flows back into the tube connecting the mouth and stomach), hypertension, and dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities).

A review of Resident 3 ' s MDS, dated 11/30/2022, indicated the resident was severely impaired in cognition skills for daily decision making and required total dependence on ADLs.

A review of Resident 3 ' s care plan, dated 1/12/2022, indicated the resident was at risk for falls and/or injuries. The care plan intervention included the resident ' s call light within reach and encourage the resident to use it for assistance as needed.

During an observation on 12/27/2022 at 9:10 a.m., Resident 3 ' s call light button was found

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| C6100 | Continued From page 6<br>under Resident 1 ' s bed. A concurrent interview with CNA 1 stated that Resident 3 ' s call light button was under Resident 1 ' s bed and not within Resident 3 ' s reach. CNA 1 stated call lights are used by residents to call for help and to call staff in case of emergency. CNA 1 stated Resident 3 could potentially fall and have injury if the call light button is not accessible to the resident.<br><br>During an interview on 1/11/2023 at 3:05 p.m., the Director of Nursing (DON) stated the call lights must be in working condition and within the resident ' s reach. The DON stated that residents would not be able to get help from the staff if the call light is not working or not within reach of the resident.<br><br>A review of the facility ' s policy and procedure titled, "Answering Call Lights," dated 8/2017, indicated the purpose was to respond to the resident ' s requests and needs. It also indicated call lights are used to respond to needs at the time of use. The policy indicated that call lights are plugged at all times and the call light will be placed within easy reach of the resident. | C6100 | | |

**POC FOR CA 00817498, CA00817680**

DISCLAIMER STATEMENT
Golden Legacy Care Center - SNF makes its best effort to operate in substantial compliance with both Federal and State Law. Preparation and/or execution of this Plan of Correction, inclusive of all pages and attachment, does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because it is required by provisions of 42 CFR 483, et seq., and Health and Safety Code 1280. In response to the Department's findings we submit the following Plan of Correction which shall constitute Golden Legacy Care Center's credible allegation of compliance.

The facility has submitted this plan of correction in order to comply with its regulatory obligation under Title 18 and 19 and to meet the ten (10) days of survey condition mandate. Likewise, the facility does not waive any objections to the merits or form any allegations contained herein. Please note that the facility may contest the merit and/or form of any of the deficiency findings alleged below and may take reasonable steps to appeal them.

**C4130 T22 DIV5 CH3 ART5-72523(a) Patient Care Policies and Procedures**

**A. HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENT /S FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:**

1:1 In-service provided to the Registered Nurse on 12/27/2023 by the Assist Director of Nursing and the Director of Staff Development. The in-service also included a video presentation on types of abuse and including reporting within 2 hours after the allegation was made.

On 12/19/2022 at 5:01 pm the facility reported to the State Survey Agency (SSA).

Resident 1 was transferred to acute hospital on 12/18/2022 for further evaluation and treatment.

**B. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN:**

All residents have the potential to be affected by the deficient practice. Residents identified with allegations of abuse had all been reported to State Survey Agency (SSA).

On 10/08/2022, 12/27/2022, 01/03/2023, 01/04/2023,and 01/08/2023 the Director of Staff Development (DSD) provided in-service regarding facility's Abuse and Neglect Prohibition Policy indicating any alleged abuse must be immediately reported to supervisor, abuse coordinator, and other officials within 2 hours after the allegation was made.

On 12/06/2022, 01/11/2023 the Director of Nursing Services and/ or designee provided in-service regarding facility's Abuse and Neglect Prohibition Policy indicating any alleged abuse must be immediately reported to supervisor, abuse coordinator, and other officials within 2 hours after the allegation was made.

On 01/13/2023 and 01/16/2023 the Activity Director provided in-service to the designee's regarding facility's Abuse and Neglect Prohibition Policy indicating any alleged abuse must be immediately reported to supervisor, abuse coordinator, and other officials within 2 hours after the allegation was made.

**C. WHAT MEASURES WILL BE PUT IN PLACE OR WHAT SYSTEMIC CHANGES THE FACILITY WILL MAKE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR:**

The facility's abuse and neglect training program will be provided to all employees, through orientation and on-going sessions at a minimum of annually to include reporting of the alleged abuse within 2 hours to the SSA. The in-service also included telephone number of the three agencies such as the Department of Public Health, Police Station, and the office of the Ombudsman, and SOC 341 form located in the nursing station.

The facility Licensed Nurses and other staff during their rounds will identify any signs of abuse, mistreatment, neglect, involuntary seclusion, injuries of unknown origin, and misappropriation of property.

Any allegations that are identified will be reported to the abuse coordinator/ designee and the appropriate steps to protect residents will be implemented immediately including reporting alleged violation and investigation with in required time frames to SSA.

The allegations of abuse are discussed during the stand-up meeting to ensure corrective actions are sustained and immediate action and resolution will be attained.

The Activity Director or Designee will report any findings regarding abuse or alleged abuse during resident council to the abuse coordinator immediate action and resolution will be attained.

Completion date: Ongoing

**D. HOW THE FACILITY PLANS TO MONITOR ITS PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. FACILITY MUST DEVELOP A PLAN FOR ENSURING THE CORRECTION IS ACHIEVED AND SUSTAINED. PLAN IS TO IMPLEMENTED, CORRECTIVE ACTION EVALUATED FOR ITS EFFECTIVENESS. POC INTEGRATED INTO THE QA SYSTEM:**

The NHA or designee will monitor corrective actions regarding allegations of abuse and reporting through on-going process and ensure that allegations are reported timely. The NHA /Designee will ensure that any issues related to any alleged abuse response time are immediately corrected.

The Activity Director or Designee will report monthly of any findings during monthly resident council for 3 months and/ or on going until compliance is met.

The NHA or designee will report the results of monitoring to the Quality Assurance /Improvement Committee (QAPI) monthly for 3 months for review and recommendations.

The QAPI Committee will monitor the process until compliance is achieved.

**POC FOR CA 00817498, CA00817680**

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Golden Legacy Care Center - SNF makes its best effort to operate in substantial compliance with both Federal and State Law. Preparation and/or execution of this Plan of Correction, inclusive of all pages and attachment, does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because it is required by provisions of 42 CFR 483, et seq., and Health and Safety Code 1280. In response to the Department's findings we submit the following Plan of Correction which shall constitute Golden Legacy Care Center's credible allegation of compliance.

The facility has submitted this plan of correction in order to comply with its regulatory obligation under Title 18 and 19 and to meet the ten (10) days of survey condition mandate. Likewise, the facility does not waive any objections to the merits or form any allegations contained herein. Please note that the facility may contest the merit and/or form of any of the deficiency findings alleged below and may take reasonable steps to appeal them.

**C6100 T22 DIV5 ART6-72631(a) Signal Systems**

**A. HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENT /S FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:**

On 12/27/2022 the call light for Resident 2 was immediately replaced by the maintenance designee.

On 12/27/2022 the call light for Resident 3 was immediately placed within reach.

On 12/27/2022 Resident 2 and Resident 3 was provided care with no concerns at that time.

On 12/27/2022 1:1 in-Service was immediately provided by the DSD to the maintenance designee.

On 12/27/2022 1:1 in-service was immediately provided by the DSD to the assigned CNA to ensure call light is properly placed within reach of the resident after each ADL care.

On 12/27/2022 the Administrator immediately checked all rooms to ensure all call lights are working and within reach.

**B. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN:**

All residents have the potential to be affected by the deficient practice. On 12/27/2022, department managers conducted room rounds to ensure all residents' call lights were within reach and functioning. Maintenance supervisor checked the functionality of all call lights on 12/14/2022, 12/27/2022, 01/16/2023, and 01/31/2023.

Department managers will conduct weekly room rounds on assigned residents and complete an audit tool to follow up with alert residents regarding any call light issues and response time and any issues will be discussed in the daily stand-up meeting.

Department managers will conduct weekly room rounds on assigned residents and complete an audit tool to test call light response time for non alert residents and any issues will be discussed in the daily stand-up meeting.

Department managers during room rounds on assigned residents will immediately correct any findings.

The Activity Director and/or Designee will conduct monthly resident council meetings and as needed and discuss call light response time and any issues will be discussed in the stand-up meeting.

The Maintenance Supervisor and/or Designee will conduct twice a month call light system check and any findings will be discussed in the stand-up for immediate action and resolution.

On 10/11/2022, 12/27/22, 01/02/2023, 01/07/20233, and 01/11/2023 the DSD and/or Designee provided an in-service to staff regarding call light facility Policy and Procedure.

On 01/13/2023 and 01/16/2023 the Activity Director provided an in-service to staff regarding call light facility Policy and Procedure.

(completion date: on going)

**C. WHAT MEASURES WILL BE PUT IN PLACE OR WHAT SYSTEMIC CHANGES THE FACILITY WILL MAKE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR:**

Department managers will conduct weekly room rounds on assigned residents and complete an audit tool to follow up with alert residents regarding any call light issues and response time and any issues will be discussed in the daily stand-up meeting for any resolution.

Department managers will conduct weekly room rounds on assigned residents and complete an audit tool to test call light response time for non alert residents and any issues will be discussed in the daily stand-up meeting for any resolution.

The Activity Director and/or Designee will conduct monthly resident council meetings and as needed and discuss call light response time and any issues will be discussed in the stand-up meeting for any follow up resolution.
The NHA (Nursing Home Administrator) or designee will review room round audits to determine compliance.

The DON or the DSD will provide continued in-service training to all staff as needed based on the findings of the audits.

Completion date: Ongoing

D. **HOW THE FACILITY PLANS TO MONITOR ITS PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. FACILITY MUST DEVELOP A PLAN FOR ENSURING THE CORRECTION IS ACHIEVED AND SUSTAINED. PLAN IS TO IMPLEMENTED, CORRECTIVE ACTION EVALUATED FOR ITS EFFECTIVENESS. POC INTEGRATED INTO THE QA SYSTEM:**

The NHA or designee will monitor corrective actions through on-going compliance and results of weekly room rounds' audits completed by the department managers. The NHA /Designee will ensure that any issues related to call light response time are immediately corrected.

The NHA or designee will report the results of monitoring to the Quality Assurance /Improvement Committee (QAPI) monthly for 3 months for review and recommendations.

The QAPI Committee will monitor the process until compliance is achieved.