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9/13/21
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FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	556004	A. BUILDING _____ B. WING _____	C 01/01/2100

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

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F 000	INITIAL COMMENTS The Following reflects the findings of the Department of Public Health (DPH) duing the investigation of an complaint conducted on 04/27/16. Complaint number: CA00484109-Substantiated Representing the the Department:, HFEN 36333 The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility.	F 000		
F 309 SS=G	PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING CFR(s): 483.25 Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to develop a comprehensive plan of care to address the identified needs of Resident 1 regarding dysphasia and aspiration precautions. Resident 1 visited the General Acute Care Hospital (GACH) on two separate dates due to aspiration dated June 13, 2015, and April 7, 2016. This deficient practice placed resident at risk for	F 309	F309 Corrective Action: Resident 1 is no longer a resident in the facility. DON # 1, Staff member # 3, and LVN # 4 no longer an employee of the facility. Identification of other Residents that are potentially affected: DON and or designee conducted an observation on 9/7/2021 during medication pass related to all residents considered to be on aspiration risk and no other residents found to be affected by the deficient practice identified. Systemic Changes: DON and or designee provided in-service education to licensed staff on 9/8/2021 until 9/9/2021 regarding Medication Administration specific to the following focus area:	

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

ADMINISTRATOR 9/10/21

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 309	Continued From page 1 choking, that can lead to death. Findings: According to admission record, Resident 1 was admitted to the facility on August 28, 2014. Resident 1 is a 90-year-old female with a history of dysphasia (difficulty in swallowing) and placed on aspiration precaution. A review of the GI procedure report dated December 05, 2014, indicated Resident 1 had an endoscopy performed due to difficulty swallowing. The exam showed narrowing of the esophagus and possible stricture. The Medical Doctor placed Resident 1 on clear liquids and to advance as tolerated. A review of the Medical Administration Record (MAR) dated June 2015, indicated Resident 1 was on aspiration precautions every shift for high-risk aspiration the start date of the order was January 07, 2015. On April 27, 2016 at 10:45 A.M., during interview with Family Member 1 on June 13, 2015, stated the Licensed Vocational Nurse 4 (LVN) was new and did not crush medication. Nurse had been at facility for one day and 2nd day she was on her on. Family Member 1 stated Resident 1 was in the dining room asked resident was she ok, resident did not respond. Resident's jaws were puffy. I asked resident was something in her mouth, before the nurse came resident had a mouth full of water. The nurse massaged resident's throat	F 309	1. Crush Medication 2. Enteral Administrations 3. Aspiration Precautions 4. Comprehensive Care Planning (Attachment 1) DSD and or designee provided in-service education to CNA's on 9/8/2021 to 9/9/2021 regarding feeding and reporting any significant change of residents under the following: 1. Dysphagia Diets 2.Aspiration Precautions (Attachment 2) DON and or Designee provided in service education to MDS nurse on 9/9/2021 regarding comprehensive care planning to address the identified needs of residents under the following: 1. Dysphagia 2. Aspiration Precautions (Attachment 1) Pharmacy Nurse consultant will conduct Medication Administration observation review during scheduled monthly Monthly review x 3 months and as needed. Findings will be discussed to the DON and or designee for further follow up and interventions. DON or designee will conduct random observation during meal times and medication administration to identify residents at risk for aspiration or difficulty swallowing weekly and as needed x 3 months. Findings will be discussed during daily stand-up meeting Mondays to Fridays for review and follow up.	

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F 309	Continued From page 2 to try to get the medication to go down. The DON 1 (Director of Nursing) and Staff Member 1 came to dining room they kept trying to give water to Resident 1 and it would not go down. DON 1, Staff Member 1, and LVN 4 no longer work at the facility. Family Member 2 asked for transportation to the hospital for Resident 1. Resident was transferred to GACH by ambulance. Family Member 1 stated that the hospital gave the resident bread, and the pill finally went down. A Review of record from GACH dated June 13, 2015, indicated Resident 1 was brought in for impacted pill at RN home in esophagus. Was supposed to be crushed apparently was not. Serial exams and reassessments were performed during the resident Emergency Department (ER) visit. Resident 1 feels pill (vitamin C) may be stuck in her throat. States Resident 1 denies feeling like she is choking but does spit saliva intermittently, no obvious airway obstruction noted. Resident 1 tolerated bread and water without difficulty, resident speaking clearly with no signs of obstruction noted. Resident 1 was discharged back to Playa Del Rey Center the same day. Nurses note dated June 13, 2015, at P.M., written by LVN 4 stated that around 11 A.M. Resident 1 was sitting in dining room with sitting with Family Member 1. Asked Resident if she want to take medicine, resident refused. Medicine was not crushed, granddaughter did not mention anything about crushing the medicine. Stated Family Member 1 put the medicine to the	F 309	Monitoring: DON and or designee will discuss any trends of findings to the QAA committee meeting monthly x 3 months and re-evaluate thereafter for continued compliance. Completion Date: September 10, 2021	

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resident's mouth. No coughing was observed during and after the medication were taken.

A review of the Speech Therapy evaluation notes dated June 17, 2015, indicated communication impaired speech production intact. Risk for aspiration, risk for inadequate nutrition/hydration. Recommended supervision needed for all meals, reduce distractions, need verbal cues, upright position at least 30 min after meals, small sips and bites when eating, slow rate; Swallow between bites. Diet recommendations-solid=puree consistencies, liquids=thin liquids. Swallowing impaired.

Interview with Family Member 1 on April 27, 2016, at 10:45 A.M. regarding 2nd time Resident 1 was taken to GACH, stated on April 7, 2016, at around 10 A.M. I asked resident how was she. She (Resident 1) could not speak, then coughed and water came out. A CNA stated resident vomit earlier that morning. She was throwing up the food because it could not get down. LVN 5 came in resident's room trying to give water and juice, but it was not going down. I asked her not to give her anymore. RN 1 and the LVN 6 that gave my granny the medication came in. The staff went and got a suction and they were trying to do deep suction. Family Member 2 asked them not to do that. Resident stayed in the hospital 3 days. Two months ago she supposed to been getting a weight gain supplement, but today is the first day I have seen it here. Sometimes when I go to the dining room during meals, there's a lot of times I have had to go get staff to help other residents.

Family Member 1 stated that the GACH gave

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medication through IV (intravenous) she was allergic to that, so that was stress on her. The surgeon stated it could have been avoided if she was offered water. Showed a video of resident on the day of April 7, 2016. The video showed Resident 1 spitting out a mouth full of clear liquid. Her facial expression showed signs of distress.

Record review indicated on April 7, 2016, in the ER the resident received normal saline 500 milliliter (ml) IV bolus and glycogen 1 mg IV time s one dose. The patient then became red and had worsening dyspnea (shortness of breath). Resident was given albuterol and atrovent nebulizers times 1 dose and Benadryl 12.5 milligram (mg) IV times 1 dose with improvement of her symptoms.

A record review from the GACH dated April 7, 2016, post-operative diagnosis: Esophageal food impaction, esophageal stricture.
Operations performed: EGD (Esophagogastroduodenoscopy, also called by various other names, is a diagnostic endoscopic procedure that visualizes the upper part of the gastrointestinal tract up to the duodenum.) Foreign body removal, Balloon dilation.
Findings indicated Retained food/crushed pill, upper esophageal stricture dilated to 8 mm (millimeter). Narrowing at GE(gastroenterology) junction, large hiatal hernia (is the protrusion of the upper part of the stomach into the thorax through the esophageal hiatus because of a tear or weakness in the diaphragm).

During visit of the facility on April 27, 2016, could not find any documentation by LVN 6 regarding

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her findings and assessment of the resident.
During interview by telephone on May 5, 2016, at 8:40 A.M., DON 2 asked if she could remain with LVN 6 during the interview, explained to DON 2 need to interview LVN 6 privately and off Speakerphone.
LVN 6 stated its been over a month. I do not quite remember anything about that day. Gave A.M. medications at 8 A.M. medication crushed in applesauce. provided water before and after.
During interview with LVN 6, papers were heard shuffling and being very apprehensive with answering the questions kept pausing between answering the questions. LVN 6 was asked is anyone instructing her on what to say, she did not respond, but responded with I really do not remember much about that day.
LVN 6 was asked who found Resident 1, she stated she found her. State she checks on residents every 20 to 30 minutes while passing medications. Then I go every hour to check on residents. I went to check back on her and she had thick saliva. I was going to suction her but Family Member 2 denied it. Asked was Family Member 2 there, she stated no, she was on the phone.
Asked again so did you find Resident 1, she stated she found her and Family Member 1 was there. Then changed and said that Family Member 1 came and got her, and then stated again, I found resident. Then stated I really do not remember.
LVN 6 stated she gave medication before breakfast, she does not know who fed her.
Asked did you give medication on an empty stomach, she stated yes it was before breakfast.
Asked do you remember anything else LVN 6 stated that she notified RN 1 and he took over.

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Asked do she remember anything else regarding that day, she replied uh-uh, sorry.
LVN 6 stated she notified RN 1 and he took over. Stated she do not remember what time.
Interview with RN 1 on May 5, 2016 at 9:15 A.M., Stated he was in a clinical meeting between 9:45-10:45 on the day of April 7, 2016. He got a call from Family Member 2 stating resident was choking. There was a relative in the room, I believe her grandniece. Stated grandniece told him resident vomit. State breakfast is served at 7:30 am, but she is a slow eater. RN 1 saw food particles on the floor and on resident bib. Resident had puree pancakes that morning. I asked who was the CNA that fed her, he stated he could not remember, she is new been at facility for two to three months.

Progress note dated April 7, 2016 at 12:48 P.M., wrote by RN 1, Stated Resident observed with thick saliva coming out of mouth about 60 ml to 80 ml. Resident 1 in wheelchair and sitting upright. Resident is a 95-year-old African-American female with history of dysphasia. Resident is alert and oriented x 2 with episodes of confusion due to dementia. Respirations even and unlabored (not having difficulty breathing). Resident tolerated dysphasia puree diet and crushed medication this morning. Medical Director (MD) aware of situation. MD aware with order to transfer residents to General Acute Care Hospital (GACH) for further evaluation secondary to episodes of vomiting and difficulty swallowing.

April 27, 2016 Interviews:

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F 309	Continued From page 7 1:34 PM, RN 2 Stated residents with dysphasia we give applesauce. Some of the residents do not have it on the MAR. Only on the diet it states if they have dysphasia or hard to swallow. Some nurses will put do not crush on MAR. Asked if I were an agency nurse or new nurse and do not know resident what will I do since it is not on the MAR. RN 2 stated you just ask the supervisor or charge nurse. Check MAR, check pulse, and blood pressure. Give medication with applesauce slowly. Most of the time gives water after, but if not, we check the mouth to see if clear. 2:00 P.M., LVN 7 stated she started in October 2016. Stated if medications need to be crushed, it would be on the MAR or on the individual Medication. Residents have a Bee with honey above their bed, this means the residents liquid needs to be thicken. Doctors' order should have it. State she have seen it on the MAR where it is on one page or on each individual box will say crush all medications. 2:15 P.M., RN 1 stated we know about crushing med's by endorsement, kardex, or look at diet on activity of daily living there is a kardex. Crush only the ones that are crushable put in applesauce. Look if they swallowed. I give liquids if that is the order. I make sure nothing left in the mouth. 5:06 P.M., DON 1 stated if a resident is diagnosed with dysphasia call MD to get orders. Make sure we have a speech therapy order for residents. If residents come in with dysphasia or aspiration precaution, Nurses should know that medication should be crushed. Only license	F 309		

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F 309	Continued From page 8 nurses are able to give medication. Record Review: Dated April 20, 2016, on MAR order indicates all medications MUST BE CRUSHED upon administering to Resident 1 and placed in applesauce for easy swallowing related to dysphasia puree diet every shift for dysphasia. A care plan dated April 07, 2016, resident exhibits or at risk for impaired swallowing related to dysphasia. Care plan Dated April 20, 2016, and initiated on this day, stated Resident 1 displays some form of dysphasia from time to time. Goal: Resident 1 to be free of any complications to airway. Created on 04/20/2016 Target date: 04/14/2016. The is the only care plan that was available on my date of visit. The target date is dated before the initiation date. Inaccurate care plan.	F 309		