POC Accepted #19152 10-23-19

PRINTED: 09/20/2019
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
	555071	A. BUILDING _____ B. WING _____	C 09/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYVIEW CARE CENTER	2000 W WASHINGTON BL LOS ANGELES, CA 90018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the Department of Public Health (DPH) during the investigation of a complaint. Complaint number: CA00647187 Representing the DPH: HFEN #19152 The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility. Five deficiencies were issued for complaint #CA00647187	F 000	The signing of this plan of correction is not an admission or agreement by this facility of the truth of the facts alleged in this statement of deficiencies and plan of correction. In fact, this plan of correction is submitted exclusively to comply with state and federal law. This plan of correction serves as the allegation of compliance.	
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).	F 580	*F-580* **Corrective Action** Resident A discharged to acute general care on October 26, 2018, per attending physician order. Resident A is no longer a resident of Sunnyview Convalescent Center after his last discharge, 10/26/18.	10/08/19

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

[signature] Administrator 10/08/19

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 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).	F 580		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: PA 10/3/19

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F 580	Continued From page 1 (II) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (III) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility's nursing staff failed to ensure they notified the responsible party for one sampled resident (Resident A) when the resident had a change in condition (blisters to the resident's right inner knee). This deficient practice resulted in the responsible party (RP) not knowing the resident had a change in condition. Findings:	F 580	*F-580* **Corrective Action** Upon notification, thirty three current residents' charts with a change of condition were audited on 10/01/19, 09/27/19 & 09/11/19 by medical record to ensure primary physician and residents' representative were notified. Resident's representative and primary physician were notified when change of condition noted and documented in resident's clinical charts. **Identification of other residents and corrective actions** Thirty three current charts with change of condition audited by medical record to ensure medical doctor and resident's representative notified. No other residents were affected. Addendum ; copy of change of condition audit and in-service sheet attached. 10/03/19.	10/03/19

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F 580	Continued From page 2 A review of Resident A's Admission Record indicated the resident was readmitted to the facility on 9/26/18, with diagnoses including dysphagia (difficulty swallowing), malnutrition (a condition that results from eating a diet in which one or more nutrients are either not enough or are too much such that the diet causes health problems), dehydration (when there is too much water lost and not enough water taken in), a urinary tract infection ([UTI] an infection affecting part or all of the urinary tract), and a gastrostomy tube (a small tube surgically placed in the stomach thru which nutrition and medication are administered). A Multidisciplinary Progress Record, dated 10/21/18 at 10:30 a.m., indicated Resident A's was noted with small closed blisters to his right medial (inside) knee, and the physician was notified. There was no written documentation of the change of condition and the responsible party (RP) was notified. On 9/19/19 at 3:11 p.m. during a telephone interview, Licensed Vocational Nurse 1 (LVN 1) stated she was off on 10/21/18. On 10/22/18 the treatment orders were clarified and she did not notify the RP. An undated facility policy titled "Change of Condition" did not indicate to notify the resident's responsible party.	F 580	**Measures to prevent recurrence** The director of nursing provided in-service to fifteen license nurses on 09/25/2019 and fifteen licensed on 10/01/19 in regards to the importance of notifying resident and/or representative and physician on change of condition and involvement of family member in plan of care as well as documentation of discussion in residents chart. **Monitoring performance and integration into quality assurance system** Medical records/designee will audit charts with change of condition on weekly basis to ensure licensed are in compliance. Findings will be reported monthly times three to Q.A committee for further review.	
F 676 SS=E	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the	F 676	Addendum . copy of change of condition audit and in-service sheet attached. 10/03/19.	

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F 676	Continued From page 3 resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility's nursing staff failed to ensure 3 of 3 sampled residents (Resident B, C, D) with a	F 676	*F-676* **Corrective Action** Upon notification, C.N.A 1,2,&3 in serviced by director of staff development on 09/20/19 regarding the updated oral care policy (Oral Care on Gastrostomy Resident) on gastrostomy resident to prevent gum disease and tooth decay and to facilitate a clean and fresh mouth. Resident BC &D assessed by licensed to identify gum disease and there was no concern noted. **Identification of other residents and corrective actions** Director of staff developer observed ten random CNAs during oral care to reinsure proper oral care provided based on policy "Oral Care on Gastrostomy Resident". No other areas were affected. Addendum: additional in-service sheet. 10/03/19	10/03/19

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F 676	Continued From page 4 gastrostomy tube ([GT] a small tube surgically placed in the stomach thru which nutrition and medication are administered) received appropriate oral care. This deficient practice placed residents at risk for mal odorous oral cavities, infection and tooth build up. Findings: a. A review of Resident B's Admission Record indicated the was readmitted to the facility on 12/4/18, with diagnosis of dysphagia (difficulty swallowing) with a GT. On 918/19 at 2:25 p.m. CNA 1 was observed providing oral care to Resident B. CNA 1 used a Lemon Glycerin Swabsticks to clean the resident's mouth. On 9/18/19 at 2:30 p.m. during an interview, CNA 1 stated sometimes she use a toothette with mouth wash to clean the resident's mouth. b. A review of Resident C's Admission Records indicated he was readmitted to the facility on 7/18/18, with diagnosis of dysphagia with a GT. On 9/18/19 at 2:35 p.m. CNA 2 was observed providing oral care to Resident C. CNA 2 used a Lemon Glycerin swabsticks to clean the resident's mouth. On 9/18/19 at 2:40 p.m. during an Interview, CNA 2 stated she was instructed to use the Lemon Glycerin swabsticks to clean the resident's mouth. c. A review of Resident D's Admission Records indicated he was readmitted to the facility on	F 676	**Measures to prevent recurrence** The director of nursing provided in-service to fifteen certified nursing assistant on 09/25/2019 and director of staff development in serviced thirty one C.N.A. on 10/01-10/02 regarding proper way of performing oral care for residents with G-tube followed by policy of "Oral Care on Gastrostomy Resident". **Monitoring performance and integration into quality assurance system** CNA team leader will check daily to ensure CNAs' are in compliance and report findings to DSD. DSD will make a weekly visual oral care check and in service/reinforce CNAs as needed. Findings will be reported to Q.A committee monthly X3 months for further review. Addendum: additional in-service sheet. 10/03/19	

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F 676	Continued From page 5 9/6/19, with a diagnosis of dysphagia with a GT. On 9/18/19 at 2:45 p.m. CNA 3 was observed providing oral care to Resident D. CNA 1 used a Lemon Glycerin swabsticks to clean the resident's mouth. On 9/18/19 at 2:50 p.m. during an interview, CNA 3 stated sometimes he use a toothette with mouth wash to clean the residents mouth. Instructions for use of the Lemon Glycerin Swabsticks indicated they are use to refresh dry mouth and throat by providing a pleasant and refreshing citrus flavor. Swab freely about the mouth area. Residents may suck on swab head to obtain more citrus flavor. An undated facility policy titled "Oral Care on a Gastrostomy Resident", indicated to prevent gum disease and tooth decay and facilitate a clean and fresh mouth. Moisten the toothette, brush the teeth and gums with gentle pressure while moving in short horizontal or circular strokes, gently brush the teeth and the surface of the tongue for approximately 2 minutes, gently wipe inside the resident's mouth, rinse the resident's mouth with a damp toothette, lubricate the resident's mouth and lips with a lemon swab.	F 676	*F-684* **Corrective Action** Upon notification, director of staff development in-serviced/ demonstrated/return demonstration to C.N.As for residents B, C, and E &F in regards to proper repositioning including pressure reducing device/pillows to completely turn residents from off their back to buttocks every two hours and as needed. Treatment nurse assessed residents B, C, E, & F on 10/03/19 to ensure if any skin breakdown and there was no findings, see attached assessment sheet dated on 10/03/19.	10/03/19
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in	F 684	**Identification of other residents and corrective actions** Director of staff development made a random rounds daily to reinsure residents are properly repositioning Q2 hours or as needed. No other residents affected.	

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F 684	Continued From page 6 accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT Is not met as evidenced by: Based on observation, interview and record review the facility's nursing staff failed to ensure four out of six sampled residents (Residents B, C, E and F) were turned at least every two hours. This deficient practice placed the residents at risk for skin breakdown. Findings: a. A review of Resident B's Admission Record indicated the resident was readmitted to the facility on 12/4/18 with diagnoses including diabetes (a chronic condition associated with abnormally high levels of sugar in the blood) and dementia (progressive loss of mental ability). A Minimum Data Set (MDS) Assessment and Care Screening, dated 9/30/19, indicated Resident B's cognitive skills for daily decision-making were severely impaired and had a functional limitation in range of motion ([ROM] the distance and direction a joint can move to its full potential) to one of the upper extremities. On 9/19/19 at 11:55 a.m., Resident B was observed lying on his back, at 2 p.m., and 3:15 p.m., Resident B was observed with his torso (part of the body that extends from the neck to the groin), slightly turned to the left with his buttocks on the mattress. b. A review of Resident C's Admission Record indicated the resident was readmitted to the	F 684	**Measures to prevent recurrence** The director of nursing in-serviced fifteen certified nursing assistants on 09/25/2019 and director of staff development in-serviced thirty one C.N.As regarding the importance of proper repositioning including using pressure reducing device/pillows to completely turn residents from off their back to buttocks every two hours and as needed and reporting skin breakdown/change of condition immediately to charge nurses/supervisor. Addendum: correction made and additional information added on 10/03/19	

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F 684	Continued From page 7 facility on 7/18/19, with diagnoses including lack of coordination (the ability to use different parts of the body together smoothly and efficiently), generalized muscle weakness and dementia. A MDS Assessment and Care Screening, dated 7/2/19, indicated Resident C's cognitive skills for daily decision-making were severely impaired, totally dependent on the facility staff for bed mobility and had a functional limitation in range of motion ([ROM]) to upper and lower extremities. On 9/19/19 at 11:55 a.m., 2 p.m., and 3:15 p.m., Resident C was observed lying on his back. c. A Review of Resident E's Admission Record indicated the resident was readmitted to the facility on 8/23/19 with diagnoses of generalized muscle weakness, lack of coordination (the ability to use different parts of the body together smoothly and efficiently, and dementia (a loss of brain functioning [memory, thinking, language, judgment, and behavior]). A MDS Assessment and Care Screening, dated 8/30/19, indicated Resident E cognitive skills for daily decision-making were severely impairment and required extensive assistance for bed mobility. On 9/17/19 at 11:55 a.m., 2 p.m., and 3:15 p.m., Resident E was observed lying on her back. d. A review of Resident F's Admission Record indicated the resident was readmitted to the facility on 7/1/19 with diagnoses of generalized muscle weakness, lack of coordination (the ability to use different parts of the body together smoothly and efficiently, and dementia (a loss of	F 684	**Monitoring performance and integration into quality assurance system** Director of staff development/ supervisor will make daily random room visit to ensure residents reposition properly at least every two hour and as needed. Findings will be reported to Q.A committee monthly X3 months for further review. Addendum: correction made and additional information added on 10/03/19	

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F 684	Continued From page 8 brain functioning [memory, thinking, language, judgment, and behavior]). A MDS Assessment, dated 8/4/19, indicated Resident F cognitive skills for daily decision-making were severely impairment and required extensive assistance for bed mobility. On 9/19/19 at 11:55 a.m., 2 p.m., and 3:15 p.m., Resident F was observed lying on her back. On 9/19/19 at 3 p.m., during an interview, the Director of Nursing (DON) stated resident's should be turned at least every two hours. On 9/19/18 at 4:16 p.m., during an interview, the Director of Staff Development (DSD) stated she in-service with demonstration to staff on repositioning resident off their buttocks using extra pillows as necessary to keep the residents off their back.	F 684	*F-690* **Corrective Action** Upon notification, resident A chart was reviewed for accurate intake and output. Resident A was voided 2-3 times per shift during observation period, per record and no bladder distention, or c/o pain noted. **Identification of other residents and corrective actions** Licensed designee reviewed two of current residents' charts with G-tube on 10 /01/19 to ensure the fluid intake and output correctly recorded. No other issues were noted and no other residents were affected. Addundum: correction made and in-service dated 10/01,10/02 & I/O audit copies attached.	10/03/19
F 690 SS=E	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the	F 690		

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F 690	Continued From page 9 resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility's nursing staff failed to correctly document the fluid out put for one of four sampled residents (Resident A). This deficient practice placed the resident at risk for unrecognized fluid imbalance. Findings: A review of Resident A's Admission Record indicated the resident was readmitted to the facility on 9/26/18, with diagnoses including dysphagia (difficulty swallowing), malnutrition (a condition that results from eating a diet in which one or more nutrients are either not enough or are too much such that the diet causes health problems), dehydration (when there is too much water lost and not enough water taken in), a	F 690	**Measures to prevent recurrence** The nursing consultant in-serviced director of nursing on 10/01/19 regarding monitoring intake and output for G-tube residents for the first thirty days and frequency of change for G-tube/incontinent residents to be 2-3 times/as needed per shift; and when change noted including color & odor of output to be immediately notified to charge nurse/supervisor. Director of nursing in-serviced fifteen licensed nurses on 09/25/19 and 10/02/19 regarding policy of intake/output and importance of monitoring intake/output per shift for G-tube residents for the first thirty days and frequency of change 2-3 times per shift for G-tube/incontinent residents and properly documenting for pain, bladder distention. Addundum: correction made and in-service dated 10/01,10/02 & I/O audit copies attached.	

PRINTED: 09/20/2019
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OMB NO. 0938-0391

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F 690	Continued From page 9 resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility's nursing staff failed to correctly document the fluid out put for one of four sampled residents (Resident A). This deficient practice placed the resident at risk for unrecognized fluid imbalance. Findings: A review of Resident A's Admission Record indicated the resident was readmitted to the facility on 9/26/18, with diagnoses including dysphagia (difficulty swallowing), malnutrition (a condition that results from eating a diet in which one or more nutrients are either not enough or are too much such that the diet causes health problems), dehydration (when there is too much water lost and not enough water taken in), a	F 690	Measures to prevent recurrence Director of nursing and staff development in-serviced a total of thirty seven licensed and C.N.As on 10/16 and 10/17 in regards to monitoring the output incontinent resident with G-tube by looking lines on briefs such as 300cc showed 2 lines indicates light, 450cc showed 3 lines indicated moderate and 600cc showed 4 lines or more indicated heavy, approximately. The output will be monitored every shift by licensed nurse/designee. Addundum: 10/17/19, correction made and in-service dated on 10/16 & 10/17.	

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F 690	Continued From page 9 resident's clinical condition demonstrates that catheterization was necessary; (II) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (III) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility's nursing staff failed to correctly document the fluid out put for one of four sampled residents (Resident A). This deficient practice placed the resident at risk for unrecognized fluid imbalance. Findings: A review of Resident A's Admission Record indicated the resident was readmitted to the facility on 9/26/18, with diagnoses including dysphagia (difficulty swallowing), malnutrition (a condition that results from eating a diet in which one or more nutrients are either not enough or are too much such that the diet causes health problems), dehydration (when there is too much water lost and not enough water taken in), a	F 690	**Measures to prevent recurrence** The nursing consultant in-serviced director of nursing on 10/01/19 regarding monitoring intake and output for G-tube residents for the first thirty days and frequency of change for G-tube/incontinent residents to be 2-3 times/as needed per shift; and when change noted including color & odor of output to be immediately notified to charge nurse/supervisor. Director of nursing in-serviced fifteen licensed nurses on 09/25/19 and 10/02/19 regarding policy of intake/output and importance of monitoring intake/output per shift for G-tube residents for the first thirty days and frequency of change 2-3 times per shift for G-tube/incontinent residents and properly documenting for pain, bladder distention. Addundum: correction made and in-service dated 10/01,10/02 & I/O audit copies attached.	

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F 690	Continued From page 10 urinary tract infection ([UTI] an infection affecting part or all of the urinary tract), and a gastrostomy tube (a small tube surgically placed in the stomach thru which nutrition and medication are administered). A Minimum Data Set (MDS) Assessment and Care Screening dated 10/3/18, indicated Resident A cognitive skills for daily decision-making were severely impairment. A review of a Physician's Order, dated 9/26/18, indicated to monitor Resident A's intake and output (I&O) for two weeks and to discontinue the order when stable. A review of an Intake/Output flow Sheets, dated 9/26/18 through 10/26/18, indicated Resident A's fluid output was documented as x 2 each shift. A review of the Evaluations of Intake/Output form indicated there was no weekly evaluation of Resident A's fluid status on the week of 10/22/18. On 9/18/19, at 1:40 p.m., during an interview, the Director of Nursing (DON) stated Resident A does not have an indwelling urinary catheter (a small tube inserted into the bladder that remains there to provide continuous urinary drainage) and is incontinent (involuntary voiding of urine and stool). The facility do not have a way to measuring fluid output for residents without an indwelling urinary catheter. The documentation x 2 indicate how many times the resident urinated not the amount of urine. An undated facility policy titled "Fluid Intake & Output" indicated fluid intake and output shall be	F 690	Evaluation of intake/output includes frequent perspiration, change in body weight, odor, and blood in urine, UTI, edema, dry mouth and dry lip and skin turgor, will be completed by licensed nurse weekly for a minimum of 30 days for resident with new G-tube to assess signs of dehydration, fluid retention and other problems related to fluid imbalance. Standard monthly lab will take place for residents with G-tube to detect dehydration, kidney involvement, and anemia and electrolyte imbalance. If changes noted through evaluation and lab result, licensed nurse immediately notify to physician and follow the order.	10/08/19

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F 690	Continued From page 10 urinary tract infection ([UTI] an infection affecting part or all of the urinary tract), and a gastrostomy tube (a small tube surgically placed in the stomach thru which nutrition and medication are administered). A Minimum Data Set (MDS) Assessment and Care Screening dated 10/3/18, indicated Resident A cognitive skills for daily decision-making were severely impairment. A review of a Physician's Order, dated 9/26/18, indicated to monitor Resident A's intake and output (I&O) for two weeks and to discontinue the order when stable. A review of an Intake/Output flow Sheets, dated 9/26/18 through 10/26/18, indicated Resident A's fluid output was documented as x 2 each shift. A review of the Evaluations of Intake/Output form indicated there was no weekly evaluation of Resident A's fluid status on the week of 10/22/18. On 9/18/19, at 1:40 p.m., during an interview, the Director of Nursing (DON) stated Resident A does not have an indwelling urinary catheter (a small tube inserted into the bladder that remains there to provide continuous urinary drainage) and is incontinent (involuntary voiding of urine and stool). The facility do not have a way to measuring fluid output for residents without an indwelling urinary catheter. The documentation x 2 indicate how many times the resident urinated not the amount of urine. An undated facility policy titled "Fluid Intake & Output" indicated fluid intake and output shall be	F 690	**Monitoring performance and integration into quality assurance system** Medical records designee will audit charts with G-tube residents on a weekly basis to ensure intake and output recoded properly. Findings will be reported to director of nursing to address if any concern arise and reported to Q.A committee monthly X3 for further review.	

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F 690	Continued From page 11 recorded for resident with GTs. Daily intake and output shall be recorded for a minimum of 30 days as ordered by the physician. At the completion of the 30-day period, a licensed nurse shall evaluate the resident to determine further need for documentation of intake and output. The evaluation shall be recorded on the intake and output assessment form.. Licensed nurses shall assess for fluid balance and shall document assessment on weekly licensed progress notes. Note: the facility's policy does not address how to obtain fluid output.	F 690	*F-842* **Corrective Action** Upon notification, licensed nurse called diagnostic labs, retrieved missing lab results and placed them in resident's A chart.	10/03/19
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-Identifiable Information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the	F 842	**Identification of other residents and corrective actions** Nurse designee did a random chart review to ensure lab and X-ray results are placed in the chart in a timely manner and abnormal lab results are reported to MD and responsible party. Missing lab and X-ray results were retrieved and placed in residents' charts. No other issues were noted.	

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F 842	Continued From page 12 records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and	F 842	**Measures to prevent recurrence** The director of nursing provided in-service to License Nurses on 09/25/2019, regarding the importance of following up with lab results, notifying the result to physicians and placing them in residents charts. Nursing designee will check labs & X-ray results when result received, notify the result to physician and sign off in the lab book. **Monitoring performance and integration into quality assurance system** Medical records designee will audit monthly to ensure licensed nurses are in compliance. Medical records will report findings to director of nursing to follow up and report to Q.A committee monthly X3 months for further review.	

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F 842	Continued From page 13 (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility's nursing staff failed to ensure laboratory and x-ray results were available in the clinical record for one of two sampled residents (Resident A). The facility failed to accurately document wound treatments for the resident. This deficient practice incorrectly documented the current medical status of the resident, placed her at risk for non-continuity of care and delay in treatment. Findings: A review of Resident A's Admission Record indicated the resident was readmitted to the facility on 9/26/18, with diagnoses including dysphagia (difficulty swallowing), malnutrition (a condition that results from eating a diet in which one or more nutrients are either not enough or are too much such that the diet causes health problems), dehydration (when there is too much water lost and not enough water taken in), a urinary tract infection ([UTI] an infection affecting part or all of the urinary tract), and a gastrostomy tube (a small tube surgically placed in the stomach thru which nutrition and medication are administered). A review of Resident A's clinical record indicated the following Physician's Orders : dated 10/22/18 - X-ray right leg (tibia/fibula) and on 10/24/18 - Labs: CBC, BMP, Pre-albumin, albumin, serum iron, serum ferritin A review of Resident A's clinical record indicated	F 842		

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F 842	Continued From page 14 the x-ray and laboratory results were not available for review. On 9/18/19 at 1:20 p.m. during an interview and clinical record review with the Director of Nursing (DON) she was not able to locate the x-ray and lab results. On 9/19/19 the undated facility policies titled "Laboratory Test" and "Reporting Critical Laboratory Values" did not address where to place laboratory or radiology results in the clinical record. b. Wound treatment orders were as follows: dated 9/26/18 - GT site cleanse with normal saline, pat dry, cover with dry dressing, 9/26/18 - Monitor pain daily during treatment on a scale of 0-10; 1-3= mild pain, 4-6= moderate pain, 7-10 = severe pain, 9/26/18 - Monitor dressing integrity daily, 10/22/18 - Right medial knee, cleanse with normal sterile saline, pat dry, apply Bacitracin (a medicated ointment), and cover with a dry dressing daily for 21 days., 10/24/18 - Left inner buttocks Stage-2 pressure ulcer; cleanse with normal sterile saline, pat dry, apply Hydragel and cover with a dry dressing daily for 30 days, 10/24/18 - Right inner buttocks Stage-1 pressure ulcer; cleanse with normal sterile saline, pa dry, apply Hydragel and cover with a dry dressing daily for 30 days, On 10/26/18 the physician ordered Resident A to be transferred to the General Acute Care Hospital (GACH) for evaluation of abnormal laboratory results. According to a Multidisciplinary Progress Record dated 10/26/18, Resident A was transferred to the	F 842		

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F 842	Continued From page 15 GACH at 11:10 a.m. A review of Treatment Record for September 2018, indicated two licensed vocational nurses (LVN) initialed for the wound and GT treatment, monitoring of pain and the integrity of the dressing on 9/27, 9/28, 9/29, and 9/30/2018. On 9/17/19 at 12:45 p.m. during an interview with LVN 1, she said she should have not documented the wound care after the resident had been transferred from the facility. However, she was not sure why she did it.	F 842		