PH HOLD

4		$\mathcal{O}$	١	$\cap$	
. )	1	<u>'```</u>	]	4	

02:06:39 p.m. 09-20-2019

7/22

DEPAR	IMENT OF HEALTH	AND HUMAN SERVICES				09/20/2019	
		& MEDICAID SERVICES				APPROVEE . 0938-0391	
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIENCLIA IDENTIFICATION NUMBER:	(X2) MULT A EUILDI		CONSTRUCTION (X)	E SURVEY PLETED	1
		555071	el Ming			C 20/2019	
NAME OF	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		1
		•	. i		00 W Washington el		1
SUNNYV	NEW CARE CENTER	•		LC	OS ANGELES, CA 90018		ı
0(4) 10	SUMMARY STA	TEMENT OF DEFICIENCIES	[ to	<u></u>	PROVIDER'S PLAN OF CORRECTION	(X5)	1
(X4) ID PREFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	<u>'</u>	(EACH CORRECTIVE ACTION SHOULD BE GROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE	
F 000	INITIAL COMMENT	rs	FO	00			
,		•	ĺ.	,	The signing of this plan of	, .	Į
ĺ	The following reflect	cts the findings of the			correction is not an admission or		1
	Department of Pub	ic Health (DPH) during the		-	agreement by this facility of the	· ·	I
	investigation of a co	smplaint.	•	i		· ·	Į
	Complaint number:	CA00847187		- 1	truth of the facts alleged in this	<b>,</b>	ŀ
,			ļ.		statement of deficiencies and plan		ı
	Representing the D	PH: HFEN #19152		- }	of correction. In fact, this plan of	l	I
'				1	correction is submitted		I
		limited to the specific	<b>.</b> .		exclusively to comply with state	1	ł
•	the findings of a full	ted and does not represent Inspection of the facility.		1	and federal law. This plan of		ł
	THE INCHIBATE LE			į	correction serves as the allegation		Ì
	Five deficiencies we #CA00647187	ere issued for complaint			of compliance.		
F 580 SS=D	Notify of Changes ( GFR(s): 483.10(g)(	Injury/Decline/Room, etc.) 14)(i)-(iv)(15)	. F 5	80	• *	· ·	
	RÁ92 40/63/44) NGE	ification of Changes.		.	•		1
		mediately inform the resident;	ļ		•	ļ · ·	
	consult with the res	ident's physicien; and notify.		. ]	•	10/08/19	
	consistent with his o	or her authority, the resident			F-580		
	representative(s) w		Ì				-
		olving the resident which has the potential for requiring		ľ	Corrective Action	1 '	1
	physician interventi		ł	-	SOL STREET TACTION	.}	1
	(B) A significant cha	ange in the resident's physical,		-	Resident A discharged to acute		
	mental, or psychoso	ocial status (that is, a	<u> </u>		General hard on Octaban 25 Gaza	Ĺ	1
		lth, mental, or psychosocial		İ	general care on October 26, 2018,		
	sizius in etiner lite-i clinical complication	threatening conditions or		-	per attending physician order.	1	ļ
•		reatment significantly (that is,		].	Resident A is no longer a resident		1
	a need to discontinu	ie an existing form of		-	of Sunnyview Convalescent	ŀ	1
	treatment due to ad	verse consequences, or to		.	Center after his last discharge,	,	
. 1	commence a new fo	orm of treatment); or		-	10/26/18,	1	ļ
,	(D) A decision to the	Insfer or discharge the		- 1			1
	resident from the fa §483.15(c)(1)(ll).	curà na abeciliab III			• <del>-</del>		1
							Ì
LABORATOR	DIRECTO S OR ROVID	ERISUPPLIER REPRESENTATIVE'S SIGN	LATURE		· ntle	(X6) DATE	_

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

FORM CMS-2557(02-99) Previous Versions Opicolete

Event ID: BWNC11

Facility ID: CA970000017

If continuation sheet Page 1 of 16

02:06:39 p.m. 09-20-2019

ENTER	S FOR MEDICARE	& MEDICAID SERVICES	<u> </u>		<u> </u>	IB NO.	<u>0938-039</u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD				LETED
•		555071	B. WING			09/2	:0/2019
AME OF P	AOVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				21	DOO W WASHINGTON BL		
UNNYV	EW CARE CENTER			L	OS ANGELES, CA 90018		
(X4) (I) PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES I MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S FLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	EE IATE	(X5) COMPLETS DATE
F 000	INITIAL COMMENT		F	000	The signing of this plan of correction is not an admission	or	10/03/1
	Department of Pub investigation of a co	•••			agreement by this facility of t truth of the facts alleged in th statement of deficiencies and	he is	
·	Complaint number:	•			of correction. In fact, this pla		
٠.	The inspection was complaint investiga	PH: HFEN #19152 Ilmited to the specific ited and does not represent I Inspection of the facility.			exclusively to comply with st and federal law. This plan of correction serves as the alleg- of compliance.	,	•
F 580	#CA00647187	ere issued for complaint (Injury/Decline/Room, etc.)	-	580			•
\$9=D	CFR(s): 483.10(g)(			oov			•
	(i) A facility must in consult with the re:	lification of Changes. nmediately inform the resident; sident's physician; and notify,					•
	representative(s) v	or her authority, the resident when there is- volving the resident which					
•	results in injury and physician intervent	d has the potential for requiring	1				
	mental, or psychos deterioration in her status in either life	ocial status (that is, a alth, mental, or psychosocial threatening conditions or					<b>!</b>
•	a need to discontin	treatment significantly (that is, nue an existing form of					
	commence a new (D) A decision to tr	dverse consequences, or to form of treatment); or ansier or discharge the					
	§483.15(c)(1)(ii).	acility as specified in					

Any deficiency statement anding with an asterisk (\*) denotes if 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 discloseble 30 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 discloseble 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.

	TRATEMENT OF DEPICIENCIES (X1) FROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING	LE CONSTRUCTION (XX	DATE SURVEY COMPLETED	
565071					COMPLETED	
AME OF	PROVIDER OR SUPPLIER		B. WING	,	09/20/2019	
	•			STREET ADDRESS, CITY, STATE, ZIP CODE		
UNNY\	/IEW CARE CENTER			2000 W WASHINGTON BL		
(X4) ID	SHAMADVET	ATEMENT OF DEFICIENCIES		LOS ANGELES, CA 90018		
PRÉFIX TAG	i (Each Deficienc	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF GORRECTION (EACH CORRECTIVE ACTION SHOULD BE GROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETO COMPLETO	
F 580			F 580	F-580		
	(14)(i) of this sectional pertinent information	ofification under paragraph (g) in, the facility must ensure that ation specified in §483.15(c)(2) avided upon request to the	•	Corrective Action	10/03/1	
•	physician. (III) The facility mus	t also promotly polity the	:	Upon notification, thirty three current residents' charts with a		
	when there is-	sident representative, if any, on or roommate assignment	•	change of condition were audit on 10/01/19, 09/27/19 & 09/11.	3	
	as specified in §48:	3.10(e)(6); or	٠	by medical record to ensure	· ·	
	State law or regulat	Ident rights under Federal or Hons as specified in paragraph		primary physician and resident representative were notified.	s'	
	(B)(10) of this section	on. It record and periodically		Resident's representative and		
	update the address	(mailing and email) and		primary physician were notifie	d	
	phone number of the representative(s).	e resident	·	when change of condition note	d i	
ĺ	§483.10(g)(15)			and documented in resident's clinical charts.	:	
I	Admission to a com	posite distinct part. A facility		Identification of other resider		
- 1	that is a composite §483.5) must disclo	distinct part (as defined in		and corrective actions	re:	
- 1	locations that comp	ation, including the various rise the composite distinct ify the policies that apply to		Thirty three current charts with		
- 1	room changes betw	een its different locations		change of condition audited by medical record to ensure medic	01	
	under §483.15(c)(9) This REQUIREMEN	IT is not met as evidenced		doctor and resident's	al:	
	Dy:	• 1 1	ĺ	representative notified.	:	
].	reculty's nursing stat	and record review the	.	No other residents were affected	d.	
	me responsible part (Resident A) when ti	y for one sampled resident				
. 11	knee). This deficien	the resident's right inner t practice resulted in the		Addendum; copy of change	<u>.</u>	
	responsible party (R had a change in con	P) not knowing the resident dition.		of condition audit and in-		
,	Findings:			service sheet attached.	ŀ ,	

If continuation sheet Page 2 of 18

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			NTED: 09/20 <mark>/2</mark> 019 FORM-APPROVED-
		& MEDICAID SERVICES		OME	3 NO. 0938-0391
	of deficiencies if correction	(X1) PROVIDER/BUPPLIER/CLIA ICENTIFICATION NUMBER:	(X2) MULTIPE A. BUILDING	E CONSTRUCTION (X	3) DATE SURVEY COMPLETED
		555071	B. WING		C 09/20/2019
NAMEOF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	
SUNNYV	TEW CARE CENTER	•		DCO W WASHINGTON BL	
,				OS ANGELES, CA 90018	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	YEMENT OF DEFIGIENCIES 'MUST BE PRICEDED BY, FULL SC IDENTIFYING INFORMATION)	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 580	Gontinued From pa	ge 2	F 580	Measures to prevent recurren	ı <u>ce</u>
· 58=E	Indicated the resided facility on 9/26/18, with dysphagia (difficulty condition that result one or more nutrient are too much such it problems), dehydrated water lost and not even are too much such it problems), dehydrated water lost and not even or all of the uring tract infection part or all of the uring tube (a small tube stomach thru which administered).  A Multidisciplinary F 10/21/18 at 10:30 a was noted with small mediat (inside) kneed notified. There was the change of condition, Licensed stated she was off of treatment orders we notify the RP.  An undated facility in Condition, did not in responsible party. Activities Dally Livin CFR(s): 483.24(a)(1)	at A's Admission Record int was readmilted to the vith diagnoses including vith the diet causes health tion (when there is too much enough water taken in), a vith (IUTI) an infection affecting nary tract), and a gastrostomy surgically placed in the vith on and medication are vith on and medication are vith on and medication are vith on and the physician was and the physician was and the physician was on written documentation of tition and the responsible party on. vith on and the responsible party on 10/21/18. On 10/22/18 the ere clarified and she did not colley titled "Change of adicate to notify the resident's g (ADLs)/Mnth Abilities i)(b)(1)-(5)(i)-(iii) in the comprehensive	F 676	The director of nursing provide in-service to fifteen license nur on 09/25/2019 and fifteen licensed on 10/01/19 in regards the importance of notifying resident and/or representative a physician on change of conditional involvement of family member in plan of care as well documentation of discussion in residents chart.  Monitoring performance and integration into quality assurance system  Medical records/designee with audit charts with change of condition on weekly basis to ensure licensed are in compliant Findings will be reported montatimes three to Q.A committee in further review.  Addendum copy of change of condition audit and inservice sheet attached.	ses s to and on as ill ince. thly for
	assessment of a res	sident and consistent with the		10/03/19.	
CON CAS OF	37(02-89) Previous Versions	Observation	<del> </del>		<u></u>

If continuation sheet Page 3 of 16

		AND HUMAN SERVICES	-		09/20/2019 APPROVED
		& MEDICAID SERVICES	T	. OMB NO.	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A: ELILDING	GOM	E SURVEY . PLETED
L	•	55507 <sup>-</sup> 1	B. WING		C 20/2019
NAMEOF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	·.
SUNNYV	Tew care center .			2000 W WASHINGTON BL	
<u> </u>	• •			LOS ANGELES, CA 90018	· .
(X4) ID PREFIX TAG	(Each Derciency	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING (NFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
		•		F-676	
F 0/8	Continued From pa		F 676		10/03/19
	residents needs an	d choices, the facility must ary care and services to		Corrective Action	
	ensure that a reside	ent's abilities in activities of			
	delly living do not di	minish unless circumstances		Upon notification, C.N.A 1,2,&3	
]	of the individual's c	inical condition demonstrate I was unavoldable. This		in serviced by director of staff	•
	includes the facility		ř	development on 09/20/19	
	•			regarding the updated oral care	
	§483.24(a)(1) A res	ident is given the appropriate		policy (Oral Care on Gastrostomy	
		ces to maintain or improve his yout the activities of daily		Resident) on gastrostomy resident	
·	living, including thos	se specified in paragraph (b)		to prevent gum disease and tooth	•
	of this section	, in a series of the series of		decay and to facilitate a clean and	
, i	E 400 (140a) A 46a 44a	r all dath (this	•	fresh mouth.	
	§483.24(b) Activities The facility must pro	or daily living. Ovide care and services in		Resident BC &D assessed by	'
	accordance with pa	regraph (a) for the following		licensed to identify gum disease	
	activities of daily livi	ng:		and there was no concern noted.	•
	8483 24/hV/1) Hvale	ne -bathing, dressing,			-
	grooming, and oral	care,	•	Identification of other residents	
.			٠.	and corrective actions	
·	§483.24(b)(2) Mobilinciuding walking,	ity-transfer and ambulation,	•		
	melacitif Asikitif,	•		Director of staff developer	
	§483.24(b)(3) Elimir	nation-tolleling,		observed ten random CNAs	
· .	6400 04/63/A 50-4		•	during oral care to reinsure proper	
	§483.24(b)(4) Dining	y-eating, including meals and		oral care provided based on	
. ,	animanal ,			policy "Oral Care on Gastrostomy	
		nunication, including		Resident".	
;	(i) Speech, (ii) Language,				
	(iii) Other functional	communication systems.		No other areas were affected.	
.	This REQUIREMEN	T is not met as evidenced	٠,		•
	by: ·	• 1	•	Addendum: additional in-	
•	review the facilities	on, interview and record nursing staff failed to ensure 3	•		
	of 3 sampled resider	nts (Resident B, C, D) with a		service sheet. 10/03/19	
		,			

Statemen	T OF DEFICIENCIES	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	8/9		OMB NO	1. APPROV 1. 0938-03
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BLILDING	PLE CONSTRUCTION G	(DC3) DAT	TE SURVEY MPLETED
		555071	B. WING		1	¢
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	- 08	<u> 20/2019</u>
SUNNY\	NEW GARE CENTER		1	2000 W WASHINGTON BL		
	NEW CARLE OF ILEK			LOS ANGELES, CA 90018		
(X4) ID PREFIX	SUMMARY ST	ATEMENT OF DEFICIENCIES	ip.	PROVIDER'S PLAN OF CORRECT	000	
TAG	REGULATORY OR I	Y MIST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	U HE	CONFIETS CONFIETS
F 676	Continued From pa	nge 4	F 676	Measures to prevent recu	rence	
•	gastrostomy tube (	(GT) a small tube surgically				Í
	piaceo in the stoma	sch thru which nutrition and		The director of nursing proving	/ided	1
.	appropriate dra adp	ninistered) received re. This deficient practice		in-service to fifteen certified		j
.	placed residents at	risk for mal adomus aret		nursing assistant on 09/25/2		}
.	cavities, infection a	nd tooth build up.		and director of staff develop		
٠ ]	Elections		ľ	in serviced thirty one C.N.A		
-1	Findings:			10/01-10/02 regarding prop	êr	
- 1	a. A review of Resi	dent B's Admission Record		way of performing oral care	for	
	indicated the was re	admitted to the facility on		residents with G-tube follow	ved by	
	12/4/18, with disono	isis of dysphadia (difficulty		policy of "Oral Care on		
	swallowing) with a (	∄l.		Gastrostomy Resident".		
	providing oral care t Lemon Glycerin Sw.	n.m. CNA 1 was observed to Resident B. CNA 1 used a absticks to clean the		Monitoring performance a	ınd	
• 1	resident's mouth.	•		integration into quality	<del></del>	
.	Ori 9/18/10 at 2:20.	o.m. during an interview, CNA		assurance system	÷.	•
	1 Stated sometimes	She use a toothette with				,
	mouth wash to clear	the resident's mouth.		CNA team leader will che	ck	,
- 1				daily to ensure CNAs' are		
· []	indicated he was res	lent C's Admission Records admitted to the facility on	, ' ]	compliance and report find		
}:	7/18/18, with diagno	sis of dysphagia with a GT.	. ]	to DSD. DSD will make a w		
ŀ	•	•		visual oral care check and in	Corth	
1:	<b>Un 9/18/19 at 2:35 p</b>	.m. CNA 2 was observed	j	service/reinforce CNAs as	<b>L</b> .	
	providing oral care to Lemon Glycerin swa	Resident C. CNA 2 used a	.]	needed.		
·  i	esident's mouth.		.	Findings will be reported to	O 4	-
· ]	l De Oldović ( = )			committee monthly X3 mon	Ų.M tha	
٠ ا ٠	z seaceu sne was ins	.m. during an Interview, CNA tructed to use the Lemon to clean the resident's		for further review.	u15 	•
F	nouth.		1	Addondsom, cddist. 11	ļ	•
				Addendum: additional in-	1	
	: A review of Residenticated he was rea (02-99) Provious Versions O	ent D's Admission Records dmitted to the facility on		service sheet. 10/03/19		

		LAND HUMAN SERVICES	<u>:</u>	Fish	VTED: '09/20 <b>/2</b> 'ORM-APPROV
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			3 NO. 0938-0
STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A BUILDING	• •	3) DATE SURVEY COMPLETED
•	*		- 14/71/0		C
		555071	B. WING		09/20/2019
NAME OF I	PROVIDER OR SUPPLIER		,	TREET ADDRESS, CITY, STATE, ZIP CODE	•
SUNNYV	IEW CARE CENTER			000 W WASHINGTON BL	
				OS ANGELES, CA 90018	<u>-</u>
(X4) ID PREFIX TAG	(EACH DEFIGIENC	Tement of deficiencies Y must be preceded by full SC identifying information)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BY CROSS-REFERENCED TO THE AFPROPRIA DEFICIENCY)	COMPLET TE DATE
F 676	Continued From pa		F 676	F-684	
		osis of dysphagla with a GT.			10[03]
	•	•		Corrective Action	101,
ļ	On 9/18/19 at 2:45	p.m. CNA 3 was observed			
	providing oral care	to Resident D. CNA 1 used a rabsticks to clean the		Upon notification, director of	
	resident's mouth.	guaugra tu ciedii die		staff development in-serviced/	
•	rodiacina madai.			demonstrated/return	1 .
	On 9/18/19 at 2:50	p.m. during an interview, CNA		demonstration to C.N.As for	
•		s he use a toothette with		residents B, C, and E &F in	•
•	mouth wash to cles	an the residents mouth.		regards to proper repositioning	,
·	Instructions for use	of the Lemon Glycerin		including pressure reducing	' . ]
		ad they are use to refresh dry		device/pillows to completely to	,rn
	mouth and throat b	y providing a pleasant and		residents from off their back to	
İ	refreshing citrus fla	vor. Swab freely about the		buttocks every two hours and a	
	to obtain more citro	ents may suck on awab head is flavor.		needed.	LS   .
		walter that different comments	1.	Treatment nurse assessed	ł
	An undated racing	policy titled "Oral Care on a lent", indicated to prevent gum		residents B, C, E, & F on	
•	disease and tooth	locay and facilitate a clean		10/03/19 to ensure if any skin	
	and fresh mouth. I	Moisten the toothette, brush		breakdown and there was no	1
	the teeth and gums	with gentle pressure while		findings, see attached assessme	ne ·
	moving in short hor	rizontal or circular strokes,		sheet dated on 10/03/19.	,,,,
	gerny proso me pa topone for approvir	eth and the surface of the nately 2 minutes, gently wipe			
	inside the resident	a mouth, rinse the resident's		•	
	mouth with a damp	toothette, lubricate the		Identification of other reside	<u>nts</u>
<b>-</b>	resident's mouth a	nd lips with a lemon swab.		and corrective actions	
F-684		•	F 684	<u> </u>	: .
\$3≈£	CFR(s): 483.25			Director of staff development	
•	§ 483.25 Quality of	care		made a random rounds daily to	<b>)</b> [
•	Quality of care is a	fundamental principle that		reinsure residents are properly	
·	applies to all treatn	ent and care provided to		repositioning Q2 hours or as	1
	assessment of a re	ased on the comprehensive sident, the facility must ensure		needed.	- 1
ļ	that residents recei	ve treatment and care in		No other residents affected.	-
			!		1

DEPARI	MENTOF HEALTH	AND HUMAN SERVICES			PŘ		09/20/2019 APPROVED-
		& MEDICAID SERVICES	• "		· ON		0938-0391
	'OF DEFICIENCIES IF CORRECTION	(X1) PROVIDER/BUPPLIER/GLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUHLDI		l'	COM	SURVEY PLETED
		555071	B. WING			09/2	; 20/2019
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	· · ·	
SUNNYV	NEW CARE CENTER	•	1		xo w washington el Os angeles, ca 90018		•
· (064) ID	SIMMARY STA	TEMENT OF DEFICIENCIES	<del>,1</del>		PROVIDERS PLAN OF CORRECTION	·	
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFI) TAG	<b>'</b>	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	DE ·	COMPLETION DATE
F 684			F6	84	Measures to prevent recurre	nce	•:
	practice, the compressed plan, and the range plan, and the range plan, and the range plan, and the range plan, and the range plan plan plan plan plan plan plan plan	VT is not met as evidenced ion, interview and record nursing staff failed to ensure pled residents B, C, and at least every two hours, ice placed the residents at risk			The director of nursing inserviced fifteen certified nursi assistants on 09/25/2019 and director of staff development serviced thirty one C.N.As regarding the importance of proper repositioning including using pressure reducing device/pillows to completely residents from off their back buttocks every two hours and needed and reporting skin breakdown/change of conditi immediately to charge nurses/supervisor.	in- turn to l as	
	A Minimum Data Se Care Screening, da Resident B's cogniti decision-making we a functional limitation the distance and dir full potential) to one On 9/19/19 at 11:55 observed lying on h p.m., Resident B we (part of the body the the groin), elightly to	at (MDS) Assessment and ted 9/30/19, indicated the skills for daily are severely impaired and had on in range of motion ([ROM] rection a joint can move to itse of the upper extremities.  i.a.m., Resident B was its back, at 2 p.m., and 3:15 as observed with his torso at extends from the neck to uned to the left with his					
	buttocks on the mat b. A review of Resid Indicated the reside	tress. lent C's Admission Record nt was readmitted to the			Addendum: correction made and additional information added on 10/03/19	Te	

02:08:21 p.m.

09-20-2019

_DEPART	MENT OF HEALTH	AND HUMAN SERVICES			ED: 09/20/2019 RM:APPRØVED-
		& MEDICAID SERVICES			IO, 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	1 -	DATE SURVEY COMPLETED
		655071	B. WING		C 09/20/2019
NAMEOFI	KOVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
VYKKULB	IEW CARE CENTER	•		2000 W WASHINGTON EL LOS ANGELES, CA 90018	
CI (LX) XI+ERFIX DAT	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX- TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
<sup>:</sup> F 684	of coordination (the the body together s	ge 7 with diagnoses including lack ability to use different parts of moothly and efficiently), weakness and dementia.	F68	integration into quality assurance system	
	A MDS Assessmen 7/2/19, Indicated Redaily decision-makin totally dependent or mobility and had a f	t and Care Screening, dated saldent C's cognitive skills for my were severely impaired, in the facility staff for bed functional limitation in range of apper and lower extremities.		Director of staff development/ supervisor will make daily random room visit to ensure residents reposition properly a least every two hour and as	
	On 9/19/19 at 11:55 Resident C was obs	i a.m., 2 p.m., and 3:15 p.m., served lying on his back. ident E's Admission Record int was readmitted to the		needed. Findings will be reported to Q.A. committee monthly X3 months for further review.	
	facility on 8/23/19 w muscle weakness, I to use different part smoothly and efficie	rith diagnoses of generalized lack of coordination (the ability is of the body together ently, and dementia (a loss of semony, thinking, language,			
•	8/30/19, indicated Fi daily decision-making	t and Care Screening, dated Resident E cognitive skills for ng were severely impairment sive assistance for bed	•		
•	On 9/17/19 at 11:55 Resident E was obs	a.m., 2 p.m., and 3:15 p.m., served lying on her back.			
	Indicated the reside facility on 7/1/19 wit muscle weakness, i to use different part	lent F's Admission Record nt was readmilited to the h diagnoses of generalized ack of coordination (the ability s of the body together intly, and dementia (a loss of	. :	Addendum: correction made and additional information added on 10/03/19	

02:08:36 p.m. 09-20-2019

		& MEDICAID SERVICES	(Vm AAIII	The same of the sa	<u>VO. 0938-039</u> DATE SURVEY
d Plan C	of deficiencies if correction	(X1) PROVIDER/SUPPLIER/GLIA EXENTIFICATION NUMBER:	A. BUILDING	· · · · · · · · · · · · · · · · · · ·	COMPLETED
		555071	B. WING		09/20/2019
AME OF I	PROVIDER OR SUPPLIER	,	1	TREET ADDRESS, CITY, STATE, ZIP CODE	
VYANU	IEW CARE CENTER			000 W Washington Bl Os angeles, ca 90018	
(X4) ID PREFIX	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	(D) PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETIO
TAG	REGULATORY OR I	_sg identifying information)	. TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 684	Continued From pa	<del>-</del>	F 684	F-690	
	brain functioning [r ]udgment, and beh	nemory, thinking, language, avior]).	•	Corrective Action	10/03/1
	A MDS Assessmer Resident F cognitiv	nt, dated 8/4/19, indicated ve skills for daily		Upon notification, resident A	
_	decision-making w	ere severely impairment and assistance for bed mobility.		chart was reviewed for accurate intake and output. Resident A w	1
	On 0/40/40 at 11-2	5 a.m., 2 p.m., and 3:15 p.m.,	. }	voided 2-3 times per shift durin	
	Resident F was ob	served lying on her back.		observation period, per record a no bladder distention, or c/o pai	
	Director of Nursing	m., during an interview, the I (DON) stated resident's It least every two hours.	•	noted.	
· ·,	On 9/19/18 at 4:16 Director of Staff De in-service with den	i p.m., during an interview, the evelopment (DSD) stated she nonstration to staff on		Identification of other resident and corrective actions	<u>ts</u>
•		ent off their buttocks using cessary to keep the residents		Licensed designee reviewed two	
		entinence, Catheter, UTI (1)-(3)	F 690		he
	§483.25(e) Inconti			recorded. No other issues were	
•	resident who is co	facility must ensure that ntinent of bladder and bowel or siservices and assistance to	n ·	noted and no other residents we affected.	re
•	maintain continent	unless his or her clinical omes such that continence is			
		resident with urinary		A dalum duma, namanti an ara-da	
		ed on the resident's sessment, the facility must		Addundum: correction made and in-service dated	
•	(i) A resident who	enters the facility without an		10/01,10/02 & I/O audit copi attached.	es

02:08:50 p.m. 09-20-2019

DEPAR	MENT OF HEALTH	AND HUMAN SERVICES			· [1		O4/24/2019 APPROVED-
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES		_	· O		0938-0391
	OF DEFICIENCIES	(X1) PROVIDENSUPPLIENCLIA	(X2) MULT	11PLL	ECONSTRUCTION	. (X3) DATE SURVEY	
AND PLAN E	F CORRECTION .	IDENTIFICATION NUMBER:	A-BUILDI	NG:		COM	PLETED
]	•				•		3
	:	555071	B' MING"			09/	20/2019
NAME OF	PROVIDER OR SUPPLIER	· .	1		REET ADDRESS, CITY, STATE, XP CODE		·
SUNNYV	IEW CARE CENTER				DO W WASHINGTON BL	•	1
<u> </u>	······································		<u> </u>	L	DS ANGELES, CA 90018		
(X4) ID PREFIX		Tement of Deficiencies ' Must be preceded by Full	PREFIX	, 1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	NF .	(XS) COMPLETION
TAG		SCIDENTIFYING INFORMATION)	TAG	`	CROSS-REFERENCED TO THE APPROP		DATE
	. ,	-	-	_	DEFICIENCY		
				]	Measures to prevent recurr	<u>encė</u>	
F 690	Continued From pa		F 69	90			
'		ondition demonstrates that		- }	The nursing consultant in-		,
·	catheterization was	necessary, enters the facility with en		- 1	serviced director of nursing	on	
		or subsequently receives one		- 1	10/01/19 regarding monitoring	ıg in-	
Ì		ioval of the catheter as soon			take and output for G-tube	-0	
		the resident's clinical condition	,		residents for the first thirty	lavs .	
		catheterization is necessary;			and frequency of change for	G-	
}	and	is Incontinent of bladder		1	and frequency of change for	С- Ъс 2-	
١.		e treatment and services to			tube/incontinent residents to		].
١, .		t infections and to restore			3 times/as needed per shift; a	inu	
	continence to the				when change noted including	3	· [
<b>\</b>	~				color & odor of output to be		<b>1</b>
	§483,25(e)(3) For a incontinence, based			}	immediately notified to char	ge	'
		sessment, the facility must		- 1	nurse/supervisor.	_	• • •
	ensure that a reside	ent who is incontinent of bowel		١	Director of nursing in-service	ed	
1	receives appropriat	e treatment and services to		:	fifteen licensed nurses on		[ [
		rmal bowel function as	}	ı	09/25/19 and 10/02/19 regai	ding	
}	possible.	NT is not met as evidenced			policy of intake/output and		
1	by:	At is not mat as evidenced	ĺ		importance of monitoring		
1		and record review the	, i		intake/output per shift for G	-tube	
1	facility's nursing sta	iff failed to correctly document	)	:	residents for the first thirty	davs	
	the fluid out put for	one of four sampled residents			and frequency of change 2-	J - :	1
ļ		deficient practice placed the			times per shift for G-		•
<u> </u>	resinent strisk tol (	unrecognized fluid imbalance.		- 1	tube/incontinent residents a	nd i	1.
	Findings:	•		}			
i i	'	•			properly documenting for p	Z111,	
		nt A's Admission Record	į		bladder distention.	•	1;
[		ent was readmitted to the · · · · · · · · · · · · · · · · · · ·	}	l			1
}		with diagnoses including / swallowing), malnutrition (a	,	. }	Addundum: correction ma	de	]
} · !		ts from eating a diet in which	Ì	-	and in-service dated		
ł	one or more nutrier	its are either not enough or			10/01,10/02 & I/O audit co	mies	
		that the diet causes health		ĺ	attached.	Live	
·		tion (when there is too much mough water taken in), a			attachen.	•	1 .
EORIL ONE #	Water roat and rrot e		<u> </u>		Fib. IT: C8 970000047 Result		

02:08:50 p.m. 09-20-2019

nen/ot	MENT OF LEATTH	AND HUMAN SERVICES				09/20/2019
		& MEDICAID SERVICES	•			4PPROVED- 0938-0391_
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MIU ABUILI		E CONSTRUCTION (X3) DATE	SURVEY LETED
	· ·	555071	B. WING			0/2019
NAME OF	ROVIDER OR SUPPLIER	•	· · · ·	S	TREET ADDRESS, CITY, STATE, ZIP CODE	,
CT INDIVIDU	EW CARE CENTER			Ż	DOG W WASHINGTON BL	
PONNIA	EM DAKE DEMIEK		•	L	OS ANGELES, CA 90018	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETION DATE
FRON	Continued From no	ana <b>G</b>	-	660	Measures to prevent recurrence	
F 690	catheterization was (ii) A resident who e indwelling catheter is assessed for ren as possible unless demonstrates that and (iii) A resident who receives appropriat prevent urinary trac continence to the e §483.25(e)(3) For it incontinence, base comprehensive as ensure that a resid receives appropriat restore as much no possible. This REQUIREME by: Based on intervied facility's nursing st the fluid out put for (Resident A). This resident at risk for Findings: A review of Reside indicated the resid facility on 9/26/18,	ondition demonstrates that a necessary, enters the facility with an or subsequently receives one noval of the catheter as soon the resident's clinical condition catheterization is necessary; is incontinent of bladder to treatment and services to at infections and to restore extent possible. It resident with fecal and on the resident's sessment, the facility must sent who is incontinent of bowel to treatment and services to ormal bowel function as incontinent of the common bowel function as the and record review the affigiled to correctly document one of four sampled residents a deficient practice placed the unrecognized fluid imbalance.	II.	690	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.	
	dysphagia (difficult condition that resu one or more nutrie are too much such problems), dehydr	with diagnoses including by swallowing), malnutrition (a lits from eating a diet in which rits are either not enough or that the diet causes health ation (when there is too much enough water taken in), a				
<u>L</u>			1		<u> </u>	

DEPAR	MENT OF HEALTH	AND HUMAN SERVICES			TED: 09/20/2019 RM-APPROVED
•		& MEDICAID SERVICES			NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. EUILDENG	LE CONSTRUCTION	DATE SURVEY COMPLETED
	•	555071	B. WING_		C 09/20/2019
NAME OF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
SUNNYVIEW CARE CENTER				2000 W WASHINGTON BL	
SUNNYVIEW CARE CENTER				LOS ANGELES, CA 96018	
(X4) (D 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 690	Continued From pa	ge 9	F 690	Measures to prevent recurrence	e .
	resident's clinical co	ondition demonstrates that		The nursing consultant in-	
	catheterization was			serviced director of nursing on	
		enters the facility with an or subsequently receives one		10/01/19 regarding monitoring i	<b>m_</b>
		noval of the catheter as soon		take and output for G-tube	
1	as possible unless	the resident's clinical condition	′		` ∮
	demonstrates that	cathelerization is necessary:		residents for the first thirty days	•
	and	!- !		and frequency of change for G-	
1.		is incontinent of bledder e treatment and services to		tube/incontinent residents to be	
		it infections and to restore		3 times/as needed per shift; and	·
	continence to the e			when change noted including	
}		•		color & odor of output to be	
	§483.25(e)(3) For a			immediately notified to charge	· 1
1	Incontinence, base	o on the resident's lessment, the facility must		nurse/supervisor.	1
	ensure that a reside	ant who is incontinent of bowel		Director of nursing in-serviced	
, i	receives appropriat	e treatment and services to		fifteen licensed nurses on	
		rmal bowel function as	i i	09/25/19 and 10/02/19 regarding	g
<u> </u>	possible.	NT is not maken avidenced		policy of intake/output and	_
	ph:	NT is not met as evidenced		importance of monitoring	
]	Based on interview	and record review the	!	intake/output per shift for G-tul	be.
	facility's nursing sta	iff failed to correctly document	:	residents for the first thirty day	s
	the fluid out put for	one of four sampled residents		and frequency of change 2-3	·
1	(Resident A). Inis	deficient practice placed the inrecognized fluid imbalance.	}	times per shift for G-	- }
<u> </u>	i eerrein ariisk 10)	SINGANAUSEG UDIG UNDSISINCO.		tube/incontinent residents and	1 .
	Findings:	•			
[ ]	- •		<u> </u>	properly documenting for pain	<b>,</b>
<b>.</b>	A review of Resider	nt A's Admission Record		bladder distention.	1:
		ent was readmitted to the With diagnoses including	1		•
1 .	dysphagia (difficult	/ swallowing), malnutrition (a	·	Addundum: correction made	
,	condition that resul	is from eating a diet in which		and in-service dated	
	one or more nutrier	its are either not enough or		10/01,10/02 & I/O audit copie	es l
	ere too much such	that the diet causes health		attached.	`   `
•		tion (when there is too much mough water taken in), a	١.	anacheu.	-
	ACOUNT HOLD WITH HOLE	archeu water taken in), a	'		,

•••	_DEPAR	IMENT OF HEALTH	AND HUMAN SERVICES	*		PRINTED	: 09/20/2019
	CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			FORM OMB NO	APPROVED- 0938-0391
	STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDENSUPPLIERICUA IDENTIFICATION NUMBER:	(XZ) MULTI A. BUILDIN	PLE CONSTRUCTION	(X3) DAT	E SURVEY APLETED
•	A		555071	B. WING_		7.	G  20/2019
	NAME OF	PROVIDER OR SUPPLIER		·· [	STREET ADDRESS, GITY, STATE, ZIP CODE	• •	
	SUNNY	VIEW CARE CENTER	•		2000 W WASHINGTON BL LOS ANGELES, CA 90018	. •	
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INPORMATION)	id PRÉFIX TAG	PROVIDER'S PLAN OF CORRECTING ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	COMPLETION COMPLETION DATE
		part or all of the urin tube (a small tube s stomach thru which administered).  A Minimum Data Se Care Screening date Resident A cognitive decision-making we have of a Physic indicated to monitor output (1&O) for two order when stable.  A review of an Intake 9/26/18 through 10/2 fluid output was door a review of the Evaluational through 10/2 fluid output was door a review of the Evaluational through 10/2 fluid output was door an indicated there was a Resident A's fluid stable inserted into the provide continuous incontinent (involuntation). The facility domeasuring fluid output indwelling urinary cated and tube inserted into the provide continuous incontinent (involuntation).	or ([UTI) an Infection affecting pary tract), and a gastrostomy urgically placed in the nutrition and medication are still placed in the nutrition and medication are it (MDS) Assessment and ad 10/3/18, indicated a skills for daily re severely impairment.  Itan's Order, dated 9/26/18, Resident A's intake and wasks and to discontinue the al-Output flow Sheets, dated wasks and to discontinue the al-Output flow Sheets, dated as x 2 each shift.  Itanions of Intake/Output form no weekly evaluation of alus on the week of 10/22/18.  In., during an interview, the DON) stated Resident A does ag urinary catheter (a small e bladder that remains there is urinary drainage) and is any volding of urine and one thave a way to ut for residents without an heter. The documentation x firmes the resident urinated	F 694	Evaluation of intake/output includes frequent perspiration change in body weight, odo blood in urine, UTI, edema, mouth and dry lip and skin will be completed by licenson nurse weekly for a minimum 30 days for resident with netube to assess signs of dehydration, fluid retention other problems related to fluinbalance.  Standard monthly lab will taplace for residents with G-to detect dehydration, kidney involvement, and anemia an electrolyte imbalance. If chanoted through evaluation an result, licensed nurse immediately to physician and followed.	on, r, and dry turgor, ed n of and lid ake ube to ad anges d lab diately	10/08/19
		An undated facility po Output" indicated flux	olicy titled "Fluid Intake & d intake and output shall be				

02:09:05 p.m. 09-20-2019

CENTERS FOR MEDICARE & MEDICALD SERVICES  AND PLAN OF CORRECTION  A BULDING  STREET ADDRESS, CIT. STATE 2P CODE  SUNNYVIEW CARE CENTER  S	DEPAR	<u>IMENT OF HEALTH</u>	AND HUMAN SERVICES			Р		: 09/20/2019 -APPROVED-
INDITITION INTO CONTRIBUTION INTO PROPERTY IN A SULDING STREET ADDRESS, CIT., STATE, 2P ODDE 2009 WWS.NINGSTOR BL LOS ANGELES, CA 90018  CAUDE PRIENT GRAND PROPERTY OF DEPOTENCES SURVEY WAS.NINGSTOR BL LOS ANGELES, CA 90018  FROM DEPOTENT VILLET OF DEPOTENCES PROPERTY TAG SUMMAY STATEMENT OF DEPOTENCES PROPERTY TAG SUMMAY SUMMAY STATEMENT OF DEPOTENCES PROPERTY TAG SUMMAY SUMMAY STATEMENT OF DEPOTENCES PROPERTY TAG SUMMAY SUMMAY STATEMENT OF DEPOTENCES PROPERTY TAG SUMMAY SUMMAY STATEMENT OF DEPOTENCE	CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			·· o		
SSS971 B. WIND  MAMEOF PROVIDER OR SUPPLIER  SUNNYVIEW CARE CENTER  SUNNYVIEW CARE CENTER  SUNNAMY STATEMENT OF DEFICIENCIES CARD DEPOSITION OF LICE DESTITIONS INFORMATION)  PRESIDENT GRAND DEPOSITION OF DEFICIENCIES CARD DEPOSITION OF LICE DESTITION OF CONTROL OF TAKE TAG  FERMINATORY OR LICE DESTITION OF CONTROL OF TAKE TAG  CONTINUED From page 10  Unitary tract inflection (BUTT) an infaction affecting part or all of the unitary tract), and a questrostomy tube (a small tube surgicelly placed in the stomach thru which nutrition and medication are administered).  A Minimum Data Set (MDS) Assessment and Care Screening dated 10/3/16, indicated Resident A cognitive skills for daily decision-making were severely impairment.  A review of a Physician's O'der, dated 8/26/18, indicated resident A's fluid cated to mointior Resident A's fluid status on the week or 100/22/18, indicated Resident A's fluid status on the week of 100/22/18, indicated there was no weekly evaluation of Resident A's fluid status on the week of 100/22/18, On 9/18/16, at 1:40 p.m., during an interview, the Director of Nursing (DON) stated Resident A does not have an indivelling urinary catheter (a small tube inserted into the bedder that remains there to provide continuous urinary dailarge) and le Incontinent (involunitary voiding of urine and stool). The facility do not have a way to measuring fluid output for residents without an indivelling 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 &			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ľ		E CONSTRUCTION .	(XS) DAT GOM	E SURVEY IFLETED
SUNNYVIEW CARE CENTER  PROPERTY OF DEFICIENCES (CAR HORSE CAN BOTH SECOND WIRESHINGTON BE. LOS ANGELES, CA 9018  PROPERTY OF DEFICIENCES (CAR HORSE CAN BOTH SECOND WIRESHINGTON BE. LOS ANGELES, CA 9018  PROPERTY OF DEFICIENCES OF THE APPROPRIATE DEFICIENCY OR LCC DENTIFYING INFORMATION)  F 690  Continued From page 10 urbary tract infection (BUTI) an infection affecting part or all of the urbary tract), and a gestrostomy tube (a small tube surgicelly placed in the stomach thru which nutrition and medication are administered).  A Minimum Data Set (MDS) Assessment and Care Screening dated 10/3/16, indicated Resident A cognitive skills for daily decision-making were severely impairment.  A review of a Physician's Order, dated 9/26/18, indicated resident Are fluid status on monitor Resident A's fluid output flow Sheets, dated 9/26/18 through 10/26/18, indicated Resident A's fluid status on the week of 10/22/18.  A review of an intake/Cutput flow Sheets, dated 9/26/18 through 10/26/18, indicated Resident A's fluid status on the week of 10/22/18.  A review of an intake/Cutput flow Sheets, dated 9/26/18 through 10/26/18, indicated 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 urbary catheter (a small tube inserted into the bicdefer that remains there to provide continuous urbary drainage) and is incidented in urbary drainage) and is incidented in the state of the courmentation x 2 Indicate how many times the resident urbated not the amount of urba.  An undated facility policy titled "Fluid Intake &				B. WING	_		1 '	· ,
CAS DISTRICT   Continued From page 10   PROVIDERS PART CORRECTION STATE   PROVIDERS PLAN OF CORRECTION SHOULD BE CARREST PROVIDERS PLAN OF CORRECTION SHOULD BE CARREST PROVIDERS PLAN OF CORRECTION SHOULD BE CARREST PROVIDERS	MAMEURI	PROVINCE OF BUPPLIER		•			•	
FREIX REGILATORY OR LEG IDENTIFYING INFORMATION)  F 690  Continued From page 10	SUNNYV	IEW CARE CENTER	•		r .	• •		
urinary tract infection (IUTI) 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 fluid cutput (I&O) for two weeks and to discontinue the order when stable.  A review of the Evaluations of Intake/Cutput 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/Cutput 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 blacider that remains there to provide continuous urinary drainage) and is incontinent (involuntary voiding of urine and stoo). 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 &	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD CROSS-RETERENCED TO THE APPROP	BE	COMPLETION DATE
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 Inteke &		urinary tract infection part or all of the uring tube (a small tube is stomach thru which administered).  A Minimum Dafa Secare Screening data Resident A cognitive decision-making we have of a Physic indicated to monitor output (I&O) for two order when stable.  A review of an intak 9/26/18 through 10/16 field output was done.	in ([UTI] an infection affecting pary tract), and a gastrostomy surgically placed in the nutrition and medication are at (MDS) Assessment and ed 10/3/18, indicated eskills for dally are severely impairment.  Islan's Order, dated 9/26/18, Resident A's intake and weeks and to discontinue the e/Output flow Sheets, dated 26/18, indicated Resident A's umented as x 2 each shift, uations of intake/Output form no weekly evaluation of	F	390	integration into quality assurance system  Medical records designee audit charts with G-tube residents on a weekly basi ensure intake and output recoded properly. Finding will be reported to directo nursing to address if any concern arise and reported Q.A committee monthly X3	will is to s r of	
An undated facility policy titled "Fluid Intake &		On 9/18/19, at 1:40 Director of Nursing (not have an indwelling tube inserted into the to provide continuous incontinent (involunt stool). The facility dimeasuring fluid outpindwelling urinary ca 2 Indicate how many not the amount of ur	p.m., during an interview, the DON) stated Resident A does not urinary catheter (a small e bladder that remains there is urinary drainage) and is ary voiding of urine and o not have a way to ut for residents without an theter. The documentation x it mes the resident urinated ine.		•			
Output indicated fluid intake and output shall be		Output indicated flu	d intake and output shall be					

09-20-2019 02:09:19 p.m.

DEPART	MENT OF HEALTH	AND HUMAN SERVICES				ED: 09/20/2019
		& MEDICAID SERVICES	,	-		RM-APPROVED- 10. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILC		E CONSTRUCTION (Xa)	DATE SURVEY . COMPLETED
		555071	B. WING	ŀ		C 09/20/2019
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	
SUNNYV	IEW CARE CENTER	•	٠.		000 w Washington Bl Os angeles, ca 90018	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEPICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	to PREF TAG	IX I	PROVIDER'S FLAN OF CORRECTION IPACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	CDIMPLETION (X2)
. F. 690	Continued From pa	ge 11	F	380	•	
	recorded for reside output shall be reco days as ordered by	nt with GTs. Daily intake and orded for a minimum of 30 the physician. At the			F-842	10/03/19
	shall evaluate the r	O-day period, a licensed nurse esident to determine further atton of intake and output.			Corrective Action	10,02,00
	The evaluation sha and output assess shall assess for flui assessment on we	auth of make and output. If he recorded on the Intake nent form. Licensed nurses d balance and shall document akly licensed progress notes. offcy does not address how to			Upon notification, licensed nurse called diagnostic labs, retrieved missing lab results and placed them in resident's A chart.	
	Resident Records - CFR(s): 483.20(f)(5	Identifiable Information 5), 483.70(I)(1)-(5)	F	842		
	(i) A facility may not resident-identifiable	ent-Identifiable information. release information that is to the public, release information that is			Identification of other resident and corrective actions	<u>s</u>
	resident-identiffable accordance with a agrees not to use o	to an agent only in contract under which the agent of disclose the information the facility itself is permitted	•		Nurse designee did a random chart review to ensure lab and X ray results are placed in the charin a timely manner and abnorma	
	professional standa must maintain med that are-	records. cordance with accepted ords and practices, the facility ical records on each resident	•	-	lab results are reported to MD ar responsible party. Missing lab and X-ray results were retrieved and placed in residents' charts.	id.
·	(i) Complete; (ii) Accurately docu (iii) Readily accessi (iv) Systematically o	ble; and			No other issues were noted.	
	all information conti	scility must keep confidential sined in the resident's records, rm or storage method of the	•			
FORM CMS-25	87(02-69) Previous Versions	Obsolete Event ID: BWNC	11 ,	Fed	Thy ID: CA970000017 If continuation sh	et Page 12 of 18

02:09:49 p.m.

09-20-2019

20/22

_DEPART	MENT OF HEALTH	AND HUMAN SERVICES			· · · · · · · · · · · · · · · · · · ·		-FORM	09/20/2019 APPROVED-
	RS FOR MEDICARE OF DEFICIENCIES	& MEDICAID SERVICES (XI) PROVIDER/BUPPLIER/CLIA	T ain i ain	<u></u>		Ol		0938-0391
	F CORRECTION	DENTIFICATION NUMBER:	A. BUILD		LE CONSTRUCTION		COM	SURVEY. PLETED
		666071	B. WING	·	•		-	C 20/2019
NAMEOFF	ROVIDER OR BUPPLIER				TREET ADDRESS, CITY, STATI	E, ZIP CODE		
SUNNYV	IEW CARE CENTER		٠.		eiod w Washington Bl Los Angèles, ca 90011	B	,	
(X4) ID PREFIX YAG	(EACH DEFICIENCY	TEMENT OF DEPICIENCIES /MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFI TAG	IX ·	PROVIDER'S PLAN (EACH CORRECTIVE.) CROSS-REFERENCED TO DEFICE	ACTION SHOULD TO THE APPROPE	BE	(X5) COMPLETION DATE
F 842	Continued From pa	ne 13	· _,	342				,
	(vl) Laboratory, radi services reports as	ology and other diagnostic required under §483.50. IT is not met as evidenced		J <del>4</del> &				· .
	by: Based on interview facility's nursing sta	and record review the ff falled to ensure laboratory						
	record for one of tw (Resident A). The f	ere available in the clinical o sampled residents acility failad to accurately eatments for the resident. This		٠		•	•	
	deficient practice in current medical stat	correctly documented the lus of the resident, placed her nully of care and delay in		•				÷
	Findings:							
	indicated the reside facility on 9/26/18, v dysphagia (difficulty condition that result one or more nutrien	it A's Admission Record nt was readmitted to the vith diagnoses including swallowing), mainutrition (a s from eating a diet in which is are either not enough or		•			•	
-	problems), dehydrai water lost and not e urinary tract infectio part or all of the urin tube (a small tube s	that the diet causes health iton (when there is too much nough water taken in), a in ([UTI] an infection affecting lary tract), and a gestrostomy urgically placed in the					•	
	stomach thru which administered).	nutrition and medication are tA's clinical record indicated			•	•		
	the following Physic dated 10/22/18 - X-r	ian's Orders : ay right leg (tibia/fibula) and CBC, BMP, Pre-albumin,						
	A review of Residen	A's clinical record indicated	_					

FORM CMS-2567(02-88) Provious Versions Obsolete

Event ID; BWNC11

Facility IC: CA970000017

If continuation sheet Page 14 of 18

_			AND HUMAN SERVICES			•	Pl		09/20/2019 APPROVED
			& MEDICAID SERVICES				0	MB NO	0938-0391
		FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		CONSTRUCTION		COM	E SURVEY IPLETED
		•	<del>55</del> 60 <b>7</b> 1	B. WING_					C 20/2019
NAME OF PROVIDER OR SUPPLIER					<b>S7</b>	REET ADDRESS, CITY, STA	TE, ZIP CODE	001	EI VAIVA
SUNNYVIEW CARE CENTER						00 w washington bl Os angeles, ca 900	<b>1</b> 9	•	
	(X4) ID PRÉFIX TAG	(XA) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC (DENTIFYING INFORMATION)				PROVIDER'S PLA (EACH CORRECTIV CROSS-REFERENCEI	N OF CORRECTION EACTION SHOULD	95	COMPLETION DATE
	F 842	the x-ray and laborator review.  On 9/18/19 at 1:20 clinical record review (DON) she was not lab results.  On 9/19/19 the und "Laboratory Test" ar Laboratory Values" place laboratory or record.  b. Wound treatment dated 9/26/18 - GT saline, pat dry, cover Monitor pain daily do-10; 1-3= mild pain severe pain, 9/26/18 at line, 10/22/18 - Rignormal sterile saline dressing daily for 21 buttocks Stage-2 prormal sterile saline cover with a dry drest 10/24/18 - Right inn	p.m. during an interview and with the Director of Nursing able to locate the x-ray and ated facility policies titled and "Reporting Critical did not address where to radiology results in the clinical orders were as follows: site cleanse with normal ar with dry dressing, 9/26/18 - uring treatment on a scale of 1, 4-6= moderate pain, 7-10 = 1 - Monitor dressing integrity that medial knee, cleanse with 1, pat dry, apply Bacifracin (a), and cover with a dry days. 10/24/18 - Left inner essure ulcer; cleanse with 2, pat dry, apply Hydragel and 3ssing daily for 30 days, are buttocks Stage-1 pressure	F 84	12				
		apply Hydragel and daily for 30 days, On 10/26/18 the phy be transferred to the (GACH) for evaluation	normal sterile saline, pa dry, cover with a dry dressing rsician ordered Resident A to deneral Acute Care Hospital on of abnormal laboratory						
		According to a Multi- dated 10/26/18, Res	disciplinary Progress Record ident A was transferred to the	*****				·	

				TIPLE NG_	CONSTRUCTION .		OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED	
	·	555071	B. WING					C 20/2019
	PROVIDER OR SUPPLIER IEW CARE CENTER			20	TREET ADDRESS, CITY, STATE, ZIP CO 100 W WASHINGTON BL DS ANGELES, CA 90018	DE ,	. vai	20/20/19
(X4) fD PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C DENTIFYING INFORMATION)	PREFI) TAG	I	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION & CROSS-REFERENCED TO THE A DEFICIENCY)	ת וווחאו	RE 3R	COMPLETIO DATE
	GACH at 11:10 a.m.		F-8	42		•		
·	(LVN) initialed for the monitoring of pain a	e wound and GT treatment, nd the integrity of the 28, 9/29, and 9/30/2018.					•	
٠.	LVN 1, she said she the wound care after	p.m. during an interview with should have not documented the resident had been facility. However, she was lit.					•	
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	•							
			•					