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FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555128	A. BUILDING _____ B. WING _____	C 07/18/2018

2018 JUL 25 PM 4:18 RECEIVED

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOWNEY COMMUNITY HEALTH CENTER	8425 IOWA STREET DOWNEY, CA 90241

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F 000	INITIAL COMMENTS The following reflects the findings of the Department of Public Health during the investigation of a complaint. Complaint No: CA00585701 Representing the Department of Public Health: HFEN #36575 The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility. Two deficiencies were issued for complaint No: CA00585701.	F 000	This Plan of Correction constitutes the facility's written credible allegation of compliance. Preparation and/or execution of this Plan of Correction does not constitute admission of agreement by the Provider of the truth of the facts alleged or the conclusion set forth on the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because of requirement by the provisions of the health and safety code section 1280 and 42 CFR 483.	
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	F 580	F580 Corrective Action Resident #1 no longer resides in the facility. Identifying Other Residents The Director of Medical Records and/or designee will assess residents to ensure that if any other residents require suctioning, the attending physician will be informed and an order is obtained. Systemic Changes of Measures The Director of Nursing or designee will conduct in-services to licensed nurses July 18 to 23, 2018 regarding facility policy and procedure on physician	8/17/18

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

Gary Myrtle | Administrator | 7/25/18

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	Continued From page 1 §483.15(c)(1)(ii). (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 failed to notify the physician and obtain orders for suctioning (procedure to remove oral secretions when patient is unable to do it on their own with the use of a plastic tube connected to a suction machine) of oral secretions for one of three sampled residents (Resident 1). This deficient practice had a potential to cause a	F 580	notification and obtaining orders for suctioning. Director of Nursing or designee will conduct monitoring for one month to ensure compliance regarding notification of physician and obtaining orders for suctioning. <u>Monitoring</u> Findings of noncompliance will be submitted by the Director of Nursing and reviewed by the Q.A.P.I. Committee monthly until ongoing compliance is achieved. The Q.A.P.I. Committee will provide additional input and oversight.	

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F 580	Continued From page 2	F 580		

delay in providing appropriate treatment for Resident 1 and other residents with respiratory problems.

Findings:

A review of Resident 1's Admission Record indicated the resident was admitted on 4/19/18, and re-admitted on 4/29/18, with diagnosis of sepsis (a life-threatening complication of an infection), dysphagia (difficulty swallowing), and gastrostomy tube (surgically inserted tube through the abdomen directly to the stomach to deliver nutrition and medication).

A review of Resident 1's History and Physical, dated 4/30/18, indicated the resident had a history of shortness of breath (SOB), and the resident does not have the capacity to understand and make decisions.

A review of Resident 1's Minimum Data Set ([MDS], a resident assessment and care screening tool), dated 5/3/18, indicated the resident had short-term memory problem and severe impairment for cognitive (ability to reason and think) skills for daily decision making. The MDS indicated Resident 1 required total assistance with personal hygiene.

A review of Speech Therapy ([ST], a health care professional who specialized in speech and language) note, dated 4/20/18, indicated Resident 1 had a gurgle voice quality that the resident was not able to clear and suction was needed to clear the voice. The note indicated Resident 1 had a semi-productive cough strength and the resident was not able to spit out the mucous and/or phlegm (liquid produced by the respiratory

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F 580	Continued From page 3 system, which is expelled by coughing). A review of Resident 1's Licensed Nurses Admission Notes, dated 4/29/18, at 9 p.m., indicated the resident was congested with phlegm and suctioning was provided. The notes did not indicate that the physician was notified and an order was obtained for Resident 1's congestion with phlegm that required suctioning. A review of ST note, dated 5/1/18, indicated Resident 1 had profound to absent swallowing abilities and was at risk for aspiration (a condition in which substances was breathed into the airways). The note indicated Resident 1 had excessive mucous collection in the oral cavity (area inside the mouth) and throat and gurgle voice quality with inability to clear it. On 5/8/18, at 9:55 a.m., during an interview, Certified Nurse Assistant 1 (CNA 1) stated Resident 1 had one incident of coughing with phlegm and it was reported to Licensed Vocational Nurse 1 (LVN 1). On 5/8/18, at 11 a.m., during an interview, LVN 1 stated Resident 1 had an occasion of oral secretions and LVN 1 stated that she had suctioned the resident's oral cavity. On 7/11/18, at 8:28 a.m., during a telephone interview, Director of Nursing (DON) stated the nursing staff should have notified the physician of Resident 1 having oral secretions and obtain an order for suctioning. A review of facility's policy and procedure titled, "Acute Condition Changes- Clinical Protocol," revised December 2015, indicated before	F 580		

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F 580	Continued From page 4 contacting a physician about someone with an acute change of condition, the nursing staff would make detailed observations and collect pertinent information to report to the Physician. The policy indicated the physician would help identify and authorize appropriate treatments and the nurse would repeat a verbal orders to the physician to ensure accurate transcription. The policy indicated the staff would monitor and document the resident's progress and responses to treatment, and the Physician would adjust treatment accordingly.	F 580		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR	F 656	F656 Corrective Action Resident #1 no longer resides in the facility. Identifying Other Residents The Director of Medical Records and/or designee will audit the medical records of all residents who have oral secretions and requires suctioning to ensure that a care plan is initiated. Systemic Changes of Measures The Director of Nursing or designee will conduct in-services to licensed nurses July 18 to 23, 2018 on facility policy/procedure regarding initiating a care plan for residents who have oral secretions and required suctioning. Director of Medical Records or designee will conduct daily monitoring for fourteen days to ensure compliance regarding initiating of care plan and then monthly thereafter.	8/17/18

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F 656	Continued From page 5 recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to initiate a care plan for one of three sampled residents (Resident 1) who had oral secretions and required suctioning (procedure to remove oral secretions when patient is unable to do it on their own with the use of a plastic tube connected to a suction machine). This deficient practice had the potential for Resident 1 and other residents to not receive the necessary care and services. Findings: A review of Resident 1's Admission Record indicated the resident was admitted on 4/19/18, and re-admitted on 4/29/18, with diagnosis of sepsis (a life-threatening complication of an infection), dysphagia (difficulty swallowing), and gastrostomy tube (surgically inserted tube	F 656	Monitoring Findings of noncompliance will be submitted by the Director of Nursing and reviewed by the Q.A.P.I. Committee monthly until ongoing compliance is achieved. The Q.A.P.I. Committee will provide additional input and oversight.	

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F 656	Continued From page 6 through the abdomen directly to the stomach to deliver nutrition and medication). A review of Resident 1's History and Physical, dated 4/30/18, indicated the resident had a history of shortness of breath (SOB), and the resident does not have the capacity to understand and make decisions. A review of Resident 1's Minimum Data Set ([MDS], a resident assessment and care screening tool), dated 5/3/18, indicated the resident had short-term memory problem and severe impairment for cognitive (ability to reason and think) skills for daily decision making. The MDS indicated Resident 1 required total assistance with personal hygiene. A review of Resident 1's physician order, dated 4/19/18, indicated oral suctioning as needed for excessive secretions. A review of Resident 1's licensed personnel weekly progress notes, dated 4/20/18, at 3 a.m. and on 4/24/18, at 9:30 a.m., indicated the resident had increased oral secretions and suction was rendered. A review of Speech Therapy ([ST], a health care professional who specialized in speech and language) note, dated 4/20/18, indicated Resident 1 had a gurgle voice quality that the resident was not able to clear and suction was needed to clear the voice. The note indicated Resident 1 had a semi-productive cough strength and the resident was not able to spit out the mucous and/or phlegm (liquid produced by the respiratory system which is expelled by coughing).	F 656		

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F 656	Continued From page 7 A review of Resident 1's Licensed Nurses Admission Notes, dated 4/29/18, at 9 p.m., indicated resident was congested with phlegm and suctioning was provided. The notes did not indicate that the physician was notified and to obtain an order for Resident 1's congestion with phlegm that required suctioning. A review of ST note, dated 5/1/18, Resident 1 had profound to absent swallowing abilities and was at risk for aspiration (a condition in which substances was breathed into the airways). The note indicated Resident 1 had excessive mucous collection in the oral cavity (area inside the mouth) and throat and gurgle voice quality with inability to clear it. On 5/8/18 at 9:55 a.m., during an interview, Certified Nurse Assistant 1 (CNA 1) stated Resident 1 had one incident of coughing with phlegm and it was reported to Licensed Vocational Nurse 1 (LVN 1). On 5/8/18 at 11 a.m., during an interview, LVN 1 stated Resident 1 had an occasion of secretions and she had suctioned the resident's oral cavity. On 5/8/18 at 4 p.m., during a review of Resident 1's health record and a concurrent interview, the Director of Nursing (DON) stated the resident did not have a care plan to address oral secretions and the need for suctioning and should have had one to address the concern. The DON also stated that any licensed nurse could initiate a care plan for a care concern as needed. He said the purpose of a care plan was to guide staff on how to provide care for the resident. A review of the facility's policy and procedure	F 656		

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F 656	Continued From page 8 titled, "Comprehensive Assessment and the Care Delivery Process," revised December 2016, indicated comprehensive assessments will be conducted to assist in developing person-centered care plan. The policy also stipulated that comprehensive assessments, care planning and the care delivery process involve collecting and analyzing information, choosing and initiating interventions, and then monitoring results and adjusting interventions.	F 656		