Accepted [redacted] 11/8/16 36526

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

PRINTED: 10/20/2016
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555099 | A. BUILDING _____ B. WING _____ | C 10/18/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LAKEWOOD HEALTHCARE CENTER | 12023 LAKEWOOD BLVD. DOWNEY, CA 90242 |

| (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 | F 000 | | |

The following reflects the findings of the Department of Public Health during the investigation of a complaint during an Abbreviated standard survey.

Complaint Number: CA00501263 - Substantiated

Representing the Department of Public Health:

Health Facilities Evaluator Nurse ID: 36526

The inspection was limited to the specific complaint investigation and does not represent the findings of a full inspection of the facility.

Four deficiencies were issued for complaint CA00501263.

Highest Severity and Scope: G

F 224 SS=G 483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN — F 224

The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to ensure one of one sample resident (Resident 1), was free from

**Preparation and/or execution of this Plan of Correction does not constitute admission by the Provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because it's required by the provisions of Health and Safety Code Section 1280 and 42 C.F.R. 483." ...**

**This Plan of Correction constitutes Lakewood's Healthcare credible allegation of compliance for the alleged deficit practices.**

**F224**

**I. Corrective Action/s:**

Resident 1 was transferred to the hospital on 08/29/16 for further evaluation.

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

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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATIDN NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555099 | A. BUILDING _____ B. WING _____ | C 10/18/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LAKEWOOD HEALTHCARE CENTER | 12023 LAKEWOOD BLVD. DOWNEY, CA 90242 |

| (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 224 | Continued From page 1<br>neglect by failing to:<br><br>1. Conduct continuous neurological assessment from 7:30 p.m. to 11 p.m., on Resident 1 who sustained a forehead laceration (cut) after a fall on 8/29/16, at 7 p.m.<br><br>2. Transfer Resident 1 to higher level of care immediately to receive the necessary care, when Resident 1 reported to staff that she thought that she broke her ribs after a fall on 8/29/16, at 7 p.m.<br><br>3. Investigate the circumstances of Resident 1's unwitnessed fall and sustaining multiple injuries, and provide this written report to State Agency representative (Evaluator) as indicated in the facility's policy and procedure.<br><br>As a result of these deficient practices, Resident 1 did not receive the necessary care in a timely manner to address her injuries. On 8/29/16, at 11:23 p.m., Resident 1 was transferred to the general acute care center (GACH) after a fall incident on 8/29/16, at 7:15 p.m., which was four hours and eight minutes after a fall. The GACH Trauma History and Physical (H&P) Report dated 8/30/16 indicated Resident 1 had a large right-sided pneumothorax (abnormal collection of air or gas in the cavity between the lungs and the chest wall, causing collapse of the lung), for which a right tube thoracostomy (surgical artificial opening through the chest wall, usually for the drainage of fluid) was placed. The H&P listed Resident 1's injuries as follows: a small abrasion and soft tissue swelling in the right temporal region (side of the head behind the eyes), blunt torso (upper) trauma, and right 7th, 8th and 12th posterior (back) rib fractures | F 224 | **II. How to Identify Other Residents:**<br><br>IDT reviewed fall that occurred in the month of October. Falls were reviewed for the following:<br><br>Presence of the neuro check for falls with head injury, neuro checks for unwitnessed falls and investigation of circumstance surrounding the falls/injuries and timeliness of intervention.<br><br>#5 residents care plan were updated to include but not limited to fall circumstance investigation and neuro-checks. No hospitalization was necessary in all cases identified. No negative outcome was observed.<br><br>In-service on Abuse was conducted by the DSD from 10/24/2016 – 10/28/2016. RN, LVN, CAN and other department attended this in-service. Fall investigation, neuro checks, assessment and timely hospitalization was discussed with the licensed nurse during the in-service.<br><br>LVN#1 & RN#2 were given 1: 1 in-services by the DON initiated on 10/24/2016 for the following topics:<br><br>• Clinical implications and importance/timeliness of conducting neurological assessment in accordance with policy and procedure after any status of any unwitnessed fall or head injury | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555099 | A. BUILDING _____ B. WING _____ | C 10/18/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LAKEWOOD HEALTHCARE CENTER | 12023 LAKEWOOD BLVD. DOWNEY, CA 90242 |

| (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 224 | Continued From page 2<br><br>Cross Reference F309 and F323.<br><br>Findings:<br><br>On 9/1/16, at 1:32 p.m., during an observation of Resident 1 in the GACH, Resident 1 was noted with bruises (skin discoloration) purplish in color to her right eye socket, and eye brow. The resident's right side of the forehead had a healing cut which was yellowish/purplish in color. Resident 1 was observed with a chest tube attached to her right side upper body, connected to a drainage container.<br><br>During a concurrent interview, Resident 1 stated "I fell while in my room, I don't remember how but they kept jamming ice to my head over and over." The resident stated a certified nursing assistant (CNA) manhandled and tied her to a wheelchair. The resident continued to cry and repeatedly stating "I don't want to go back to the facility."<br><br>A review of the Resident 1's Admission Record indicated she was admitted to the facility on 6/3/16 and readmitted on 8/22/16 with diagnoses that included generalized muscle weakness, psychosis (a severe mental disorder in which thought and emotions are so impaired that contact is lost with external reality), and seizure disorder (uncontrolled jerking movement of the body and momentary loss of awareness).<br><br>A review of Resident 1's H&P dated 6/6/16 indicated the resident did not have the capacity to understand and make decisions.<br><br>A review of the Minimum Data Set (MDS, an assessment and care screening tool), dated | F 224 | • Clinical symptoms that would require immediate transfer after an unwitnessed fall or head injury<br><br>• Policy on Unusual Occurrences or Injuries of Unknown Origin<br><br>**III. Systemic Changes:**<br><br>a. DON/Designee in-services the Licensed Nurses initiated on 10/24/2016 for the following topics:<br><br>• Clinical implications and importance of conducting neurological assessment in accordance with policy and procedure after any status of any unwitnessed fall or head injury<br><br>• Clinical symptoms that would require immediate transfer after an unwitnessed fall<br><br>• Policy on Unusual Occurrences or injuries of unknown origin<br><br>b. Upon a resident incident of fall, Licensed Nurse will do a thorough investigation and body assessment for injuries which includes the vital signs & pain rating. A neurological assessment will be completed for any unwitnessed fall or head injury per facility's protocol. This will be | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555099 | A. BUILDING _____ B. WING _____ | C 10/18/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LAKEWOOD HEALTHCARE CENTER | 12023 LAKEWOOD BLVD. DOWNEY, CA 90242 |

| (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 224 | Continued From page 3<br>7/13/16, indicated Resident 1 had no memory problems, usually makes self-understood and had the ability to understand others. The MDS indicated the resident was not steady, but able to stabilize self without staff assistance, and required supervision setup help only for bed mobility, transfer, walk in room and corridor.<br><br>A review of the facility's document titled "SBAR (Situation, Background, Assessment and Recommendation) a technique that can be used to facilitate prompt and appropriate communication," dated 8/29/16, at 6:45 a.m., indicated Resident 1 was in bed, yelling, screaming for no apparent reason. When staff tried to talk to her, the resident continued to scream, started kicking and tried to bite staff. The note indicated that Resident 1 was on 1:1 monitoring and that an associated behavior at the time of this change was that the resident was seen placing herself on the floor. The documentation indicated there was discoloration noted at the resident's right upper back and left elbow.<br><br>A review of SBAR dated 8/29/16, at 7:15 p.m., indicated Resident 1 was found on the floor, along the hallway by certified nursing assistant 1 (CNA 1). The SBAR notes did not address the resident's injuries.<br><br>A review of the Licensed Personnel Progress Notes dated 8/29/16, at 11:10 p.m., indicated Resident 1 was alert and oriented, and walk up to the ambulance gurney (A stretcher or litter used for moving residents who require medical care). The note indicated after the resident got into the gurney the resident went to deep sleep. At 11:23 p.m., the progress notes indicated the resident's | F 224 | documented in the Licensed Nurses' note and Neurological Assessment form.<br><br>c. Any change of conditions post fall, resident's Primary MD will be notified for immediate transfer of resident, as well as notification of Responsible Party.<br><br>d. Post Fall, the IDT will review the event during the Fall Meeting after Stand Up daily M-F & by RN Supervisor during weekends with IDT to investigate the event further and recommend appropriate interventions and update the Plan of Care, as well as follow ups from the Post Fall Huddle. A full IDT review of fall that occurred on the weekend will be completed on Monday.<br><br>e. Any unknown fractures or unknown origin of events will be reported to Administrator/DON or Designees as soon as possible for immediate reporting to appropriate agencies.<br><br>f. Medical Records will complete the Change of Condition audits daily and findings will be given to DON/Designee for follow through.<br><br>**IV. Monitoring:**<br><br>DON/Designee will present any Investigations related to Unknown Fracture or Unknown Origin during the Monthly QAA Meeting for review and further recommendation. Trending will be review for need of further re-education of staff. | |

Accepted 11/08/16 36526

PRINTED: 10/20/2016
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 |
|---|---|---|---|
| | 555099 | A. BUILDING _____ B. WING _____ | C 10/18/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LAKEWOOD HEALTHCARE CENTER | 12023 LAKEWOOD BLVD. DOWNEY, CA 90242 |

| (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 224 | Continued From page 4<br>care was transferred to paramedics. The resident continued to be non-responsive.<br><br>A review of Resident 1's Paramedics Report dated 8/29/16 indicated that the paramedics were dispatched at 11 p.m., and arrived in the facility at 11:07 p.m. The documentation indicated a 911 (emergency number) responded to a complaint of head trauma from an unwitnessed ground level fall around 7:00 p.m., this evening with hematoma (localized swelling that is filled with blood caused by a break in the wall of a blood vessel) to back of the head. The Paramedics Report indicated the resident had a second fall unwitnessed approximately 30 minutes later resulting in a hematoma above the right eye with right rib pain. The report indicated that the resident told the staff that her ribs were broken around 7:00 p.m. and the facility did not call 911 for four (4) hours.<br><br>A review of the GACH Trauma History and Physical Report dated 8/30/16 indicated Resident 1 had a large right-sided pneumothorax, for which a right tube thoracostomy was placed. The documentation indicated the resident had a small abrasion and soft tissue swelling in the right temporal region. The list of injuries indicated the following:<br><br>1. Status post fall<br>2. Blunt torso trauma<br>3. Right-sided pneumothorax<br>4. Right 7th, 8th and 12th posterior rib fractures.<br><br>On 9/1/16, at 5:05 p.m., during an interview with the director of nurses (DON) he stated that Resident 1 was not assess for neurological status because there was no head injuries on 8/29/16 after a fall. | F 224 | **11/7/2016. Addendum to F224:**<br><br>**Corrective actions to those found to be affected by the practice:** Resident #1 was transferred to the acute hospital on 8/29/2016. Return not anticipated.<br><br>**Identification of others residents with the potential to be affected by this practice and corrective actions:**<br><br>Residents with falls, Reported falls or other incident with head injury and Unwitnessed falls in the month of October and moving forward were/will be assessed and records reviewed by the IDT for completeness and timeliness of needed services. The RN supervisor will immediately assist the Licensed nurse with assessment to include continuous neurological assessment and initiate investigation through the "Huddle" for further evaluation / root cause analysis of the fall and development of plan of care.<br><br>**Systemic changes in place to ensure the practice does not recur:** Resident with Un-witnessed fall, injury (ies) of unknown origin, residents reported falls and other incidents that might result in potential head injuries will be reported to the RN supervisor immediately and RN sup will initiate the assessment to include continuous neurological assessment and assessment for other internal/external injuries. | 11-7-16<br>#1<br>11-7-16 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555099 | A. BUILDING _____ B. WING _____ | C 10/18/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LAKEWOOD HEALTHCARE CENTER | 12023 LAKEWOOD BLVD. DOWNEY, CA 90242 |

| (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 224 | Continued From page 5<br><br>On 9/1/16, at 5:30 p.m., during an interview, license vocational nurse 1 (LVN 1) stated around 7 p.m., on 8/29/16 she was passing medication and was called by CNA 1 to assess Resident 1. LVN 1 stated the resident had a laceration at resident's right side of the forehead, but was not too big. LVN 1 stated she did assessed Resident 1's neurological status after the fall, but did not do it continuously.<br><br>On 9/2/16, at 8:16 a.m., upon request of the investigation report regarding Resident 1 incident of fall and/or placing herself on the floor on 8/29/16, the DON declined to provide the investigation stated that it was protected by their quality assurance committee.<br><br>On 9/6/16, at 2:00 p.m., during an interview, the fire department chief (FDC) stated upon picking-up Resident 1 from the facility, the resident had an injury to her right eye. The FDC stated there was bloody gauze around resident's head, and "We did not remove the gauze, so it would not aggravate it."<br><br>On 9/26/16, at 3:26 p.m., during an interview, RNS 2 stated she was called in at 7:00 p.m., on 8/29/16 by LVN 1 to assess Resident 1 who sustained a fall. RNS 2 stated she assessed Resident 1, but failed to document the assessment. RNS 2 was unable to provide the documentation of resident's neurological assessment after a fall from 7 p.m., to 11 p.m., on 8/29/16. She also did not know the actual injuries that Resident 1 suffered after a fall.<br><br>On 9/30/16, at 3:20 p.m., upon request of the written report investigation regarding Resident 1 | F 224 | Neurological checks will be conducted in accordance to the revised facility policy and procedure to meet the industry's standard and the need of the patient.<br><br>In accordance with the facility's policy and procedures, the facility shall report injuries of unknown origin to CDPH and ombudsman within 24 hours. Furthermore, the facility shall investigate circumstances of injuries of unknown origins and report summary of findings to CDPH within 5 business days.<br><br>**Monitoring Performance to ensure solutions achieved are sustained.**<br><br>Designated quality assurance nurse(es) will review falls within 24 hours for appropriate interventions and completeness and report findings to the Assistant Director of Nursing Services for immediate follow up.<br><br>These findings will be reported to the DON on Mon – Fri during the daily clinical review/report meeting. The ADON will review theses finding on the weekends and update the DON.<br><br>The DON will further review findings, identify trends and areas of performance improvement opportunity for educational needs for future teaching. DON will report findings to the QAA committee for review and recommendations. | 11-7-16 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555099 | A. BUILDING _____ B. WING _____ | C 10/18/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LAKEWOOD HEALTHCARE CENTER | 12023 LAKEWOOD BLVD. DOWNEY, CA 90242 |

| (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 224 | Continued From page 6<br>unwitnessed fall on 8/29/16, the assistant administrator stated that the report was with the DON. However, the written investigation report was not provided.<br><br>According to the 4/1/15, facility's revised policy and procedure tilted "Abuse Reporting and Investigation - Operational Manual Abuse and Neglect," the purpose indicated to protect the health, safety, and welfare of the facility residents by ensuring that all reports of resident abuse, mistreatment, neglect, or injuries of an unknown source are promptly and thoroughly investigated. The policy indicated the administrator will provide a written report of the results of all abuse investigations and appropriate action taken to Licensing and Certification and others that may be required by state or local laws, within (5) working days of the reported allegation. | F 224 | | |
| F 226 SS=D | 483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES<br><br>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review, the facility failed to investigate an unwitnessed fall with injury as indicated in the facility's policy and procedure for one of one sampled residents (Resident 1).<br><br>This deficient practice had the potential to cause reoccurrence of the incident, jeopardizing the | F 226 | **F226**<br><br>**I. Corrective Action/s:**<br><br>Resident 1 was transferred to the hospital on 08/29/16 for further evaluation.<br><br>**II. How to Identify Other Residents:**<br><br>a. Residents who have had falls during the month of October 2016 have been reviewed by the IDT. Revision started on 10/24/2016 for further interventions and any additional Plan of | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555099 | A. BUILDING _____ B. WING _____ | C 10/18/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LAKEWOOD HEALTHCARE CENTER | 12023 LAKEWOOD BLVD. DOWNEY, CA 90242 |

| (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 APPRDPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 226 | Continued From page 7<br>safety of the resident.<br><br>Findings:<br><br>A review of the Resident 1's Admission Record indicated she was admitted to the facility on 6/3/16 and readmitted on 8/22/16 with diagnoses that included generalized muscle weakness, psychosis (a severe mental disorder in which thought and emotions are so impaired that contact is lost with external reality), and epilepsy (uncontrolled jerking movement of the body and momentary loss of awareness).<br><br>A review of the Minimum Data Set (MDS, an assessment and care screening tool), dated 7/13/16, indicated Resident 1 had no memory problems, usually makes self-understood and had the ability to understand others. The MDS indicated the resident required supervision (oversight, encouragement or cueing) setup help only from the staff for bed mobility, transfer, walk in room and corridor, was continent (had control) of bowel and bladder functions, and no previous falls in the last month.<br><br>A review of the general acute care hospital (GACH) Trauma History and Physical Report dated 8/30/16 indicated Resident 1 had a large right-sided pneumothorax (abnormal collection of air or gas in the cavity between the lungs and the chest wall, causing collapse of the lung), for which a right tube thoracostomy (surgical artificial opening through the chest wall, usually for the drainage of fluid) was placed. The documentation indicated the resident had a small abrasion and soft tissue swelling in the right temporal region (side of the head behind the eyes). The list of injuries indicated the following: | F 226 | Care revisions. #5 Residents were identified who needed the revisions on their Plan of Care. When possible, fall circumstances were investigated during chart review and care plan updated from conclusion of the root cause analysis of the fall.<br><br>b. LVN#1 & RN#2 were given 1: 1 in-services by the DON was started on 10/24/2016 for the following topics:<br><br>• Clinical implications and importance of conducting neurological assessment in accordance with policy and procedure after any status of any unwitnessed fall or head injury<br><br>• Clinical symptoms that would require immediate transfer after an unwitnessed fall or head injury<br><br>• Policy on Unusual Occurrences or Injuries of Unknown Origin<br><br>**III. Systemic Changes:**<br><br>a. DON/Designee initiated in-services with Licensed Nurses on for the following topics:/<br><br>• Clinical implications and importance of conducting neurological assessment in accordance with policy and procedure after any status of any unwitnessed fall or head injury | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555099 | A. BUILDING _____ B. WING _____ | C 10/18/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LAKEWOOD HEALTHCARE CENTER | 12023 LAKEWOOD BLVD. DOWNEY, CA 90242 |

| (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 226 | Continued From page 8<br><br>1. Status post fall<br>2. Blunt torso (upper body) trauma<br>3. Right-sided pneumothorax<br>4. Right 7th, 8th and 12th posterior (back) rib fractures.<br><br>On 9/1/16, at 5:30 p.m., during an interview with license vocational nurse (LVN 1), stated that she was called by certified nurse assistance CNA to assess Resident 1 who had suffered a fall. LVN 1 stated the resident had a cut to her forehead, right side.<br><br>On 9/2/16 at 8:02 a.m., during a telephone interview with certified nursing assistant 1 (CNA 1), stated the charge nurse might witness the fall since she was closer to Resident 1. CNA 1 stated that she assisted her to get the resident up from the floor. CNA 1 further stated ice packs were applied to Resident 1's bumps to the forehead.<br><br>On 9/2/16 at 8:16 a.m., during an interview with the director of nurses DON he stated he could not provide the incident report information paperwork because it was protected by the quality assessment and assurance (QAA).<br><br>A review of the facility's undated Policy and Procedures titled "Mandated Reporter," indicated that if a serious bodily injury was sustained, the facility will call local law enforcement, and fax a written report to the local ombudsman and the Department of Public health. | F 226 | • Clinical symptoms that would require immediate transfer after an unwitnessed fall or head injury<br><br>• Policy on Unusual Occurrences or Injuries of Unknown Origin<br><br>b. Upon a resident incident of fall, Licensed Nurse will do a thorough investigation and body assessment for injuries which includes the vital signs & pain rating. A neurological assessment will be completed for any unwitnessed fall or head injury per facility's protocol. This will be documented in the Licensed Nurses' note and Neurological Assessment form.<br><br>c. Any change of conditions post fall, resident's Primary MD will be notified for immediately transfer of resident, as well as notification of Responsible Party.<br><br>d. Post Fall, the IDT will review the event during the Fall Meeting after Stand Up daily M-F & by RN Supervisor during weekends with IDT to investigate the event further and recommend appropriate interventions and update the Plan of Care, as well as follow ups from the Post Fall Huddle. A full IDT review of fall that occurred on the weekend will be completed on Monday.<br><br>e. Any unknown fractures or unknown origin of events will be reported to Administrator/ | |
| F 309 SS=G | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING | F 309 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555099 | A. BUILDING _____ B. WING _____ | C 10/18/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LAKEWOOD HEALTHCARE CENTER | 12023 LAKEWOOD BLVD. DOWNEY, CA 90242 |

| (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 309 | Continued From page 9<br>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, the facility failed to ensure one of one sampled resident (Resident 1), who had history of grand mal seizure (a tonic [the person initially stiffens and loses consciousness, causing them to fall to the ground], and clonic phase [following the tonic phase, the clonic phase will start as the muscles begin to spasm and jerk, and loss of alertness]), and episodes of placing herself on the floor, received necessary care and services by failing to:<br><br>1. Assess and identify if Resident 1 episodes of placing herself on the floor was a behavior or a type of seizure.<br><br>2. Monitor Resident 1's behavioral patterns and provide a safe environment as indicated in the seizure disorder plan of care<br><br>3. Assess Resident 1's neurological status as indicated in the facility's policy and procedure, to identify early changes in level of consciousness to prevent delayed interventions.<br><br>4. Conduct a thorough body assessment when Resident 1 reported to staff that she thought that she broke her ribs after a fall on 8/29/16, at 7 | F 309 | Designee as soon as possible for immediate reporting to appropriate agencies.<br><br>f. Medical Records will complete the Change of Condition audits daily and findings will be given to DON/Designee for follow through.<br><br>**IV. Monitoring:**<br><br>DON/Designee will present any Investigations related to known Fracture or fractures of Unknown Origin during the Monthly QAA Meeting for review and further recommendation. Trending will be review for need of further re-education of staff.<br><br>**F309**<br><br>**I. Corrective Action/s:**<br><br>Resident 1 was transferred to the hospital on 08/29/16 for further evaluation.<br><br>**II. How to Identify Other Residents:**<br><br>IDT reviewed falls that occurred in the month of October and reviewed residents with known seizure disorder and known residents with behavior that might put them at risk for self | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555099 | A. BUILDING _____ B. WING _____ | C 10/18/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LAKEWOOD HEALTHCARE CENTER | 12023 LAKEWOOD BLVD. DOWNEY, CA 90242 |

| (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 309 | Continued From page 10 | F 309 | | |

p.m., and transfer Resident 1 to higher level of care immediately.

As a result of these deficient practices, Resident 1 was found on the hallway floor on 8/29/16, at 7:15 p.m., with a cut on the forehead and was not transferred to the general acute care center (GACH) until 11:23 p.m. (four hours and eight minutes after a fall). The GACH identified Resident 1 with a large right-sided pneumothorax (abnormal collection of air or gas in the cavity between the lungs and the chest wall, causing collapse of the lung), which required a right tube thoracostomy (surgical artificial opening through the chest wall, usually for the drainage of fluid), a small abrasion and soft tissue swelling in the right temporal region (side of the head behind the eyes), blunt torso (upper) trauma, and right 7th, 8th and 12th posterior (back) rib fractures.

Cross Reference to F323

Findings:

On 9/1/16, at 1:32 p.m., during an observation of Resident 1 in the GACH, Resident 1 was observed with bruises (skin discoloration) purplish in color to her right eye socket, and eye brow. The resident's right side of the forehead had a healing cut which was yellowish/purplish in color. Resident 1 was observed with a chest tube attached to her right side upper body, connected to a drainage container.

During a concurrent interview, Resident 1 stated "I fell while in my room, I don't remember how but they kept jamming ice to my head over and over."

A review of Resident 1's History and Physical

injury i.e. throwing self on the floor. . Records were reviewed for the following:

- Care plan to include behavior, assessment, intervention either in the form of creating a safe environment, medication adjustment or timely hospitalization for further eval and treatment. .
- Presence of the neuro check for falls with head injury,
- neuro checks for unwitnessed falls
- investigation of circumstance surrounding the falls/injuries and timeliness of intervention with adequate root cause analysis of fall/behavior etc.

#5 residents care plan were updated to include but not limited to fall circumstance investigation and neuro-checks and #2 residents were referred to psychiatrist for follow up. No hospitalization was necessary in all cases identified. No negative outcome was observed.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555099 | A. BUILDING _____ B. WING _____ | C 10/18/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LAKEWOOD HEALTHCARE CENTER | 12023 LAKEWOOD BLVD. DOWNEY, CA 90242 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PRDVIDER'S PLAN DF CDRRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 309 | Continued From page 11 | F 309 | | |

(H&P) from the GACH dated 8/18/16 indicated the resident had an uncontrolled seizure disorder with recurrent seizures due to non-compliance with medications. The H&P indicated the resident's Dilantin (an anti-seizure medication) level was 2.2 microgram (mcg/ml) (Reference range 10.0-20.0 mcg/mL, this is use in determining therapeutic dosing, managing adverse effects and toxicity). The resident was admitted and given intravenous (through the vein) Keppra (anti-seizure medication) and was discharged back to the facility on 8/22/16.

A review of e Resident 1's Admission Record indicated she was admitted to the facility on 6/3/16 and readmitted on 8/22/16 with diagnoses that included generalized muscle weakness, psychosis (a severe mental disorder in which thought and emotions are so impaired that contact is lost with external reality), and seizure disorder (uncontrolled jerking movement of the body and momentary loss of awareness).

The care plan dated 6/3/16, titled "Seizures," indicated at risk for injuries due to seizures disorders. The interventions included to maintain a safe environment for the resident and monitor behavioral patterns.

A review of Resident 1's H&P dated 6/6/16 indicated the resident did not have the capacity to understand and make decisions.

A review of the Minimum Data Set (MDS, an assessment and care screening tool), dated 7/13/16, indicated Resident 1 had no memory problems, usually makes self-understood and had the ability to understand others. The MDS indicated the resident was not steady, but able to

a. Residents with Dxs Seizure Disorders and behaviors which may result in self injury such as putting self on the floor were reviewed by the IDT on 10/24/2016 – 10/28/2016 for further interventions and any additional Plan of Care revisions. #1 Residents were identified who needed the revisions on their Plan of Care.

b. LVN#1 & RN#2 were given 1: 1 in-services by the DON on 10/25/2016 for the following topics:

- Clinical implications and importance of conducting neurological assessment in accordance with policy and procedure after any status of any unwitnessed fall or head injury
- Assessment and clinical symptoms that would require immediate transfer after an unwitnessed fall or head injury or other changes of condition.
- Emphasis on assessment of injury/behavior, timeliness of intervention including but not limited to hospital transfer as needed.
- Policy on Unusual Occurrences or Injuries of Unknown Origin
- Policy on Change Conditions, including seizure activities and individualized behavior plan such as putting self on floor

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555099 | A. BUILDING _____ B. WING _____ | C 10/18/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LAKEWOOD HEALTHCARE CENTER | 12023 LAKEWOOD BLVD. DOWNEY, CA 90242 |

| (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 309 | Continued From page 12 | F 309 | | |

stabilize self without staff assistance, and required supervision setup help only for bed mobility, transfer, walk in room and corridor.

A review of the facility's document titled "SBAR (Situation, Background, Assessment and Recommendation) a technique that can be used to facilitate prompt and appropriate communication," dated 8/29/16, at 6:45 a.m., indicated Resident 1 was in bed, yelling, screaming for no apparent reason. When staff tried to talk to her, the resident continued to scream, started kicking and tried to bite staff. The note indicated that the resident was on 1:1 monitoring and that another associated behavior with this change was that the resident was placing herself on the floor. The documentation indicated there was discoloration noted at resident's right upper back and left elbow.

A review of SBAR dated 8/29/16, at 7:15 p.m., indicated Resident 1 was found on the floor, along the hallway by certified nursing assistant 1 (CNA 1). The notes indicated the following vital signs:
- Blood pressure of 136/80 milliliter mercury (mm Hg) (normal range 120/80 mm Hg0, pulse rate 86 beat per minute (bpm) (normal range 70 to 100 bpm),
- Respiratory rate 20 breathes per minute (normal rate 12-20 breaths per minute),
- Body temperature 98.6 degrees Fahrenheit (°F) (normal temperature 91.8-100.8 °F),
- Oxygen saturation (oxygen in the blood) was 99 percent (%) (Normal range from 95 to 100 %).

The SBAR Progress notes indicated the physician was notified and ordered to transfer

**III. Systemic Changes:**

a. DON/Designee in-services the Licensed Nurses on 10/24/2016 – 10/15/2016 for the following topics:

- Clinical implications and importance of conducting neurological assessment in accordance with policy and procedure after any status of any unwitnessed fall or head injury.
- Clinical symptoms that would require immediate transfer after an unwitnessed fall or head injury
- Policy on Unusual Occurrences or injuries of unknown origin
- Policy on Change Conditions, including seizure activities and individualized behavior plan such as putting self on floor

b. DSD/Designee in-services the CNAs on Abuse with emphasis on unauthorized restraint on 10/24/2016 – 10/28/2016

c. Upon a resident incident of fall or behavior such as putting self on floor, CAN to notify Licensed Nurse for a thorough investigation, root cause analysis and body assessment for injuries which includes the vital signs & pain rating. A neurological assessment will be completed for any un-witness fall, head injury or seizure activity per facility's protocol. This

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIDN | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555099 | A. BUILDING _____ B. WING _____ | C 10/18/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LAKEWOOD HEALTHCARE CENTER | 12023 LAKEWOOD BLVD. DOWNEY, CA 90242 |

| (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 309 | Continued From page 13 | F 309 | | |

Resident 1 to the emergency department (GACH) for evaluation. The notes indicated that the resident was waiting to be picked up. The documentation did not specify who was going to pick up the resident and did not address the resident's actual injuries.

A review of the Licensed Personnel Progress Notes dated 8/29/16, at 11:10 p.m., indicated Resident 1 was alert and oriented, and walked up to the ambulance gurney (A stretcher or litter used for moving residents who require medical care). The note indicated after the resident got into the gurney the resident went into a deep sleep. At 11:23 p.m., the progress notes indicated Resident 1's care was transferred to paramedics. The resident continued to be non-responsive.

A review of Resident 1's Paramedics Report dated 8/29/16 indicated that the paramedics were dispatched at 11 p.m., and arrived in the facility at 11:07 p.m. The documentation indicated a 911 (emergency number) responded to a complaint of head trauma from an unwitnessed ground level fall around 7:00 p.m., this evening with hematoma (localized swelling that is filled with blood caused by a break in the wall of a blood vessel) to back of the head. The Paramedics Report indicated Resident 1 had a second fall unwitnessed approximately 30 minutes later resulting in a hematoma above the right eye with right rib pain. The report indicated that the resident told the staff that her ribs were broken around 7:00 p.m. and the facility did not call 911 for four (4) hours.

A review of the GACH Trauma History and Physical Report dated 8/30/16 indicated Resident 1 had a large right-sided pneumothorax, for which

will be documented in the Licensed Nurses' note and Neurological Assessment form.

d. Any change of conditions post fall/ behavior which causes self injury such as putting self on floor, resident's Primary MD will be notified for immediate transfer of resident, as well as notification of Responsible Party.

e. Post Fall & Post Behavior such as Putting Self on Floor, the IDT will review the event during the Fall Meeting after Stand Up daily M-F & by RN Supervisor during weekends with IDT to investigate the event further and recommend appropriate interventions and update the Plan of Care, as well as follow ups from the Post Fall Huddle. A full IDT review will be completed on Monday.

g. Medical Records will complete the Change of Condition audits daily and findings will be given to DON/Designee for follow through.

h. DON/Designee to review any delayed in transfer of residents to hospital post Change of Conditions daily. Findings will be discussed during Daily Stand Up Meetings for further investigation of the event & recommendations.

**IV. Monitoring:**

DON/Designee will present during the Monthly QAA Meetings the # of residents with Dxs. of Seizures & Behaviors such as putting self on

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555099 | A. BUILDING _____ B. WING _____ | C 10/18/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LAKEWOOD HEALTHCARE CENTER | 12023 LAKEWOOD BLVD. DOWNEY, CA 90242 |

| (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 309 | Continued From page 13<br>Resident 1 to the emergency department (GACH) for evaluation. The notes indicated that the resident was waiting to be picked up. The documentation did not specify who was going to pick up the resident and did not address the resident's actual injuries.<br><br>A review of the Licensed Personnel Progress Notes dated 8/29/16, at 11:10 p.m., indicated Resident 1 was alert and oriented, and walked up to the ambulance gurney (A stretcher or litter used for moving residents who require medical care). The note indicated after the resident got into the gurney the resident went into a deep sleep. At 11:23 p.m., the progress notes indicated Resident 1's care was transferred to paramedics. The resident continued to be non-responsive.<br><br>A review of Resident 1's Paramedics Report dated 8/29/16 indicated that the paramedics were dispatched at 11 p.m., and arrived in the facility at 11:07 p.m. The documentation indicated a 911 (emergency number) responded to a complaint of head trauma from an unwitnessed ground level fall around 7:00 p.m.; this evening with hematoma (localized swelling that is filled with blood caused by a break in the wall of a blood vessel) to back of the head. The Paramedics Report indicated Resident 1 had a second fall unwitnessed approximately 30 minutes later resulting in a hematoma above the right eye with right rib pain. The report indicated that the resident told the staff that her ribs were broken around 7:00 p.m. and the facility did not call 911 for four (4) hours.<br><br>A review of the GACH Trauma History and Physical Report dated 8/30/16 indicated Resident 1 had a large right-sided pneumothorax, for which | F 309 | **11/7/2016: Addendum F 309:**<br><br>**Corrective Actions:** Resident #1 was transferred to the acute hospital. Return not anticipated.<br><br>**How to identify other residents with potential of being affected -- with corrective actions:** Other residents with early morning blood draw refusal had their blood draw rescheduled for after 0800am. This will enable further resources like psychologist, social service and DON's intervention to facilitate the blood draw.<br><br>**Systemic changes in place to ensure the practice does not recur:** The concept of STOP and WATCH has been implemented to staff and visitors to identify subtle changes in residents' condition and to immediate report these findings/observations to the licensed nurses for further intervention.<br><br>The RN supervisor will further assess resident for cause of behavior and communicate findings to MD for possible diagnostic exam as needed.<br><br>Resident with Un-witnessed fall, injury (ies) of unknown origin, residents reported falls and all or other incident that might result in potential head injuries will be reported to the RN supervisor immediately and RN sup will initiate the assessment to include continuous | 11-7-16<br><br>11-7-16 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555099 | A. BUILDING _____ B. WING _____ | C 10/18/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LAKEWOOD HEALTHCARE CENTER | 12023 LAKEWOOD BLVD. DOWNEY, CA 90242 |

| (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 309 | Continued From page 14 | F 309 | | |

a right tube thoracostomy was placed. The documentation indicated the resident had a small abrasion and soft tissue swelling in the right temporal region. The list of injuries indicated the following:

1. Status post fall
2. Blunt torso trauma
3. Right-sided pneumothorax
4. Right 7th, 8th and 12th posterior rib fractures.

On 9/1/16, at 5:30 p.m., during an interview, licensed vocational nurse 1 (LVN 1) stated around 7 p.m., on 8/29/16, she was passing medication and was called by CNA 1 to assess Resident 1. LVN 1 stated she cleaned the laceration (cut) on the resident's right side of the forehead, and notified the primary care physician. LVN 1 stated that the resident's laceration was not too big. LVN 1 stated that a regular ambulance (ambulances that provide transportation for residents who do not require cardiac [heart] monitoring) was called to transfer the resident to the GACH. However, when the resident got into the gurney, the resident went into a deep sleep, and the ambulance declined to transport the resident, and the 911 was called.

On 9/6/16, at 2:00 p.m., during an interview, fire department chief (FDC) stated upon picking-up Resident 1 from the facility, the resident had an injury to her right eye. The FDC stated there was bloody gauze around the resident's head, and "We did not remove the gauze, so it would not aggravate it."

On 9/26/16, at 3:26 p.m., during an interview, RNS 2 stated she was called in at 7:00 p.m., on 8/29/16 by LVN 1 to assess Resident 1 who

floors with negative findings for trending's and further recommendation.

DON to present findings from the audits from any delay of transfers on any Change of Conditions for trending's and further recommendation.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555099 | A. BUILDING _____ B. WING _____ | C 10/18/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LAKEWOOD HEALTHCARE CENTER | 12023 LAKEWOOD BLVD. DOWNEY, CA 90242 |

| (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 309 | Continued From page 14<br>a right tube thoracostomy was placed. The documentation indicated the resident had a small abrasion and soft tissue swelling in the right temporal region. The list of injuries indicated the following:<br><br>1. Status post fall<br>2. Blunt torso trauma<br>3. Right-sided pneumothorax<br>4. Right 7th, 8th and 12th posterior rib fractures.<br><br>On 9/1/16, at 5:30 p.m., during an interview, licensed vocational nurse 1 (LVN 1) stated around 7 p.m., on 8/29/16, she was passing medication and was called by CNA 1 to assess Resident 1. LVN 1 stated she cleaned the laceration (cut) on the resident's right side of the forehead, and notified the primary care physician. LVN 1 stated that the resident's laceration was not too big. LVN 1 stated that a regular ambulance (ambulances that provide transportation for residents who do not require cardiac [heart] monitoring) was called to transfer the resident to the GACH. However, when the resident got into the gurney, the resident went into a deep sleep, and the ambulance declined to transport the resident, and the 911 was called.<br><br>On 9/6/16, at 2:00 p.m., during an interview, fire department chief (FDC) stated upon picking-up Resident 1 from the facility, the resident had an injury to her right eye. The FDC stated there was bloody gauze around the resident's head, and "We did not remove the gauze, so it would not aggravate it."<br><br>On 9/26/16, at 3:26 p.m., during an interview, RNS 2 stated she was called in at 7:00 p.m., on 8/29/16 by LVN 1 to assess Resident 1 who | F 309 | neurological assessment and assessment for other internal/external injuries.<br><br>Neurological checks will be conducted in accordance to the revised facility policy and procedure to meet the industry's standard and the need of the patient.<br><br>In accordance to the facility's policy and procedures, the facility shall report injuries of unknown origin to CDPH and ombudsman within 24 hours. Furthermore, the facility shall investigate circumstances of injuries of unknown origins and report summary of findings to CDPH within 5 business days.<br><br>**Monitoring Performance to ensure solutions achieved are sustained.**<br><br>Designated quality assurance nurse will review falls within 24 hours for appropriate interventions and completeness and report findings to the Assistant Director of Nursing Services for Immediate follow up.<br><br>These findings will be reported to the Mon – Fri during the daily clinical review/report meeting. The ADON will review theses finding on the weekends.<br><br>The DON will further review findings, identify trends and areas of performance improvement opportunity for educational needs. DON will report findings to the QAA committee for review and recommendations. | 11-7-16<br><br>11-7-16 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555099 | A. BUILDING _____ B. WING _____ | C 10/18/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LAKEWOOD HEALTHCARE CENTER | 12023 LAKEWOOD BLVD. DOWNEY, CA 90242 |

| (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 309 | Continued From page 15 | F 309 | | |

sustained a fall. RNS 2 stated she assessed Resident 1, but failed to document the assessment. RNS 2 was unable to provide the documentation of resident's neurological assessment after a fall from 7:30 p.m., to 11 p.m., on 8/29/16. She also did not know that Resident 1 sustained a laceration in her forehead. RNS 2 was unable to explain the reason that it took four hours before a resident was transferred to the GACH.

On 10/3/16, at 11:19 a.m., during an interview, RNS 1 stated Resident 1 was not assessed if episodes of dropping herself on the floor were a seizure or a behavior. RNS 1 stated Resident 1's neurological assessment should have been done on 8/29/16 after Resident 1 sustained a head injury from a fall. RNS 1 stated the resident had to be monitored every 15 minutes for the first hour, 30 minutes for one hour and then every four hours for a total of 72 hours by standard of practice.

A review of the 1/1/12, facility's policy and procedures titled "Neurological Assessment," indicated following an unwitnessed fall; nursing staff shall perform neurological checks every four (4) hours for the first 24 hours, then every eight (8) hours, until attending physician states it is no longer necessary or in 72 hours if resident's condition is stable and showing no signs and symptoms of neurological injury.

According to the 1/8/13, Long Term Care Nursing Library, indicated neurological checks for head injuries included assessment of the resident for changes in level of consciousness, observation of injuries including lacerations, and performing frequent neurological assessments every:

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555099 | A. BUILDING _____ B. WING _____ | C 10/18/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LAKEWOOD HEALTHCARE CENTER | 12023 LAKEWOOD BLVD. DOWNEY, CA 90242 |

| (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 309 | Continued From page 16 | F 309 | | |

15 minutes for two hours
30 minutes for two hours
60 minutes for four hours
Eight hours for 16 hours
Eight hours until at least 72 hours have elapse and resident is stable
(<http://www.hcpro.com/print/LTC-287387-10704/Neurological-checks-for-head-injuries.html>)

A review of the facility's undated policy and procedures titled "Change of Condition Notification," indicated the licensed nurse will assess the change of condition and determine what nursing intervention are appropriate before notifying the attending physician. The licensed nurse must observe and assess the overall condition utilizing a physical assessment and chart review. The policy indicated the licensed nurse must document the assessment.

| F 323 SS=G | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES | F 323 | | |
|---|---|---|---|---|

The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to ensure that one of one sample resident, Resident 1, who was assessed as having a high risk for falls, had history of falls

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555099 | A. BUILDING _____ B. WING _____ | C 10/18/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LAKEWOOD HEALTHCARE CENTER | 12023 LAKEWOOD BLVD. DOWNEY, CA 90242 |

| (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 323 | Continued From page 17 | F 323 | | |

and had a behavior of placing herself on the floor, was provided with adequate supervision to prevent further falls for by failing to:

1. Provide 1:1 monitoring as indicated in the SBAR (Situation, Background, Assessment, and Recommendation) dated 8/29/16, at 7:30 a.m.

2. Follow the facility's policy and procedures on fall management program to identify risk factors and root cause of resident behavior and for licensed nurses and/or interdisciplinary team to develop a plan of care according to the identified cause.

3. Maintain functional cameras in the hallways to capture actual condition of the resident prior to the incident that can be used to identify cause and develop plan of care according to the facility's policy and procedure.

As a result of these deficient practices, Resident 1 sustained a second fall on 8/29/16, at 7:15 p.m., and was transferred to the general acute care center (GACH) and was found with a large right-sided pneumothorax (abnormal collection of air or gas in the cavity between the lungs and the chest wall, causing collapse of the lung), for which a right tube thoracostomy (surgical artificial opening through the chest wall, usually for the drainage of fluid) was placed. Resident 1 also sustained a small abrasion and soft tissue swelling in the right temporal region (side of the head behind the eyes), blunt torso (upper body) trauma, and right 7th, 8th and 12th posterior (back) rib fractures.

Findings:

**F323**

I. Corrective Action/s:

Resident 1 was transferred to the hospital on 08/29/16 for further evaluation.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555099 | A. BUILDING _____ B. WING _____ | C 10/18/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LAKEWOOD HEALTHCARE CENTER | 12023 LAKEWOOD BLVD. DOWNEY, CA 90242 |

| (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 323 | Continued From page 18<br>During an observation in the GACH on 9/1/16, at 1:32 p.m., Resident 1 was observed with bruises (skin discoloration) and her right eye socket and eye brow were purplish in color. The resident's right side of the forehead had a healing cut which was yellowish/purplish in color. Resident 1 was observed with a chest tube attached to her right side upper body that connected to a drainage container.<br><br>During a concurrent interview, Resident 1 stated "I fell while in my room, I don't remember how, but they kept jamming ice to my head over and over."<br><br>A review of the Resident 1's Admission Record indicated she was admitted to the facility on 6/3/16 and readmitted on 8/22/16 with diagnoses that included generalized muscle weakness, psychosis (a severe mental disorder in which thought and emotions are so impaired that contact is lost with external reality), and seizure disorder (uncontrolled jerking movement of the body and momentary loss of awareness).<br><br>A review of Resident 1's History and Physical (H&P) dated 6/6/16, indicated the resident did not have the capacity to understand and make decisions.<br><br>A review of the Minimum Data Set (MDS, an assessment and care screening tool), dated 7/13/16, indicated Resident 1 had no memory problems, usually makes self-understood and had the ability to understand others. The MDS indicated the resident was not steady, but able to stabilize self without staff assistance, and required supervision setup help only for bed mobility, transfer, walk in room and corridor. | F 323 | II. How to Identify Other Residents:<br><br>a. Residents with Dxs Seizure Disorders and Behavior such as putting self on floor were reviewed by the IDT on 10/25/2016 – 10/28/2016 for further interventions and any additional Plan of Care revisions. #1 Resident was identified who needed the revisions on their Plan of Care.<br><br>b. LVN#1 & RN#2 were given 1: 1 in-services by the DON on for the following topics:<br><br>• Clinical implications and importance of conducting neurological assessment in accordance with policy and procedure after any status of any unwitnessed fall or head injury.<br><br>• Clinical symptoms that would require immediate transfer after an unwitnessed fall or head injury<br><br>• Policy on Unusual Occurrences or Injuries of Unknown Origin<br><br>• Policy on Change Conditions, including seizure activities and individualized behavior plan such as putting self on floors<br><br>III. Systemic Changes:<br><br>a. DON/Designee in-services the Licensed Nurses on 10/24/2016 – 10/28/2016 for the following topics: | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555099 | A. BUILDING _____ B. WING _____ | C 10/18/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LAKEWOOD HEALTHCARE CENTER | 12023 LAKEWOOD BLVD. DOWNEY, CA 90242 |

| (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 323 | Continued From page 19<br><br>A review of the Fall Assessment dated 8/22/16 indicated Resident 1 scored 13 (A total score above 10 represents high risk for fall).<br><br>The care plan dated 8/26/16, titled "Fall Risk Prevention and Management, indicated at risk for falls due to lack of awareness, cognitive deficit, impulsive behaviors, forgets to call/wait for assistance and engages in independent transfer/ambulation despite explanation of risks. The care plan indicated actual falls on 8/29/16. The interventions included; "to provide an environment that supports minimized hazards over which the facility has control and to remind the resident to use call light."<br><br>A review of the facility's document titled "SBAR (Situation, Background, Assessment and Recommendation) a technique that can be used to facilitate prompt and appropriate communication," dated 8/29/16, at 6:45 a.m., indicated Resident 1 was in bed, yelling, screaming for no apparent reason. When staff tried to talk to her, the resident continued to scream, started kicking and tried to bite staff. The note indicated that Resident 1 was on 1:1 monitoring and that an associated behavior at the time of this change was that the resident was seen placing herself on the floor. The documentation indicated there was discoloration noted at the resident's right upper back and left elbow.<br><br>A review of the Licensed Personnel Progress Notes dated 8/29/16, at 10 a.m., indicated Resident 1 was in her room, no episodes of placing herself on the floor but with screaming outburst. At 12 p.m., the progress notes indicated | F 323 | • Clinical implications and importance of conducting neurological assessment in accordance with policy and procedure after any status of any unwitnessed fall or head injury.<br><br>• Clinical symptoms that would require immediate transfer after an unwitnessed fall or head injury<br><br>• Policy on Unusual Occurrences or Injuries of Unknown Origin<br><br>• Policy on Change Conditions, including seizure activities and individualized behavior plan such as putting self on floors<br><br>b. DSD/Designee in-services the CNAs on 10/24/2016 – 10/28/2016 for the following topics:<br><br>• Clinical implications and importance of conducting neurological assessment in accordance with the facility policy of any unwitnessed fall or head injury<br><br>• Clinical symptoms that would require immediate transfer after an unwitnessed fall or head injury<br><br>• Policy on Unusual Occurrences or Injuries of Unknown Origin | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555099 | A. BUILDING _____ B. WING _____ | C 10/18/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LAKEWOOD HEALTHCARE CENTER | 12023 LAKEWOOD BLVD. DOWNEY, CA 90242 |

| (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 CRDSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 323 | Continued From page 20 | F 323 | | |

that the resident was moved to the East wing station, in stable condition and will continue to monitor.

A review of SBAR dated 8/29/16, at 7:15 p.m., indicated Resident 1 fell along the hallway and was found on the floor by certified nursing assistant 1 (CNA 1). The notes indicated the physician was notified and ordered to transfer the resident to a GACH.

A review of the Licensed Personnel Progress Notes dated 8/29/16, at 11:10 p.m., indicated Resident 1 was alert and oriented, and walked to the ambulance gurney (A stretcher or litter used for moving residents who require medical care). The note indicated after the resident got into the gurney, the resident went into a deep sleep. At 11:23 p.m., the progress notes indicated the resident care was transferred to paramedics. The resident continued to be non-responsive.

A review of Resident 1's Paramedics Report dated 8/29/16 indicated that the paramedics were dispatched at 11 p.m., and arrived in the facility at 11:07 p.m. The documentation indicated a 911 (emergency number) responded to a complaint of head trauma from an unwitnessed ground level fall around 7:00 p.m., this evening with hematoma (localized swelling that is filled with blood caused by a break in the wall of a blood vessel) to back of the head. The Paramedics Report indicated the resident had a second fall unwitnessed approximately 30 minutes later resulting in a hematoma above the right eye with right rib pain. The report indicated that the resident told the staff that her ribs were broken around 7:00 p.m. and the facility did not call 911 for four (4) hours.

- Policy on Change Conditions, including seizure activities and individualized behavior plan such as putting self on floors

c. Cameras on the hallways were adjusted by on 10/24/2016 by the maintenance director to be able to record and retain data for 30 days. Camera was also adjusted to capture activities on the east hallway.

d. When the resident has behaviors which may cause self harm a root cause analysis of the resident behaviors will be conducted.

e. Upon a resident incident of fall or behavior such as putting self on floor, Licensed Nurse will do a thorough investigation and body assessment for injuries which includes the vital signs & pain rating. A neurological assessment will be completed for any unwitnesss fall, head injury or seizure activity per facility's protocol. This will be documented in the Licensed Nurses's note and Neurological Assessment form.

f. Any change of conditions post fall/ behavior such as putting self on floor, resident's Primary MD will be notified for immediate transfer of resident, as well as notification of Responsible Party.

g. Post Fall & Post Behavior such as Putting Self on Floor, the IDT will review the event during

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555099 | A. BUILDING _____ B. WING _____ | C 10/18/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LAKEWOOD HEALTHCARE CENTER | 12023 LAKEWOOD BLVD. DOWNEY, CA 90242 |

| (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 323 | Continued From page 21 | F 323 | | |

A review of the GACH Trauma History and Physical Report dated 8/30/16 indicated Resident 1 had a large right-sided pneumothorax, for which a right tube thoracostomy was placed. The documentation indicated the resident had a small abrasion and soft tissue swelling in the right temporal region. The list of injuries indicated the following:

1. Status post fall
2. Blunt torso trauma
3. Right-sided pneumothorax
4. Right 7th, 8th and 12th posterior rib fractures.

During an interview on 9/1/16, at 5:30 p.m., the licensed vocational nurse (LVN 1) stated while she was passing medications around 7 p.m., CNA 1 called her to assess Resident 1 who had suffered a fall in a hallway. LVN 1 stated the resident had a cut to her right side of the forehead. LVN 1 stated she cleaned the wound with saline and notified the primary care physician.

On 9/2/16, at 8:02 a.m., during a telephone interview with CNA 1 she stated that she assisted LVN 1 to get the resident up from the floor. CNA 1 further stated ice packs were applied to Resident 1's bumps to the forehead.

On 9/2/16, at 10:50 a.m., the assistant administrator was asked for the video footage of Resident 1's fall incident in the hallway on 8/29/16. The assistant administrator stated that the video footage was only for 24 hours, and the cameras for the particular hallway were not working.

On 9/7/16, at 9:34 a.m., during a telephone

the Fall Meeting after Stand Up daily M-F & by RN Supervisor during weekends with IDT to investigate the event further, complete root cause analysis and recommend appropriate interventions and update the Plan of Care, as well as follow ups from the Post Fall Huddle.

h. During the weekends, the RN Supervisor will review the events with Rehab. Dept. and another IDT member to conduct the Post Event IDT for appropriate interventions & revision of Plan of Care.

i. Medical Records will complete the Change of Condition audits daily and findings will be given to DON/Designee for follow through.

j. DON/Designee to review any delayed in transfer of residents to hospital post Change of Conditions daily. Findings will be discussed during Daily Stand Up Meetings for further investigation of the event & recommendations.

**IV. Monitoring:**

DON/Designee will present during the Monthly QAA Meetings the # of residents with Dxs of Seizures & Behaviors of putting self on floors with negative findings for trendings and further recommendation.

DON will present findings from the audits from any delay of transfers on any Change of

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555099 | A. BUILDING _____ B. WING _____ | C 10/18/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LAKEWOOD HEALTHCARE CENTER | 12023 LAKEWOOD BLVD. DOWNEY, CA 90242 |

| (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 323 | Continued From page 22 | F 323 | | |

interview with the primary care physician he stated Resident 1 sustained several falls on 8/29/16. The primary care physician stated that he gave an order after the last fall to transfer Resident 1 to a GACH due to the laceration to the forehead.

During an interview and review of Resident 1's medical record on 9/26/16, at 1:49 p.m., the registered nurse supervisor (RNS 1) stated that on 8/29/16, she worked the morning shift (7 a.m., to 3 p.m. shift) Resident 1 was transferred to the East unit for close monitoring of placing herself on the floor behaviors. RNS 1 was asked what type of close monitoring was provided to Resident 1, RNS 1 stated 1:1 monitoring, however, RNS 1 was unable to provide the specific caregiver's name assigned to Resident 1 for 1:1 monitoring. RNS 1 was unable to provide documentation and explain the reason for Resident 1's placing herself on the floor. The cause was not assessed and the behavior was not communicated to the staff to prevent occurrences.

On 9/26/16, at 3:26 p.m., during and interview, RNS 2 stated she was called in at 7:00 p.m., by LVN 1 to assess Resident 1 who sustained a fall. RNS 2 stated she assessed Resident 1, but failed to document the assessment. RNS 2 further stated Resident 1 was transferred to a GACH due to a cut sustained to her forehead.

On 9/26/16, at 4:05 p.m., during an interview and review of Resident 1's medical record, the director of nurses (DON) stated he could not provide the fall investigation because it was protected by the QAA (quality assessment and assurance, a committee that checks on standards and quality of care by conducting

Conditions during the monthly QA meeting for trendings and further recommendation.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555099 | A. BUILDING _____ B. WING _____ | C 10/18/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LAKEWOOD HEALTHCARE CENTER | 12023 LAKEWOOD BLVD. DOWNEY, CA 90242 |

| (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 323 | Continued From page 23 | F 323 | | |

quality assessment reviews, develops reference points and guidance for caregiver/providers on relevant issues). The DON read the Resident 1's care plan and stated the precautions and implementations were to provide a safe environment free of clutter, monitor of medications, providing activities, call light within reach, and well-lit environment. When asked if the care plan interventions were relevant to the identified behavior of Resident 1 placing herself on the floor, the DON did not offer an answer.

A review of the 3/1/2016, facility's revised policy and procedures titled "Fall Management Program," indicated to provide a safe environment that minimizes complications associated with falls. The policy indicated the licensed nurse and/or interdisciplinary team will develop a plan of care according to the identified risk factors and root cause, and will evaluate the resident's response to the plan of care during weekly summary evaluation and update resident's plan of care as necessary.