		AND HUMAN SERVICES	150	PRINTED: 10/20/2016
STATEMENT OF C	DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 8 6 36 52 6 6 6 6 6 6 6 6 6
		555099	B WING	C 10/18/2016
	VIDER OR SUPPLIER HEALTHCARE C	ENTER ENTER		STREED ADDRESS, CITY, STATE, ZIP CODE 12023 LAKEWOOD BLVD. DOWNEY, CA 90242
(X4) ID PREF(X TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE COMPLETION CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY)
F 000 : IN	ITIAL COMMENT	rs	F 000	0:
De investa Con Rei He Con the Second High	epartment of Public vestigation of a control	T IEGLECT/MISAPPROPRIATN velop and implement written	F 224	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.
		ect, and abuse of residents on of resident property.		: F224
				I. Corrective Action/s:
by: Ba rev	: ased on observati riew, the facility fa	IT is not met as evidenced ion, interview, and record ailed to ensure one of one esident 1), was free from		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.

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

001110	TO TOTA INLEDIO TIVE	G MILDIONID OLIVOLO			CIVIL	<u> </u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION DING	(X	(3) DATE SURVEY COMPLETED
		555099	B. WING			C 10/18/2016
NAME OF I	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP	CODE	10) 10/2010
	OOD HEALTHCARE C	ENTER		12023 LAKEWOOD BLVD. DOWNEY, CA 90242		,
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIA	
F 224	neglect by failing to 1. Conduct continue from 7:30 p.m. to 1: sustained a forehea on 8/29/16, at 7 p.m. 2. Transfer Resider immediately to rece Resident 1 reported she broke her ribs a p.m. 3. Investigate the ci unwitnessed fall an and provide this wri representative (Eva facility's policy and i As a result of these 1 did not receive the manner to address 11:23 p.m., Resider general acute care incident on 8/29/16, hours and eight mir Trauma History and 8/30/16 indicated R right-sided pneumo air or gas in the cav chest wall, causing which a right tube th opening through the drainage of fluid) wa Resident 1's injuries and soft tissue swe	cous neurological assessment of p.m., on Resident 1 who ad laceration (cut) after a fall on. In 1 to higher level of care give the necessary care, when it to staff that she thought that after a fall on 8/29/16, at 7 or cumstances of Resident 1's disustaining multiple injuries, atten report to State Agency cluator) as indicated in the procedure. In the staff that she thought that after a fall on 8/29/16, at 1 was transferred to the center (GACH) after a fall of 1.15 p.m., which was four nutes after a fall. The GACH of Physical (H&P) Report dated esident 1 had a large thorax (abnormal collection of the procedure of the lung), for no acostomy (surgical artificial exchest wall, usually for the as placed. The H&P listed is as follows: a small abrasion alling in the right temporal		II. How to Identify Other Resolution IDT reviewed fall that occurre October. Falls were reviewed to Presence of the neuro check for injury, neuro checks for unwinvestigation of circumstance falls/injuries and timeliness of #5 residents care plan were upout not limited to fainvestigation and neurohospitalization was necessated identified. No negative outcom Inservice on Abuse was conducted from 10/24/2016 – 10/28/2016 and other department attended Fall investigation, neuroche and timely hospitalization was the licensed nurse during the interest nurse nurs	sidents: d in the more for the follow for falls with itnessed falls e surrounding intervention pdated to ince the circumst ro-checks. ary in all come was observated by the 16. RN, LVN, the this in-services, assessed as discussed an-service. 1 in-service 4/2016 for ons of conduct a after any st	wing: head s and g the h. clude tance No cases ved. DSD CAN rvice. ment with and cting ance
	Resident 1's injuries and soft tissue swe region (side of the h	s as follows: a small abrasion		or any unwithessed fall or	nead injury	

posterior (back) rib fractures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED	
		555099	B. WING		C 40/48/2046	
NAME OF PROVIDER OR SUPPLIER LAKEWOOD HEALTHCARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES			ID	STREET ADDRESS, CITY, STATE, ZIP CODE 12023 LAKEWOOD BLVD. DOWNEY, CA 90242 PROVIDER'S PLAN OF CORRECTION	10/18/2016	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG			
	Resident 1 in the C with bruises (skin of to her right eye soor resident's right side out which was yello Resident 1 was ob attached to her right to a drainage contact. During a concurrer "I fell while in my rothey kept jamming The resident stated (CNA) manhandled The resident continstating "I don't wan A review of the Resident contact she was 6/3/16 and readmit that included gener psychosis (a sever thought and emotion contact is lost with disorder (uncontrol body and momental A review of Reside indicated the reside understand and manual contact and manual	p.m., during an observation of SACH, Resident 1 was noted discoloration) purplish in color cket, and eye brow. The e of the forehead had a healing owish/purplish in color. served with a chest tube ht side upper body, connected ainer. Int interview, Resident 1 stated from, I don't remember how but ice to my head over and over." In dia certified nursing assistant diand tied her to a wheelchair. The did not to cry and repeatedly in the good back to the facility. It is don't see weakness, a mental disorder in which one are so impaired that external reality), and seizure lied jerking movement of the ary loss of awareness). Int 1's H&P dated 6/6/16 ent did not have the capacity to		 Clinical symptoms that would reimmediate transfer after an unwith fall or head injury Policy on Unusual Occurrences or Info Unknown Origin III. Systemic Changes: DON/Designee in-services the Lice Nurses initiated on 10/24/2016 for following topics: Clinical implications and important conducting neurological assessmen accordance with policy and proceafter any status of any unwitnessed finead injury Clinical symptoms that would reimmediate transfer after an unwitnesfall Policy on Unusual Occurrences or injoin of unknown origin Upon a resident incident of fall, Lice Nurse will do a thorough investigation and assessment for injuries which includes the signs & pain rating. A neurological assessivill be completed for any unwitnessed falled injury per facility's protocol. This with 	ensed rithe ce of nt in edure fall or essed juries juries juries vital ment all or	
		imum Data Set (MDS, an are screening tool), dated			;	

CENTERS FOR MEDICAN	LE & MEDICAID SERVICES			U	<u>IMR IAO</u> .	<u> </u>
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	СОМ	E SURVEY PLETED
	555099	B. WING				C 18/2016
NAME OF PROVIDER OR SUPPLIE	R	<u> </u>	STRI	EET ADDRESS, CITY, STATE, ZIP CODE	1 1 41	
				23 LAKEWOOD BLVD.		
LAKEWOOD HEALTHCARE	CENTER	ĺ		WNEY, CA 90242		
		,l		· · · · · · · · · · · · · · · · · · ·		
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(XS) COMPLETION DATE
։ F 224 ։ Continued From բ	2202 3	, 				r.
	-	,	224:	documented in the Licensed Nurses' n		
	Resident 1 had no memory	;			ote and	
	makes self-understood and	i	:	Neurological Assessment form.		
	understand others. The MDS	İ		s. Any change of conditions most full as	! -! 4/ -	
	dent was not steady, but able to			c. Any change of conditions post fall, re		
	out staff assistance, and	1 1 1	:	Primary MD will be notified for im-		
	ion setup help only for bed	i I	İ	transfer of resident, as well as notifica-	ation of	
mobility, transfer,	walk in room and corridor.	:		Responsible Party.		:
Δ review of the fac	cility's document titled "SBAR		!			ŧ
	ound, Assessment and			d. Post Fall, the IDT will review the even		
) a technique that can be used			the Fall Meeting after Stand Up daily M	•	
to facilitate promp				RN Supervisor during weekends with	IDT to	
	dated 8/29/16, at 6:45 a.m.,			investigate the event further and reco	mmend	
	at 1 was in bed, yelling,			appropriate interventions and update t	he Plan	
	apparent reason. When staff	1		of Care, as well as follow ups from the F	ost Fall	
	, the resident continued to	•	:	Huddle. A full IDT review of fall that o	ccurred	
	icking and tried to bite staff.	!		on the weekend will be completed on M		
	d that Resident 1 was on 1:1			, , , , , , , , , , , , , , , , , , ,	oaa,.	
	at an associated behavior at the			e. Any unknown fractures or unknown o	origin of	
-	e was that the resident was		1	events will be reported to Administrate		
	elf on the floor. The			or Designees as soon as possible for imm	•	1/2
documentation inc	dicated there was discoloration	:		reporting to appropriate agencies.	iiculate	
noted at the resid	lent's right upper back and left			reporting to appropriate agencies.		<i>−</i> 3 b = 1
elbow.				f. Medical Records will complete the Cha	ange of	16
				Condition audits daily and findings will b	_	
	dated 8/29/16, at 7:15 p.m.,			to DON/Designee for follow through.	e giveii	
	t 1 was found on the floor,			to both besignee for follow (fillough.		
	by certified nursing assistant 1			IV. Monitoring:		
	AR notes did not address the			14. Inducting.		
resident's injuries.				DON/Designee will present any Investi	gations	
						:
	censed Personnel Progress	•		related to Unknown Fracture or Un		:
	16, at 11:10 p.m., indicated			Origin during the Monthly QAA Meet		
	ert and oriented, and walk up to	!		review and further recommendation. Tr	•	
	rney (A stretcher or litter used	:		will be review for need of further re-edu	ucation	
	nts who require medical care).			of staff.		
	d after the resident got into the	:				
	nt went to deep sleep. At 11:23	i				
p.m., the progress	notes indicated the resident's					

01/07	7/2013 07:43	56	28693468	LAK	KEWO	00D) \	PAGE	02/10
				Δc	(6	offd.		: 10/20/2016
DEPART	MENT OF HEALTH	A٨	ID HUMAN SERVICES	1 30	Ÿ	100011/ 0/60/		APPROVED
CENTER	RS FOR MEDICARE	&	MEDICAID SERVICES		١	11()X 116 36726		. 0938-0391
	OF DEFICIENCIES) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE	CONSTRUCTION		E SURVEY
	F CORRECTION	•	IDENTIFICATION.NUMBER:	A BUILDI		The state of the s	COM	IPLETED
			ĺ		_			C
			555099	B. WING	_	5312 MON		/18/2016
NAME OF B	PROVIDER OR SUPPLIER			 -	37	REET ADDRESS, CITY, STATE 24 CODE	1 4	10/2010
	•		· ·			2023 LAKEWOOD BLVD.		
LAKEWO	OOD HEALTHCARE C	EN	TER	•		OWNEY, CA 90242		
7543.40	CURRANOV CTA	TER	MENT OF DEFICIENCIES	<u></u> _		PROVIDER'S PLAN OF CORRECTION		
(X4) ID PREFIX			IST BE PRECEDED BY FULL	ID PREFIX	x I	(EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETION
TAG	REGULATORY OR L	SC į	DENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROP	PRIATE	DATE
						DEFICIENCY)	<u> </u>	<u> </u>
		!						i I
F 224	Continued From pa	ge	4	F.2	24	11/7/2016. Addendum to FZ	24:	
	care was transferre	d t	o paramedics. The resident	ļ				
	continued to be nor	1-FÉ	esponsive.			Corrective actions to those found	to be	1
,					- 1	affected by the practice: Resident	#1 was	
			's Paramedics Report			transferred to the acute hospital on 8/2	29/2b16.	i
ļ			d that the paramedics were			Return not anticipated.		1
			and arrived in the facility at		1	· · · · · · · · · · · · · · · · · · ·		1
			nentation indicated a 911 esponded to a complaint of		1	Identification of others residents v	rith the	
			unwitnessed ground level	1		potential to be affected by this prac	tice and	
,			this evening with hematoma			corrective actions:		
			t is filled with blood caused		- 1		_	1
			of a blood vessel) to back		- [Residents with falls, Reported falls of		
			medics Report indicated			incident with head injury and Unwitnes		
	the resident had a s	ъeс	ond fall unwitnessed			in the month of October and moving		
			ites later resulting in a			were/will be assessed and records revi	•	ا ال
			right eye with right rib pain.		- 1	the IDT for completeness and timel	iness of	_1'
			nat the resident told the staff		- [services.	$\{t_{k}\}$
			ten around 7:00 p.m. and			The RN supervisor will immediately as		
	the lacility did flot c	an :	911 for four (4) hours.			Licensed nurse with assessment to	include	1 4
	A review of the GA	'n	Trauma History and			continuous neurological assessmen	it and f	
			8/30/16 indicated Resident	1		Initiate investigation through the "Hud	ldle" for	
	1 had a large right-	side	ed pneumothorax, for which			further evaluation / root cause analysi	s of the	
			my was placed. The		- 1	fall and development of plan of care.		
[ed the resident had a small					
			e swelling in the right			Systemic changes in place to ensu		
		e li	ist of injuries indicated the	Ì		practice does not recur: Resident v		1
ì	following:	- 1				witnessed fall, injury (les) of unknown		
	4 Obstral mast fall :	j		[residents reported falls and other incide		1
ļ	 Status post fall Blunt torsp traum 					might result in potential head injuries		1,16
	3. Right-sided prieu		nthorax	ĺ		reported to the RN supervisor immedia	-	1,17
			2th posterior rib fractures.			RN sup will initiate the assessment to		1117
	and the state of t	- ! '	- and pro-contract the traces were	•		continuous neurological assessmen		1
İ	On 9/1/16, at 5:05 p	.m	., during an interview with			assessment for other internal/external in	njuries,	
	the director of nurse	es ((DON) he stated that					
!	Resident 1 was not	as	sess for neurological status		-			
		по	head Injuries on 8/29/16					<u>'</u>
	after a fall.	i			Ţ			

01/07/2013 07:43 5628693468

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 10/20/2016 FORM APPROVED

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES		11 X 116 36526	OMB NO	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENITIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	CON (X3) DAT	E SURVEY
		555099	B. WING		1	C /18/2016
NAME OF F	PROVIDER OR SUPPLIER	'	S'	TREET ADDRESS, CITY, STATE, ZIP CO		10/2010
LAKEWO	OOD HEALTHCARE O	ENTER	. 12	2023 LAKEWOOD BLVD. OWNEY, CA 90242		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 224	license vocational 7 p.m., on 8/29/16 and was called by LVN 1 stated the reresident's right side too blg. LVN 1 state 1's neurological state it continuously. On 9/2/16, at 8:16 investigation report of fall and/or placin 8/29/16, the DON convestigation stated quality assurance of the department chipicking-up Resident had an injustated there was ble head, and "We did would not aggravat. On 9/26/16, at 3:26 RNS 2 stated she was 8/29/16 by LVN 1 to sustained a fall. RI Resident 1, but fails assessment. RNS documentation of reassessment after a	p.m., during an interview, nurse 1 (LVN 1) stated around she was passing medication CNA 1 to assess Resident 1. esident had a laceration at to of the forehead, but was not ed she did assessed Resident atus after the fall, but did not do a.m., upon request of the regarding Resident 1 incident g herself on the floor on declined to provide the 1 that it was protected by their committee. p.m., during an interview, the ef (FDC) stated upon at 1 from the facility, the ary to her right eye. The FDC cody gauze around resident's not remove the gauze, so it e it." i. p.m., during an interview, was called in at 7:00 p.m., on assess Resident 1 who NS 2 stated she assessed and to document the 2 was unable to provide the esident's neurological fall from 7 p.m., to 11 p.m., on lid not know the actual injuries	F 224	Neurological checks will be accordance to the revised facility procedure to meet the industry's the need of the patient. In accordance with the facility shall repunknown origin to CDPH and within 24 hours. Furthermore, the investigate circumstances of unknown origins and report findings to CDPH within 5 busines. Monitoring Performance to ensachieved are sustained. Designated quality assurance review falls within 24 hours for interventions, and completeness findings to the Assistant Direct Services for immediate follow up. These findings will be reported to Mon—Fri during the daily clinical meeting. The ADON will review on the weekends and update the IThe DON will further review find trends and areas of performance opportunity for educational neet teaching. DON will report finding committee for review and recommittee	ity policy and standard and standard and standard and ort injuries of lombudsman he facility shall injuries of summary of sdays. Sure solutions nurse(es) will be appropriate and report or of Nursing or the DON on review/report theses finding DON. dings, identify improvement ads for future as to the QAA	1107016

FORM CMS-2587(02-99) Previous Versions Obsolete

On 9/30/16, at 3:20 p.m., upon request of the written report investigation regarding Resident 1

Event ID: C2L511

Facility ID: CA940000008

If continuation sheet Page 6 of 24

	ENT DF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION		X3) DATE SURVEY COMPLETED		
		555099	B. WING		C 10/18/2016
	PROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 12023 LAKEWOOD BLVD. DOWNEY, CA 90242	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTION
F 224	Continued From pa		F 22	4	
	administrator state DON. However, the was not provided.	n 8/29/16, the assistant d that the report was with the e written investigation report	: ! !	: : :	
	and procedure tilte Investigation - Ope Neglect," the purport health, safety, and by ensuring that all mistreatment, negl source are prompt! The policy indicate a written report of tinvestigations and Licensing and Cert be required by stati working days of the 483.13(c) DEVELO ABUSE/NEGLECT. The facility must depolicies and proced mistreatment, negliand misappropriation. This REQUIREMED by: Based on interview failed to investigate as indicated in the for one of one sam.	, ETC POLICIES evelop and implement written	F 220	F226 I. Corrective Action/s: Resident 1 was transferred to the hospio8/29/16 for further evaluation. II. How to Identify Other Residents: a. Residents who have had falls during month of October 2016 have been review the IDT. Revision started on 10/24/2016 further interventions and any additional Page 10.	g the red by 1,0

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	O.T. IJEDIOT ITE	WINEDION NO OCITATOCO			<u></u>	1410 140	. 0000 000 1
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILC		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			, DOILE				С
		555099	B. WING	`		10	/18/2016
NAME OF I	PROVIDER OR SUPPLIER			,	STREET ADDRESS, CITY, STATE, ZIP CODE		
L A 14571846	000 HEALTHOADS 0	CUTCO		-	12023 LAKEWOOD BLVD.		
LAKEW	OOD HEALTHCARE C	ENTER] [DOWNEY, CA 90242		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	, ID	1	PROVIDER'S PLAN OF CORRECTIO	<u>·</u>	(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRDP DEFICIENCY)	BE	COMPLETION DATE
E 226	0	. 7		•••			
F 220	Continued From pa	—	F 2	226			1
	safety of the reside	nt.			Care revisions. #5 Residents were ide	=	1
	! =				who needed the revisions on their Plan o	f Care.	
,	ˈ Findings:				When possible, fall circumstances	were	
	A	Manada Ada San San San San San San San San San Sa			investigated during chart review and car	e plan	
		sident 1's Admission Record			updated from conclusion of the root	cause	
		admitted to the facility on			analysis of the fall.		
		ted on 8/22/16 with diagnoses					
		alized muscle weakness,			b. LVN#1 & RN#2 were given 1: 1 in-servi	ices by	
		e mental disorder in which ons are so impaired that			; the DON was started on 10/24/2016 f	or the	
		external reality), and epilepsy			following topics:		
		g movement of the body and					
	momentary loss of				 Clinical implications and impo 	rtance	
		awareriessy.			of conducting neurological assessme	nt in	1
	A review of the Min	imum Data Set (MDS, an			accordance with policy and procedure aft	erany	
	assessment and ca	re screening tool), dated Resident 1 had no memory			status of any unwitnessed fall or head inju	тгу	
		nakes self-understood and			• Clinical symptoms that would r	equire	
		derstand others. The MDS			immediate transfer after an unwitnessed	fall or	
	indicated the reside	ent required supervision			head injury		
		gement or cueing) setup help			• •		1
		or bed mobility, transfer, walk			 Policy on Unusual Occurrence 	es or	ر ۱
		r, was continent (had control)			Injuries of Unknown Origin		
		er functions, and no previous					3.
	falls in the last mon	th.			1 III. Systemic Changes:		jt
	A review of the gen-	eral acute care hospital			a. DON/Designee initiated in-services	with	
	(GACH) Trauma Hi	story and Physical Report			Licensed Nurses on for the following topi		•
		ated Resident 1 had a large			clocation realized on for the following topi	c3./	
		thorax (abnormal collection of			Clinical implications and impo	rtance	
		rity between the lungs and the			of conducting neurological assessme		
		collapse of the lung), for			accordance with policy and procedure aft		•
		horacostomy (surgical artificial			status of any unwitnessed fall or head inju		•
		e chest wall, usually for the			. Status or any unwitnessed rail of near Hijt	ıı y	
	drainage of fluid) w						
		cated the resident had a small					
		ssue swelling in the right			i		
	remporarregion (SI)	de of the head behind the			1		

eyes). The list of injuries indicated the following:

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		555099	B. WING	- 	10	C / 18/2016	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 12023 LAKEWOOD BLVD. DOWNEY, CA 90242		718/2016	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ULD BE	(X5) COMPLETION DATE	
F 309	fractures. On 9/1/16, at 5:30 plicense vocational rowas called by certificance and called by certificance and called the resident right side. On 9/2/16 at 8:02 a interview with certificance she was close stated that she assifted that director of nurse provide the incident because it was protassessment and assessment and assifted that if a serious booffacility will call local written report to the Department of Publicance in the short of the partment of the partm	er body) trauma amothorax d 12th posterior (back) rib o.m., during an interview with nurse (LVN 1), stated that she ied nurse assistance CNA to who had suffered a fall. LVN 1 had a cut to her forehead, o.m., during a telephone ied nursing assistant 1 (CNA 1 isted her to get the resident up its 1 further stated ice packs sident 1's bumps to the o.m., during an interview with es DON he stated he could not a report information paperwork its ected by the quality is surance (QAA). oity's undated Policy and of Mandated Reporter," indicated filly injury was sustained, the law enforcement, and fax a local ombudsman and the lice health. CARE/SERVICES FOR		Clinical symptoms that we immediate transfer after an unwith head injury Policy on Unusual Occurinjuries of Unknown Origin b. Upon a resident incident of factorized will do a thorough investigation assessment for injuries which included signs & pain rating. A neurological will be completed for any unwitnes head injury per facility's protocol. documented in the Licensed Nurse Neurological Assessment form. c. Any change of conditions post fall Primary MD will be notified for it transfer of resident, as well as not Responsible Party. d. Post Fall, the IDT will review the eather Fall Meeting after Stand Up dail RN Supervisor during weekends with investigate the event further and it appropriate interventions and updated of Care, as well as follow ups from the Huddle. A full IDT review of fall the on the weekend will be completed on the events will be reported to Adiason.	rences or II, Licensed on and body es the vital assessment is sed fall or This will be of note and in mediately ification of the Plan in Post Fall of the Occurred in Monday.		

	TEMENT OF DEFICIENCIES (X1) PRDVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION DENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED		
		555099	B. WING_		10	C / 18/2016
NAME OF F	PROVIDER OR SUPPLIER	.L	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE		1012010
I AKE/MO	OOD HEALTHCARE O	PENTED		12023 LAKEWOOD BLVD.		
LANLIVO	JOD HEALINGAILE (SENTER		DOWNEY, CA 90242		
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F 309	Continued From pa	age 9	F 30	: 19 .		
		it receive and the facility must		Designee as soon as possible for it	nmediate	:
	provide the necess	sary care and services to attain		reporting to appropriate agencies.		
		hest practicable physical, osocial well-being, in	i	f. Medical Records will complete the (`hange of	4
		ie comprehensive assessment		Condition audits daily and findings wil		1
	and plan of care.			to DON/Designee for follow through.		·
			: :			: :
	This REQUIREMENT is not met as evidenced by:			IV. Monitoring:		l
	Based on observa	tion, interview, and record	•	DON/Designee will present any Inve	stigations	
		failed to ensure one of one	:	related to known Fracture or fra		
		Resident 1), who had history of (a tonic [the person initially		Unknown Origin during the Mont		
		consciousness, causing them		Meeting for review and	further	
		d], and clonic phase [following	1	recommendation. Trending will be re need of further re-education of staff.	sview to:	
		e clonic phase will start as the	i	need of further re-education of stant.		
:		pasm and jerk, and loss of isodes of placing herself on	:	:		
:		necessary care and services	!			
		ntify if Resident 1 episodes of	:	F309		
	placing herself on t type of seizure.	the floor was a behavior or a		I. Corrective Action/s:		
	2. Monitor Residen	t 1's behavioral patterns and		Resident 1 was transferred to the ho	spital on	l
	provide a safe envi	ironment as indicated in the		08/29/16 for further evaluation.		
	seizure disorder pla	an or care		II. How to Identify Other Residents:		,
		t 1's neurological status as		OF maritaninal falls for a sum of the		- t
		ility's policy and procedure, to		IDT reviewed falls that occurred in the of October and reviewed residents wi		y.
;	prevent delayed int	ges in level of consciousness to		seizure disorder and known reside		ا ''ی
	Prevent delayed the	CIVERROITS.		behavior that might put them at risi		;
		ugh body assessment when				
		d to staff that she thought that after a fall on 8/29/16, at 7	!	1		

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<u> </u>	COT OIL MILDIOMIC	G MEDIOMID OF LANGED			_	VID ITO.	0000.0001
STATEMENT OF DEFICIENCIES (X1) PRDVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			i ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		555099	B. WING			1	C 18/2016
NAME DF F	RDVIDER OR SUPPLIER	<u> </u>	<u> </u>	S1	TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKEWO	OD HEALTHCARE C	ENTER			2023 LAKEWOOD BLVD. OWNEY, CA 90242		
					·		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIDE (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	8E	(X5) COMPLETION OATE
F 309	Continued From pa	=	; F3	809			
•	p.m., and transfer F care immediately.	Resident 1 to higher level of	,		injury i.e. throwing self on the floor were reviewed for the following:	Records	
	1 was found on the 7:15 p.m., with a cutransferred to the gransferred	deficient practices, Resident hallway floor on 8/29/16, at it on the forehead and was not eneral acute care center p.m. (four hours and eight. The GACH identified arge right-sided pneumothorax in of air or gas in the cavity and the chest wall, causing.), which required a right tube ical artificial opening through			 Care plan to include behavior, asses intervention either in the form of a safe environment, me adjustment or timely hospitalizate further eval and treatment. Presence of the neuro check for fahead injury, neuro checks for unwitnessed falls 	creating dication tion for	•
	small abrasion and temporal region (sideyes), blunt torso (u	ally for the drainage of fluid), a soft tissue swelling in the right de of the head behind the upper) trauma, and right 7th, ior (back) rib fractures.		!	investigation of circumstance surr the falls/injuries and timelin intervention with adequate roof analysis of fall/behavior etc.	ess of	16
	Cross Reference to	F323			#5 residents care plan were updated to but not limited to fall circur		
i :	Resident 1 in the G observed with bruis in color to her right The resident's right healing cut which w Resident 1 was obsattached to her right to a drainage conta	5, at 1:32 p.m., during an observation of 1 in the GACH, Resident 1 was with bruises (skin discoloration) purplish o her right eye socket, and eye brow. Lent's right side of the forehead had a cut which was yellowish/purplish in color. 1 was observed with a chest tube to her right side upper body, connected			investigation and neuro-checks a residents were referred to psychiat follow up. No hospitalization was nece all cases identified. No negative outco observed.	nd #2 rist for ssary in	
	"I fell while in my ro	om, I don't remember how but i ce to my head over and over."					

A review of Resident 1's History and Physical

OLIVICITO I OTVINEDIO/ IIV	E & MEDIONID SERVICES). U938-U39T
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG		TE SURVEY MPLETED
	555099	B. WING _		10	C /18/2016
NAME OF PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CO		
			12023 LAKEWOOD BLVD.		
LAKEWOOD HEALTHCARE	CENTER				
			DOWNEY, CA 90242		
PRÉFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PRDVIDER'S PLAN DF CDRI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
5,000					
F 309 Continued From p	age 11	F 30)9 [:]		
(H&P) from the GA	ACH dated 8/18/16 indicated		a. Residents with Dxs Seizure	Disorders and	
	n uncontrolled seizure disorder	Ì	behaviors which may result in s	elf injury such	
	ures due to non-compliance		as putting self on the floor were		
	The H&P indicated the				
	(an anti-seizure medication)		the IDT on 10/24/2016 - 10		
	ogram (mcg/ml) (Reference		further interventions and any add	litional Plan of	
	cg/mL, this is use in		Care revisions. #1 Residents w	ere identified	1
	Deutic dosing, managing		who needed the revisions on their	r Plan of Care.	
	d toxicity). The resident was		b. LVN#1 & RN#2 were given 1: 1	in-services by	•
	n intravenous (through the vein)		the DON on 10/25/2016 for	-	
• • • •	re medication) and was		topics:		
discharged back to	the facility on 8/22/16.	•	topics.		
A review of a Desi	deat the Administra Decora		Clinical implications an	d importance	
	dent 1's Admission Record	•	·	•	
	admitted to the facility on		of conducting neurological as		
	tted on 8/22/16 with diagnoses		accordance with policy and proce	dure after any	
	ralized muscle weakness,		status of any unwitnessed fall or h	ead injury	
	e mental disorder in which	1			
	ons are so impaired that		 Assessment and clinic 	al symptoms	
	external reality), and seizure	!	that would require immediate tra	nsfer after an	
	lled jerking movement of the	!	unwitnessed fall or head inju	ırv or other	
body and moment	ary loss of awareness).		changes of condition.	,	,4
			changes of contaction.		16
	ed 6/3/16, titled "Seizures,"		• Emphasis on asses	sment of	٠ ٦ ٔ
indicated at risk for	r injuries due to seizures		•		16
disorders. The inte	rventions included to maintain	i	injury/behavior, timeliness o		1
a safe environmen	t for the resident and monitor	: 	including but not limited	to hospital	
behavioral patterns		1	transfer as needed.		
	nt 1's H&P dated 6/6/16	1	 Policy on Unusual Oc 	currences or	
	ent did not have the capacity to	:	Injuries of Unknown Origin		
understand and ma	ake decisions.				
			 Policy on Change 	Conditions,	
A review of the Mir	imum Data Set (MDS, an		including seizure activities and	individualized	
assessment and c	are screening tool), dated		behavior plan such as putting self		
	Resident 1 had no memory		Tarrette President as Parting Jen		
	makes self-understood and	· ·			
	nderstand others. The MDS		•		
	ent was not steady, but able to	! !			l
majorica the resid	since and a not because but apic to	:	:		

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FREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) F 309 Continued From page 12 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.,	CLITTE	INO I OTT WILD OF THE	A MEDICAID SERVICES			CIVID INC.	. 0000-000
NAME OF PROVIDER OR SUPPLIER LAKEWOOD HEALTHCARE CENTER CAN ID SUMMARY STATEMENT OF DEFICIENCIES 1000MNEY, CA 90242				1			
NAME OF PROVIDER OR SUPPLIER LAKEWOOD HEALTHCARE CENTER (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 309 Continued From page 12 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 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.,						i	
LAKEWOOD HEALTHCARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 309 Continued From page 12 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 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. 1203 LAKEWOOD BLVD. DOWNEY, CA 90242 PROVIDER'S PLAN OF CORRECTION (SCHOL) (SCHOL) (SCHOL) (SCHOL) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (DATE OF THE APPROPRIATE (D		·	555099	B. WING			18/2016
(X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION) F 309 Continued From page 12 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 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.,	NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
(X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 309 Continued From page 12 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 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.,	LAKEWO	OOD HEALTHCARE C	FNTFR	į	12023 LAKEWOOD BLVD.		
F 309 Continued From page 12 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.,	LAKETT	OOD TILALITIOAKE O	ENTER		DOWNEY, CA 90242	_	
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.,	PREFIX	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREFIX	X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A	SHOULD BE	(X5) COMPLETION DATE
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),		Continued From pastabilize self withous required supervision mobility, transfer, where A review of the faci (Situation, Backgron Recommendation) to facilitate prompt communication," daindicated Resident screaming for no attried to talk to her, the scream, started kind the monitoring and that with this change was placing herself on the indicated there was resident's right upport of SBAR of indicated Resident along the hallway be (CNA 1). The note signs: Blood pressure of Hg) (normal range beat per minute (bp bpm), Respiratory rate 2 rate 12-20 breaths Body temperature	it staff assistance, and in setup help only for bed valk in room and corridor. Share and a setup help only for bed valk in room and corridor. Share and a setup that can be used and appropriate ated 8/29/16, at 6:45 a.m., 1 was in bed, yelling, parent reason. When staff the resident continued to king and tried to bite staff, that the resident was on 1:1 another associated behavior as that the resident was the floor. The documentation of discoloration noted at the resident was the floor. The documentation of discoloration noted at the resident was the floor. The documentation of discoloration noted at the resident was found on the floor, yeartified nursing assistant 1 is indicated the following vital 136/80 milliliter mercury (mm 120/80 mm Hg0, pulse rate 86 mm) (normal range 70 to 100 to breathes per minute (normal per minute), 198.6 degrees Fahrenheit (°F)	F 3	III. Systemic Changes: a. DON/Designee in-services Nurses on 10/24/2016 – 10/15 following topics: • Clinical implications ar of conducting neurological a accordance with policy and proce status of any unwitnessed fall or l • Clinical symptoms that immediate transfer after an unwi head injury • Policy on Unusual O injuries of unknown origin • Policy on Change including seizure activities and behavior plan such as putting self b. DSD/Designee in-services the O with emphasis on unauthorized 10/24/2016 – 10/28/2016 c. Upon a resident incident of fa such as putting self on floor, Licensed Nurse for a thorough root cause analysis and body a injuries which includes the vital rating. A neurological assessi	the Licensed 5/2016 for the of importance assessment in edure after any head injury. would require itnessed fail or of individualized for floor conditions, individualized for floor conditions on all or behavior can to notify investigation, assessment for I signs & pain ment will be	3°
- Oxygen saturation (oxygen in the blood) was 99 completed for any un-witness fall, head injury percent (%) (Normal range from 95 to 100 %). The SBAR Progress notes indicated the		- Oxygen saturation percent (%) (Normal	n (oxygen in the blood) was 99 al range from 95 to 100 %).				

physician was notified and ordered to transfer

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. DOILE				С
		555099	B. WING	<i>i</i>		10/	/18/2016
NAME OF F	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKEWO	OOD HEALTHCARE (CENTER		i .	2023 LAKEWOOD BLVD. OWNEY, CA 90242		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	Continued From pa		F3	309 [:]		<u> </u>	
	for evaluation. The	emergency department (GACH) e notes indicated that the ng to be picked up. The			will be documented in the Licensed Note and Neurological Assessment form.	lurses′	:
:	documentation did	not specify who was going to it and did not address the			d. Any change of conditions post fall/ be which causes self injury such as putting s floor, resident's Primary MD will be notifi	elf on ed for	,
	Notes dated 8/29/1 Resident 1 was ale to the ambulance of used for moving re care). The note ind into the gurney the sleep. At 11:23 p.n indicated Resident paramedics. The re non-responsive.	ensed Personnel Progress 6, at 11:10 p.m., indicated ert and oriented, and walked up gurney (A stretcher or litter sidents who require medical licated after the resident got resident went into a deep n., the progress notes 1's care was transferred to esident continued to be nt 1's Paramedics Report			immediate transfer of resident, as we notification of Responsible Party. e. Post Fall & Post Behavior such as Puttir on Floor, the IDT will review the event of the Fall Meeting after Stand Up daily M-IRN Supervisor during weekends with Investigate the event further and recompappropriate interventions and update the of Care, as well as follow ups from the Polluddle. A full IDT review will be complete Monday.	ng Self during - & by DT to imend e Plan st Fall	
	dated 8/29/16 indice dispatched at 11 p. 11:07 p.m. The do (emergency number head trauma from a fall around 7:00 p.m. (localized swelling to by a break in the woof the head. The PResident 1 had a supproximately 30 m hematoma above to the report indicate that her ribs were but the facility did not consider the second of the facility did not consider the second of t	ated that the paramedics were m., and arrived in the facility at cumentation indicated a 911 er) responded to a complaint of an unwitnessed ground level n., this evening with hematoma that is filled with blood caused all of a blood vessel) to back tranedics Report indicated econd fall unwitnessed innutes later resulting in a he right eye with right rib pain. It does not be that the resident told the staff troken around 7:00 p.m. and all 911 for four (4) hours.			g. Medical Records will complete the Char Condition audits daily and findings will be to DON/Designee for follow through. h. DON/Designee to review any delay transfer of residents to hospital post Char Conditions daily. Findings will be disc during Daily Stand Up Meetings for foliovestigation of the event & recommendated iv. Monitoring: DON/Designee will present during the McQAA Meetings the # of residents with D Seizures & Behaviors such as putting se	ed in nge of ussed urther cions.	30 30 10 10 10 10 10 10 10 10 10 10 10 10 10
	Physical Report dat	ted 8/30/16 indicated Resident is sided pneumothorax, for which		;			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT/FICATION NUMBER:		E CONSTRUCTION		E SURVEY
		555099	B. WING		- 1	C
	PROVIDER OR SUPPLIER OOD HEALTHCARE	3	S 1	TREET ADDRESS, CITY, STATE, ZIP CODE 2023 LAKEWOOD BLVD. DOWNEY, CA 90242	. 10/	/18/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING (NFORMATION)	ID PREFIX TAG	PROVIDER'S FLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLO BE	(X5) COMPLETION DATE
F 309	Resident 1 to the for evaluation. The resident was waiti documentation did pick up the reside resident's actual in A review of the Lic Notes dated 8/29/Resident 1 was all to the ambulance used for moving recare). The note in into the gurney the sleep. At 11:23 prindicated Residen paramedics. The non-responsive. A review of Resided dated 8/29/16 Indicated at 11 principal property numbers of the head. The Resident 1 had a sapproximately 30 hematoma above The report indicated that her ribs were the facility did not A review of the GAPhysical Report did not the same control of the GAPhysical Report did not the same control of the GAPhysical Report did not the same control of the GAPhysical Report did not the same control of the GAPhysical Report did not the same control of the GAPhysical Report did not the same control of the GAPhysical Report did not the same control of the GAPhysical Report did not the same control of the GAPhysical Report did not the same control of the GAPhysical Report did not the same control of the GAPhysical Report did not the same control of the GAPhysical Report did not the same control of the GAPhysical Report did not the same control of the GAPhysical Report did not the same control of the GAPhysical Report did not the same control of the GAPhysical Report did not the same control of the sam	emergency department (GACH) e notes indicated that the ng to be picked up. The d not specify who was going to nt and did not address the		and the same of th	#1 was Return not potential e actions: lood draw eduled for e further envice and the blood potential residents' out these nurses for s resident emunicate c exam as y (ies) of ells and all potential the RN ill initiate	11-7-16

FORM CMS-2667(02-99) Previous Versions Obsolete

Event ID: C2L511

Facility ID: CA940000006

If continuation sheet Page 14 of 24

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				E SURVEY IPLETED		
			A. BOILE				С
		555099	B. WING				18/2016
NAME OF	PROVIDER OR SUPPLIER	·	· · · · · ·	ST	REET ADDRESS, CITY, STATE, ZIP CODE	·	
LAKEWO	OOD HEALTHCARE C	ENTER			023 LAKEWOOD BLVD.		
				DO	OWNEY, CA 90242		<u>, </u>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
	documentation indicabrasion and soft titemporal region. The following: 1. Status post fall 2. Blunt torso traum 3. Right-sided pneud 4. Right 7th, 8th and On 9/1/16, at 5:30 plicensed vocational around 7 p.m., on 8 medication and was Resident 1. LVN 1 laceration (cut) on the forehead, and notification and the transportation for recardiac [heart] monthe resident got into the into a deep sleep, attransport the resident 1 from the injury to her right ey bloody gauze around "We did not remove aggravate it." On 9/26/16, at 3:26	stomy was placed. The cated the resident had a small such swelling in the right relist of injuries indicated the material mothorax of 12th posterior rib fractures. Some, during an interview, nurse 1 (LVN 1) stated (1/29/16, she was passing so called by CNA 1 to assess stated she cleaned the he resident's right side of the red the primary care physician. The resident's laceration was stated that a regular		309	floors with negative findings for trending further recommendation. DON to present findings from the auditions and trending's and recommendation.	ts from	
		assess Resident 1 who	! !				ı

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION G		E SURVEY
		EEEAno	D IANNE	-	1.	С
NAME OF	EDOLOGICO OD OVERVIE	555099	B. WING		10.	18/2016
÷	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP CODE 12023 LAKEWOOD BLVD. DOWNEY, CA 90242		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 309	documentation in abrasion and soft temporal region. following: 1. Status post fall 2. Blunt torso traus 3. Right-sided pnot 4. Right 7th, 8th a On 9/1/16, at 5:30 licensed vocation around 7 p.m., on medication and w Resident 1. LVN laceration (cut) or forehead, and not LVN 1 stated that not too big. LVN 1 ambulance (ambutransportation for cardiac [heart] mot the resident got into the resident got into the resident got into the resident 1 from the linjury to her right obloody gauze around aggravate it."	costomy was placed. The dicated the resident had a small tissue swelling in the right. The list of injuries indicated the list of injuries indicated the sumothorax and 12th posterior rib fractures. O.p.m., during an interview, all nurse 1 (LVN 1) stated 8/29/16, she was passing as called by CNA 1 to assess 1 stated she cleaned the inthe resident's right side of the ified the primary care physician, the resident's laceration was stated that a regular plances that provide residents who do not require contoring) was called to transfer and the ambulance declined to sent, and the 911 was called. I.p.m., during an interview, fire (FDC) stated upon picking-up the facility, the resident had an eye. The FDC stated there was und the resident's head, and we the gauze, so it would not	F 305		icted in licy and lard and licy and lurles of pudsman lity shall ries of nary of lurles of nary of lurles of nary of lurles on the lidentify wement.	11-7-16
	RNS 2 stated she	6 p.m., during an interview, was called in at 7:00 p.m., on				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: C2L611

Facility ID: CA940000006

If continuation sheet Page 15 of 24

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	TIPLE CONSTRUCTION ING		ATE SURVEY OMPLETED
		555099	B. WING		10	C 0/18/2016
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIF 12023 LAKEWOOD BLVD. DOWNEY, CA 90242		
(X4) ID PREFIX TAG	EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING (NFORMATIDN)	ID PREFIX TAG	PROVIDER'S PLAN OF C X (EACH CORRECTIVE ACTII CROSS-REFERENCED TO THE DEFICIENCY	DN SHDULD BE HE APPRDPRIATE	(X5) COMPLETION DATE
F 309	Resident 1, but far assessment. RN documentation of assessment after on 8/29/16. She assustained a lacer was unable to exhours before a reGACH. On 10/3/16, at 11 RNS 1 stated Reepisodes of drop seizure or a behave neurological assessing on 8/29/16 after linjury from a fall. to be monitored chour, 30 minutes	page 15 RNS 2 stated she assessed ailed to document the IS 2 was unable to provide the fresident's neurological ra fall from 7:30 p.m., to 11 p.m., also did not know that Resident 1 ration in her forehead. RNS 2 plain the reason that it took four esident was transferred to the 1:19 a.m., during an interview, sident 1 was not assessed if ping herself on the floor were a avior. RNS 1 stated Resident 1's resident 1 sustained a head RNS 1 stated the resident had every 15 minutes for the first for one hour and then every four of 72 hours by standard of		309		
	procedures titled indicated followin staff shall perform (4) hours for the (8) hours, until at longer necessary condition is stable symptoms of neu-According to the Library, indicated injuries included changes in level injuries including	/1/12, facility's policy and "Neurological Assessment," g an unwitnessed fall; nursing n neurological checks every four first 24 hours, then every eight tending physician states it is no or in 72 hours if resident's e and showing no signs and prological injury. 1/8/13, Long Term Care Nursing neurological checks for head assessment of the resident for of consciousness, observation of lacerations, and performing				

PRINTED: 10/20/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING С 555099 B WING 10/18/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 12023 LAKEWOOD BLVD. LAKEWOOD HEALTHCARE CENTER **DOWNEY, CA 90242** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) (D (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 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 | 483.25(h) FREE OF ACCIDENT F 323 SS=G | HAZARDS/SUPERVISION/DEVICES 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.

by:

This REQUIREMENT is not met as evidenced

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 (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			COM	E SURVEY IPLETED	
		555099	B. WING				C 18/2016
	PROVIDER DR SUPPLIER	ENTER		12023 l	ADDRESS, CITY, STATE, ZIP CODE AKEWOOD BLVD. IEY, CA 90242		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TD THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 323	was provided with a prevent further falls 1. Provide 1:1 mon SBAR (Situation, B Recommendation) 2. Follow the facility fall management properties and root cause of relicensed nurses and develop a plan of cause. 3. Maintain function capture actual conditions and develop plan of policy and procedure actual conditions are sult of these and develop plan of policy and procedure. As a result of these are substained a second p.m., and was transcare center (GACH right-sided pneumons)	r of placing herself on the floor, adequate supervision to a for by failing to: itoring as indicated in the ackground, Assessment, and dated 8/29/16, at 7:30 a.m. It's policy and procedures on rogram to identify risk factors esident behavior and for d/or interdisciplinary team to are according to the identified that cameras in the hallways to dition of the resident prior to a be used to identify cause of care according to the facility's re. It deficient practices, Resident and fall on 8/29/16, at 7:15 aftered to the general acute of and was found with a large othorax (abnormal collection of		323			
	chest wall, causing which a right tube to opening through the drainage of fluid) was ustained a small a swelling in the right head behind the eye	wity between the lungs and the collapse of the lung), for horacostomy (surgical artificial e chest wall, usually for the as placed. Resident 1 also abrasion and soft tissue temporal region (side of the les), blunt torso (upper body) th, 8th and 12th posterior		Res	3 Corrective Action/s: ident 1 was transferred to the hospita 29/16 for further evaluation.	al on	
							i

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	TIPLE	CONSTRUCTION	(X3) DAT	E SURVEY
AND PLAN C	PF CORRECTION	IDENTIFICATION NUMBER:	A. BUILC	ING_			MPLETED
		555099	8. WING				C / 18/2016
NAME OF I	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 10	10/2010
					023 LAKEWOOD BLVD.		
LAKEWO	OOD HEALTHCARE C	ENTER		DC	OWNEY, CA 90242		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
=	· · · · · · · · · · · · · · · · · · ·		· _	; ;			
F 323	323 Continued From page 18		F:	323			
		tion in the GACH on 9/1/16, at	:	:	II. How to Identify Other Residents:		
	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		!	,	a. Residents with Dxs Seizure Disorde	rr and	
			i	!	Behavior such as putting self on floor		
		ehead had a healing cut which		:	reviewed by the IDT on 10/25/20		
		lish in color. Resident 1 was			10/28/2016 for further interventions ar		
		est tube attached to her right			additional Plan of Care revisions. #1 Re		
		at connected to a drainage			was identified who needed the revision		
	container.	J			their Plan of Care.)II3 OII	
	During a concurrent interview, Resident 1 stated				b. LVN#1 & RN#2 were given 1: 1 in-serv	ices by	
		oom, I don't remember how, ning ice to my head over and			the DON on for the following topics:	·	
	over.				 Clinical implications and impo 	rtance	
	A review of the Res	sident 1's Admission Record			of conducting neurological assessme	ent in	
		admitted to the facility on			accordance with policy and procedure aft	ter any	•
		ted on 8/22/16 with diagnoses	i		status of any unwitnessed fall or head inju	ury.	•
		ralized muscle weakness,	i	1			
		e mental disorder in which	i		 Clinical symptoms that would r 		
		ons are so impaired that	i	1	immediate transfer after an unwitnessed	fall or	
		external reality), and seizure	į	i	head injury		
	•	lled jerking movement of the					
	, body and momenta	ary loss of awareness).			Policy on Unusual Occurrence	ces or	
	A review of Reside	nt 1's History and Physical			Injuries of Unknown Origin		
		6, indicated the resident did not	1		Policy on Change Conc	ditions,	
	` ,	o understand and make			including seizure activities and individu		, " p = 0
	decisions.			:	behavior plan such as putting self on floo		
	A review of the Min	nimum Data Set (MDS, an					
		are screening tool), dated			III. Systemic Changes:		
		Resident 1 had no memory			DOM/Outland Street, March 11		i
		makes self-understood and			a. DON/Designee in-services the Li		
	had the ability to ur	nderstand others. The MDS			Nurses on 10/24/2016 - 10/28/2016 f	or the	
	indicated the reside	ent was not steady, but able to			following topics:		
		ut staff assistance, and					
	required supervision	on setup help only for bed	:				

mobility, transfer, walk in room and corridor.

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CENTER	43 FUR MEDICARE	& MEDICAID SERVICES			<u>U</u>	MR NO.	<u>0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l		CONSTRUCTION		PLETED
		555099	B. WING		 	10/1	; 8/2016
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				12	023 LAKEWOOD BLVD.		
LAKEWO	OOD HEALTHCARE C	ENTER			OWNEY, CA 90242		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE :	(X5) COMPLETION DATE
F 323		Assessment dated 8/22/16 1 scored 13 (A total score	F 3	323	 Clinical implications and implications and implications of conducting neurological assessmaccordance with policy and procedure a status of any unwitnessed fall or head in 	ent in fter any	
	Prevention and Ma falls due to lack of a impulsive behaviors assistance and eng transfer/ambulation. The care plan indic The interventions in environment that su	d 8/26/16, titled "Fall Risk nagement, indicated at risk for awareness, cognitive deficit, s, forgets to call/wait for lages in independent despite explanation of risks. ated actual falls on 8/29/16. Included; "to provide an apports minimized hazards ity has control and to remind call light."			 Clinical symptoms that would immediate transfer after an unwitnesses head injury Policy on Unusual Occurrer Injuries of Unknown Origin 	require ditions,	:
	(Situation, Backgro Recommendation) to facilitate prompt communication," da indicated Resident screaming for no attried to talk to her, to scream, started kick The note indicated monitoring and that time of this change seen placing hersel documentation indicated at the reside elbow.	ated 8/29/16, at 6:45 a.m., 1 was in bed, yelling, pparent reason. When staff the resident continued to king and tried to bite staff. that Resident 1 was on 1:1 an associated behavior at the was that the resident was f on the floor. The cated there was discoloration nt's right upper back and left			 b. DSD/Designee in-services the CN 10/24/2016 - 10/28/2016 for the fortopics: Clinical implications and improf conducting neurological assessm accordance with the facility policy unwitnessed fall or head injury Clinical symptoms that would immediate transfer after an unwitnessed head injury Policy on Unusual Occurrent Injuries of Unknown Origin 	ortance ent in of any require	\rac{1}{2}
	Notes dated 8/29/1 Resident 1 was in h	ensed Personnel Progress 6, at 10 a.m., indicated her room, no episodes of the floor but with screaming		:			

outburst. At 12 p.m., the progress notes indicated

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			<u>OMB NO. 0938-039</u>	<u> 91</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		555099	B. WING		С	
		222033	D. WING		10/18/2016	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKEWO	OOD HEALTHCARE C	ENTER		12023 LAKEWOOD BLVD.		
				DOWNEY, CA 90242		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECT: X (EACH CORRECTIVE ACTION SHOU CRDSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLETION	Ŋ
F 323	Continued From pa	ao 20	! !	00		
1 323			F 3		nditions,	
		is moved to the East wing		,		
		ndition and will continue to		including seizure activities and indivi		
	monitor.			behavior plan such as putting self on flo	iors	
	· Δ review of SRAR o	lated 8/29/16, at 7:15 p.m.,		c. Cameras on the hallways were adju	stad by	
		1 fell along the hallway and		on 10/24/2016 by the maintenance dir		
		oor by certified nursing		be able to record and retain data for		
		. The notes indicated the			,	
		ed and ordered to transfer the	I	Camera was also adjusted to capture a	cuvities	
	resident to a GACH			on the east hallway.		
				d. When the resident has behaviors wh	ich may	
		nsed Personnel Progress		cause self harm a root cause analysi	•	
		3, at 11:10 p.m., indicated		resident behaviors will be conducted.	Of the	
		t and oriented, and walked to		resident behaviors will be conducted.		
		ney (A stretcher or litter used		e. Upon a resident incident of fall or b	ehavior	
		s who require medical care).		such as putting self on floor, License		
i		after the resident got into the twent into a deep sleep. At		will do a thorough investigation an		
		gress notes indicated the		assessment for injuries which includes		
		ransferred to paramedics. The		signs & pain rating. A neurological assi		
		to be non-responsive.		will be completed for any unwitnesss fa		
				injury or seizure activity per facility's p		
	A review of Resider	it 1's Paramedics Report		This will be documented in the I		
		ated that the paramedics were				
		n., and arrived in the facility at :		Nurses's note and Neurological Asso	essment (
	•	cumentation indicated a 911		form.	71.7 ¹³	
		r) responded to a complaint		f. Any change of conditions nost fall / h	iobaulor.	
		n an unwitnessed ground level		f. Any change of conditions post fall/ b such as putting self on floor, resident's		ļ
		i., this evening with hematoma i				ł
		hat is filled with blood caused if all of a blood vessel) to back		MD will be notified for immediate tra		
		aramedics Report indicated		resident, as well as notification of Res	MINDIE	
		econd fall unwitnessed		Party.		
		inutes later resulting in a		g. Post Fall & Post Behavior such as Put	ring Self	
		ne right eye with right rib pain.		on Floor, the IDT will review the even		
		that the resident told the staff		on riddi, the ibi wal leview tile even	. uuring	
		roken around 7:00 p.m. and				
		all 911 for four (4) hours.				

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CENTER	CENTERS FOR MEDICARE & MEDICAID SERVICES			OMB NO. 0938-0				
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED			
					С			
		555099	B. WING		10/18/2016			
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
LAKEWO	OOD HEALTHCARE C	ENTER		12023 LAKEWOOD BLVD. DOWNEY, CA 90242				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		D BE COMPLETION			
:	Physical Report dat 1 had a large right-a right tube thoraco documentation indicates and soft titemporal region. The following: 1. Status post fall 2. Blunt torso traum 3. Right-sided pneu 4. Right 7th, 8th and During an interview licensed vocational she was passing m CNA 1 called her to suffered a fall in a hresident had a cut to forehead. LVN 1 st with saline and notiphysician. On 9/2/16, at 8:02 a interview with CNA LVN 1 to get the result for the following to the following the foll	CH Trauma History and red 8/30/16 indicated Resident sided pneumothorax, for which stomy was placed. The cated the resident had a small saue swelling in the right re list of injuries indicated the mothorax of 12th posterior rib fractures. on 9/1/16, at 5:30 p.m., the nurse (LVN 1) stated while redications around 7 p.m., assess Resident 1 who had rallway. LVN 1 stated the or her right side of the ated she cleaned the wound fied the primary care. a.m., during a telephone of the stated that she assisted rehead. a.m., the assistant sked for the video footage of ident in the hallway on ant administrator stated that		the Fall Meeting after Stand Up daily A RN Supervisor during weekends with investigate the event further, complet cause analysis and recommend apprinterventions and update the Plan of well as follow ups from the Post Fall Humber to the Post Fall Humber to the Post fall	a IDT to lete root propriate Care, as ddle. Visor will pt. and let in le			
		as only for 24 hours, and the 📑 ticular hallway were not		any delay of transfers on any Cha	inge of			

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

working.

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CENTENS I ON MEDICANE	& MEDICAID SEKVICES			OMP MC	<u>, </u>
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION DING		TE SURVEY MPLETED
	555099	B. WING		4.0	C
11115 OF BROWNESS OF SUPPLIES	33033	D. W.10			/18/2016
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
LAKEWOOD HEALTHCARE C	FNTER		12023 LAKEWOOD BLVD.		
			DOWNEY, CA 90242		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		OULD BE	(X5) COMPLETION DATE
E 222 Onethough France	22		1	-	
F 323 Continued From pa		, F3	323		
	rimary care physician he		Conditions during the monthly QA		
	ustained several falls on		trendings and further recommenda	tion.	
	ry care physician stated that				
	ter the last fall to transfer	!	i		
forehead.	CH due to the laceration to the	I			
During an interview	and review of Resident 1's				
	0/26/16, at 1:49 p.m., the				
	pervisor (RNS 1) stated that				
	ked the morning shift (7 a.m.,				j
	dent 1 was transferred to the				
	nonitoring of placing herself				Į.
	rs. RNS 1 was asked what	:			
	oring was provided to Resident	1			
	monitoring, however, RNS 1		•		
	de the specific caregiver's				
name assigned to F	Resident 1 for 1:1 monitoring.	l.			
	to provide documentation and				
	or Resident 1's placing				
	The cause was not assessed				l
	as not communicated to the				
staff to prevent occ	ırrences.				
On 9/26/16, at 3:26	p.m., during and interview,				14
	as called in at 7:00 p.m., by				47
	sident 1 who sustained a fall.				iu '
RNS 2 stated she a	ssessed Resident 1, but failed				
to document the as:	sessment. RNS 2 further				Ì
	as transferred to a GACH due	!			İ
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				
	OON) stated he could not				
	stigation because it was				
protected by the QA	A (quality assessment and ittee that checks on				

standards and quality of care by conducting

STATEMENT OF DEFICIENCIES AND PLAN OF CDRRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED
		555099	B. WING			C 10/18/2016
NAME OF PROVIDER OR SUPPLIER LAKEWOOD HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, 12023 LAKEWOOD BLVD. DOWNEY, CA 90242	ZIP CODE	10/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		TION SHOULD THE APPROPE	BE COMPLETION
F 323	points and guidance relevant issues). To care plan and state implementations we environment free of medications, provide reach, and well-lite the care plan intervidentified behavior on the floor, the DC A review of the 3/1/2 and procedures title Program," indicated environment that meassociated with falls licensed nurse and develop a plan of carisk factors and rooresident's response	reviews, develops reference e for caregiver/providers on the DON read the Resident 1's difference and the precautions and the precautions and the precautions and the precautions and the precautions and the following activities, call light within the provide and the prov	F	323		
			:			:
			;			: