Jul. 2. 2015 3:34PM

No. 2978 P. 9

STATEMEN AND PLAN	T OF DEFICIENCIÉS OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPE A. BUILDING		O. 0938-0 TE SURVE MPLETED
		056167	B. WING		C 7/0 <u>2/20</u> 15
NAME OF	PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	TO ESTE !
CENTIN	ELA SKILLED NURSI	NG & WELLNESS CENTRE WEŞT		50 FLOWER STREET	
(X4) ID	TO VORMINE	ATEMENT OF DEFICIENCIES	·	NGLEWOOD, CA 90301	
PREFIX TAG	i (Each Deificienc	Y MUST BE FRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLE DATE
F 000	INITIAL COMMENT	rs	F 000	Centinela Skilled Nursing and Wellness Centre West submits this	
er eg er	T-			Plan of Correction as the part of	
	The following reflect	cts the findings of the		the requirements under state and	
į	Department of Publi Abbreviated survey.	ic Healin during an	`	federal law. The plan of correction	1
1	Population still by		ĺ	is submitted in accordance with	
	Complaint Number:	CA00445136 - Substantiated		specific regulatory requirements. It	İ
.	Complaint Number:	CA00445590 - Substantiated		shall not be construed as	ļ
İ		ĺ		admission of any alleged deficiency	
	Inspection was limit	ed to the specific complaint(s)	ĺ	cited or any liability. The provider	Į
J	investigated and do	es not represent the findings		submits this plan of correction with	I
1	of a full inspection o	r the facility.	l	the intention that it is inadmissible	İ
}	Representing the De	epartment of Public Health:		by any third party in any civil, criminal action or proceedings	
1				against the provider or its	ļ
-	Surveyor: 06616, RE	HS, HFE II		employee, agents, officers,	
- 1	History Coursely, and	1 O	i	directors, or shareholders.	-
	Highest Severity and 483.20(d), 483.20(k)		'. = 070	The provider reserves the right to	
55=D	COMPREHENSIVE	CARE PLANS	F 279	challenge the cited findings if at	
00-0	DOM: NEIMENONE		į	any time the provider determines	
	A facility must use th	e results of the assessment	į	that the disputed findings are	
	o develop, review ar	nd revise the resident's	j	relied upon in a manner adverse to	
	comprehensive plan	of care.	· . j	the interests of the provider either	
١,	The facility must day	elop a comprehensive care	j	by the governmental agencies or their party.	
l è	plan for each residen	et that includes measurable		then party.	
6	bjectives and timeta	bles to meet a resident's	.	F279	
l n	nedical, nursing, and	i mental and psychosocial		Corrective action for residents	
		led in the comprehensive	1	found to have been affected by	
a	issessment.			this deficiency:	
١	he care plan must d	escribe the services that are		Comprehensive care plan was	
		ain or maintain the resident's		immediately developed to address	
h	ighest practicable pl	nysical, mental, and	-	the medical, nursing, mental, and	
þ	sychosocial well-bei	ng as required under	}	psychosocial needs of the resident.	
		vices that would otherwise		Specific care plan developed to	
		33.25 but are not provided exercise of rights under	1	address resident's specific needs	
ا ا	76 m iiie 18916211(2 (weiolee of tights affact	1	·	

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

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No. 2978 P. 10

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 07/02/2015 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING COMPLETED 056167 B. WING 07/02/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 950 FLOWER STREET CENTINELA SKILLED NURSING & WELLNESS CENTRE WEST INGLEWOOD, CA 90301 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID PREFIX (X6) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) during transfers from bed to F 279 Continued From page 1 F 279 wheelchair and vice versa. Care §483.10, including the right to refuse treatment plan indicated step-by-step process under §483.10(b)(4). during resident transfer from one surface to another. The Director of This REQUIREMENT is not met as evidenced Nursing and Director of Staff Development also in-serviced staff 6/19/15 by: Based on observation, interview and record to transfer resident to wheelchair review, the facility falled to develop a three times a week as tolerated for comprehensive plan of care that addressed socialization and activities on specific intervention on how to transfer a resident 6/19/15 and 6/30/15. Who was totally dependent on staff for one of one resident (1). This deficient practice had the Corrective action for residents potential for the resident to experience discomfort that maybe affected by this and possible injury during transfer. deficiency: Findings: The MDS coordinator and the According to the admission record, Resident 1 assistant MDS coordinator will was admitted to the facility on 5/16/2015 with review residents' initial care plans diagnoses that included chronic obstructive with in the 5th day of admission. pulmonary disease (COPD, lung disease), The Director of DON will review abnormality of gait, muscle weakness, paralysis the care plans for newly admitted agitans (involuntary tremors), lumbosacral and readmitted residents on a spondylosis and general osteoarthrosis. weekly basis. The Director of Nursing Services A review of the Minimum Data Set (MDS, an and Director of Staff Development assessment care screening tool) dated 5/22/2015 have in-serviced staff regarding indicated the resident was independent with her cognitive skills for daily decision-making. The appropriate transfer techniques resident was totally dependent on staff for using the lift and lifter sheet on transfer with one person physical assist. 6/19/15 and 6/30/15. There was a care plan dated May 16, 2015 for Measures that will be put into impaired physical functioning, as manifested by place to ensure that this required extensive assistance during transfer. deficiency does not recur: The goals indicated the resident will be able to attain highest functional mobility/ADLs daily within three months. The approaches included provide assistance with ADLs performance every shift

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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Nc. 2978 P. 11

PRINTED: 07/02/2016 FORM APPROVED

		& MEDICAID SERVICES		0		APPROV . 0938-03	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI/ AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A BUILDIN	(X3) DATE SURVEY COMPLETED		<u></u>	
		056167 ·	B. WING		į.	C	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 0//	02/2015	
CENTIN	iela skilled nursin	ig & Wellness Centre Wes	г	950 FLOWER STREET INGLEWOOD, CA 90301			
(X4) ID PREFIX TAG	i (EACH DEFIC!ENCY	IEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL IC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	8E	(XS) COMPLETIO DATE	N
F 312 SS=D	environment, and as safely, and provide of transfer. The care provided interventions on how was totally dependent director of staff development addressed how transferred from one 483.25(a)(3) ADL CADEPENDENT RESIDENT A resident who is une daily living receives to transferred the contract of the contra	ntain safe and hazard free sist during transfer with enough support during than did not address specific to transfer a resident who not on staff. and record review, the lopment on June 16, 2015 at table to provide care plant the resident will be surface to another. IRE PROVIDED FOR	F 27	spot check staff during resident ransfers from bed to whee and vice versa on a weekly I The Director of Nursing and Director of Staff Developme conduct on-the-spot in-servinappropriate technique is rupon transferring the resident Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to eathat this deficiency has been corrected and will not recur Trends and concerns will be communicated to the quarter	ent will dent lchair basis. ent will ice if noted ent.		
	by: Based on observation review, the facility fails was assessed as total transfer was assessed transfer for one of one deficient practice resuccomplaining of disconfilled Findings: According to the admit	ssion record the resident cility on 5/16/2015 with		steering committee by the Diof Nursing for further review recommendations. F312 Corrective action for resident found to have been affected this deficiency: Interdisciplinary Team meeting was immediately conducted with the resident to address reside preference to be transferred wheelchair for socialization and activities on 6/17/15. Social with was able to recover the reside personal wheelchair. IDT	and ts by with ent's to nd	el17/15	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

No. 2978 P. 12

PRINTED: 07/02/2015 FORM APPROVED

CENT	ERS FOR MEDICARE	& MEDICAID SERVICES					APPROV	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED			
			A. DOILE	JII4G ,				
		056167	B. WING	·	<u> </u>	1	C /02/2015	
NAME C	F PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 07	02/2015	
CENTI	NELA SKO I ED NURSIN	IG & WELLNESS CENTRE WES	_		50 FLOWER STREET			
			' [IN	IGLEWOOD, CA 90301			
(X4) 10 PREFIX	SUMMARY STA	TEMENT OF DEFICIENCIES	ID.		PROVIDER'S PLAN OF CORRECTION	1	(3/5)	\dashv
TAG	REGULATORY OR LE	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	AF	COMPLEYKO CAYE	N
	+	•		J	DEFICIENCY	W-1 E		
5.64	•				January I.			ヿ
F 31	2 Continued From pag		F3	12	developed a care plan to sa	fely and		
	abnormality of gail,	muscle weakness, paralysis		-	comfortably get the residen of-bed three times a week a	t out-		
1	agitans (involuntary	tremors), lumbosacral	l		tolerated for socialization a			ľ
	spondylosis and ger	teral osteoarthrosis.		- 1	activities.	nd		
	A review of the Minis	num Data Set (MDS, an	ļ		activities.			-
	assessment care so	reening tool) dated 5/22/2015	1	-	Corrective action for reside			-
	indicated the resider	it was independent with her			that maybe affected by this			1
	cognitive skills for da	ily decision-making. The		- -	deficiency:	.	•	
	resident was totally o	lependent upon the nursing				Ī		ı
	staff for transfer with	one person physical assist.	-	1	Interdisciplinary Team will re	:		ľ
	The resident's function	onal range of motion		ł	the residents' needs related			1
	limitations indicated	right and left lower			getting out-of-bed (OOB) wit			1
	extremities impairms	ent, and used wheelchair as occurred on and off the			5 th day of admission. Nursing	will		1
	unit.	Complian on and on the			create an appropriate plan o	fcare		1
				١	to carry out OOB orders and			1
	During an interview o	n June 16, 2015, at 3:40		İ	update quarterly and as need	ded.		
	p.m., Resident 1 state	ed, "she would love to get up						Т
	out of bed and social	ize with other residents, but			Measures that will be put in	to		ı
	the staff have a hard	lime transferring me from			place to ensure that this	1		I
,	the bed using the me	chanical lift to the			deficiency does not recur:			J,
•	Micelunali. The les	Ident further stated, "I had I the other facility I was in				1		
	before going into the	hospital." The resident			The Director of Nursing and	- 1		1
	stated she was uncon	nfortable in the facility's			Director of Staff Developmen	t will		L
	wheelchair and stated	i, I am upset that I cannot		1	do spot checks to staff during			
	have my wheelchair fi	rom the previous facility."			resident transfers from bed to wheelchair and vice versa on			
	In an internation of the th	and the section of the first section is				a		ł
	In an interview with the	e director of staff developer			weekly basis. The Director of Nursing and Director of Staff	ł		1
1	the resident was not a	:30 p.m., when asked if why assessed for safe transfer.			Development will conduct on-			Į.
	he said the resident w	as confused and was		1	spot in-service if inappropriate	rue-		
	unable to make her ne	eds known.			technique is noted upon	-		l
	483.25(h) FREE OF A	CCIDENT	F 323		transferring the resident.			
	HAZARDS/SUPERVIS				and the content.			
ļ	T L . A 1000 -				Measures that will be			
l	The facility must ensure	re that the resident			implemented to monitor the			
- 1	environment remains a	as free of accident hazards						
				1	_	1		

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

No. 2978 P. 13

PRINTED: 07/02/2015 FORM APPROVED OMB NO 0938-0391

STATEMENT			STATE OF TAR OF	(<u>.</u> 0938-03	91
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLU			(X1) FROVIDENSUPPLIENCLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
ļ			056167	B. WING	3 <u></u>	<u>. </u>		C	•
NAME OF PROVIDER OR SUPPLIER			J	-	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> 07/</u>	02/2015		
ı	CENTIN	El A GIZA LEG MANAGE				60 FLOWER STREET			
l	CENTRA	ela skilled nursin	G & WELLNESS CENTRE WES	T	1				i
INGLEWOOD, CA (XA) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDED									
	PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E ATE	COMPLETION DATE	N
	F 323	Continued From the		ł	ľ	continued effectiveness of t			ヿ
	1. 420	Continued From pag		F 3	323				- [
		as is possible; and e	ach resident receives			corrective action taken to er	isure		
		adequate supervision	n and assistance devices to	_		that this deficiency has been			
		prevent accidents.			- 1	corrected and will not recur:	i		-
	į					Trends and concerns will be	ı		ı
	j					communicated to the quarter	rly QA		1
	1		i			steering committee by the Di	rector		1
	į	This DECHIDEMENT	 			of Nursing for further review	and		1
		by:	is not met as evidenced			recommendations.			1
		Based on observation	n, interview and record			F323	- 1		1
		review, the facility fall	led to ensure the staff were		- 1	Corrective action for resident	.		1
	ĺ	trained on how to train	sfer resident appropriately			found to have been affected			1
		to prevent injuries and	d to ensure the resident was		ļ	this deficiency:	by		1
].	resident (1).	oly for one of one sampled		i	Interdisciplinary Team meetin	_		ı
]	sesidefit (1).	. 1			held immediately to assess	- 1		
		Findings:	i			resident's concerns during	10	e/17/15	ı
	1.	· winings.	·			transfers on 6/17/15. Care pla		,	ĺ
	- 11	During an interview or	n June 16, 2015 at 3:40			was developed to provide	n		
	(i	p.m Resident 1 state	d, "she would love to get up		- [j	•	
	- 18	out of bed and socialize	ze with other residents, but		}	appropriate transfer technique	es		1
	t	he slaff have a hard t	ime transferring me from		ŀ	using the lift and lifter sheet.			L
	16	he bed using the med	hanical lift to the wheel			Resident educated regarding ri	isk	1-1-	l
	0	chair." The resident fo	Irther stated, she was			and benefits of getting out-of-	bed (417/15	l
	[placed backward in a	swing that lifts her out from			and resident verbalized	- 1	. ,	l
		ner bed in a "hogtled p	position,".			understanding on 6/17/15.			
	i li	n an interview with ce	rtified nursing assistant A		1	Corrective action for residents	.		
	10	CNAA), on June 16.	2016, on the 3-11 shift, at		-	that maybe affected by this			
	4	:00 p.m., when asked	how residents are		1	deficiency:	}		
	tr	ansferred from the be	ed to a wheelchair, CNAA					J	
	S	taled, "I get another s	laff member to assist and			Nursing will assess the resident	۱,,	J	ļ
	W	/e do a two person as	sist. "When the surveyor		1	needs for safe transfers from ar	nd	ļ	
	j a:	ska if they use a med	hanical lift for transferring			surface. Care plan for transfers		· 1	
	į re	esidents? CNA A state	d she does not use the lift.			be initiated with in the first 5 da			
	. aı	nd it is much faster to	transfer residents with the			of admission and quarterly and			
	2:	ssistance of another (ONA.			needed.	as	·	
	Jan 2n	an interview the Dire	ctor of Staff Development		1			ł	
	ļ #/3	an mirel aigh (ie Dhe	croi di stati develobweut		1		- 1	1	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Nc. 2978 P. 14

PRINTED: 07/02/2015 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES FORM A OMB NO. 0							
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (K1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056167			IPLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED			
		056167	B, WING_		C		
NAME	OF PROVIDER OR SUPPLIER			STREET ADDRESS. CITY, STATE, ZIP CODE	07/02/2015		
CENTINELA SKILLED NURSING & WELLNESS CENTRE WEST			т	950 FLOWER STREET INGLEWOOD, CA 90301			
(X4) II PREFI TAG	X (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	RE COMPLEYION		
F 32	(DSD) at 4:15 p.m.	sleted. "Slaff are provided	F 32	Measures that will be put in	nto		
F 328 \$S=0	(DSD) at 4:15 p.m. Initial Training during training is provided in mechanical lift. How the training records for resident transfer, is provided upon initiatining does not inc. When asked to reviewer no logs available 483.25(k) TREATMED NEEDS The facility must ensproper treatment and special services; injections; Parenteral and entercolostomy, ureterost Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT by: Based on observation review, the facility faller receiving oxygen has outside the resident's	stated, "Staff are provided their orientation. No further regarding the use of wever, when asked to review for the mechanical lift used the DSD stated, the training lat orientation and in-service dude the mechanical lift. Ew the training logs, there are for review. ENT/CARE FOR SPECIAL ure that residents receive if care for the following at fluids; omy, or ileostomy care; is not met as evidenced in, interview and recorded to ensure resident warning slone posted	F 328	Measures that will be put in place to ensure that this deficiency does not recur: The Director of Nursing and Director of Staff Developme in-service staff regarding saft transferring residents from a surface. The Director of Staff Development will provide staff Development will provide staff Development will provide staff Development will provide staff Development will provide staff Development will provide staff Development will provide staff Development will provide staff Development will provide staff Development will provide staff Development will provide staff Development will provide staff Development will provide staff Development will provide staff Development will provide staff Development will provide staff Development will provide staff Development will provide staff Development will provide staff Development D	nt will ety in any faff te use ring sting ented (9/30//) ne sure		
	a potential for fire. Findings:			this deficiency: The charge nurse placed precautionary oxygen in use si			
	On 6/16/2015, at 2:30	p.m., an unannounced visit	İ				

- Jul. 2. 2015 3:36PM

DEPARTMENT OF HEALTH AND HUMAN SERVICES

No. 2978 P. 15 PRINTED: 07/02/2015 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION . (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X9) DATE SURVEY IDENTIFICATION NUMBER: A BUILDING COMPLETED 056167 B. WING 07/02/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 950 FLOWER STREET CENTINELA SKILLED NURSING & WELLNESS CENTRE WEST INGLEWOOD, CA 90301 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (XS) COMPLETION DATE PREFIX EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LCC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY Continued From page 6 outside the door for room 28 on F 328 was conducted to investigate a complaint. During 6/16/15. the initial tour of the facility accompanied by the facility's administrator, the resident in room 28A Corrective action for residents was observed receiving oxygen. During that maybe affected by this observation, there were no warning signs posted deficiency: on the door outside the room to indicate oxygen in use. The administrator and both charge nurses checked all other rooms At 2:45 p.m., in an interview during the facility throughout the facility and no tour, the administrator was asked if warning signs similar deficiency noted. are posted outside the room while oxygen was in The Director of Nursing in-serviced use. The administrator replied, "Yes, warning staff on keeping precautionary signs should be posted outside the resident's oxygen in use sign outside of any room when oxygen is in use." room that has an oxygen A review of the facility's policy and procedure concentrator inside on 6/19/15. dated January 2012 for Oxygen therapy stipulated to place "Oxygen in use" sign on Measures that will be put into resident's door when oxygen is in use. However, place to ensure that this there were no signs posted. deficiency does not recur: The Director of Nursing and designee will conduct daily inspection to monitor compliance. Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur: Trends and concerns will be communicated to the quarterly QA steering committee by the Directo of Nursing and Administrator for further review and recommendations.

FORM CMS-2667 (02-69) Previous Versions Obsolale

Event ID: EOVY11

Facility ID: CA910000005

if continuation sheet Page 7 of 7