STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555099	A. BUILDING _____ B. WING _____	C 02/16/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the Department of Public Health during a complaint investigation. Complaint Number: CA00543707 Substantiated with no regulatory violations Representing the Department of Public Health: Evaluator: 38551, RN, HFEN Inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility. One deficiency was issued as a result of CA00543707	F 000	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 deficient practices.** **F 323: Free of Accident Hazards / Supervision / Devices.**	
F 323 SS=D	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(d)(1)(2)(n)(1)-(3) (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.	F 323	**Corrective actions for cited practice:** • Resident #1 was discharged to acute hospital via 911on 7/11/2017 due to sudden changes in medical condition with licensed nurse following changes in condition policy and procedures and documentation. • Resident #1 is no longer at the facility. • No other resident affected by the practice.	2/22/18

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

RECEIVED
FEB 23 2018
HEALTH FACILITIES
INSPECTION DIV.

Asst Admin 2/22/18

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

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F 323	Continued From page 1 (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits.of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to follow its policy and the plan of care for one of three sampled residents (Resident 1), by not ensuring supervision and adequate monitoring was provided to prevent accidents, hazards, and physical injuries. Resident 1, who had a history of wandering, was not supervised and was found in another resident's room with a right upper lip cut, bruising to the right cheek and was unresponsive. These deficient practices resulted in Resident 1 being unsupervised, found unconscious, requiring a transfer to a general acute care hospital (GACH) for 13 days. Resident 1 was intubated (insertion of a tube into a person or a body part, especially the trachea [a tube-like portion of the respiratory tract] for ventilation [supply of air to the lungs]) and placed on a mechanical ventilator (a mode of assisted or controlled ventilation using mechanical devices that cycle automatically to generate airway pressure). Findings:	F 323	• Nursing Staffs was given in-service by DON / DSD given emphasis on monitoring resident's whereabouts frequently on 2/19/2018 and 2/20/2019.. **Identification of other residents with the potential of being affected by same practice and implemented corrective measures:** • Quality improvement plan analysis indicates continuous evaluation of residents identified on admission, re-admission or changes in condition to be at risk for wondering by the RN supervisors with appropriate plan of care. • Other residents identified to be of high risk or possible to be at risk as discuss in the stand up meeting by DON, huddle between shift changes by RN supervisors and licensed nurses as observed by caregivers shall immediately re-assess with MD notification to ensure continuous safety of residents to prevent being affected by the same of similar practice.	

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F 323	Continued From page 2 A review of Resident 1's Admission Face Sheet indicated the resident was admitted to the facility on June 27, 2017. Resident 1's diagnoses included dementia (loss of memory and other mental abilities severe enough to interfere with daily life) and psychosis (severe mental disorder in which thought and emotions are so impaired that contact is lost with external reality). A review of Resident 1's Minimum Data Set (MDS), a standardized assessment and care-screening tool, dated July 4, 2017, indicated Resident 1's cognition (thought process) was mildly impaired. The MDS indicated Resident 1 required minimal assistance from staff transferring to and from one place to the other and with activities of daily living (ADLs). A review of Resident 1's care plan titled, "Wandering/Elopement," dated June 27, 2017, indicated the resident was at risk for wandering and would be oriented to the environment and facility's routine as well as provided with a consistent routine. A review of Resident 1's care plan titled, "Behavioral/Psychotropic Medication," dated June 27, 2017, indicated the resident had a physical behavior problem that posed a danger to herself or others. The staff interventions indicated to monitor Resident 1 to monitor for antecede (triggering) behaviors, provide a calm environment, use redirection and minimize environmental stressors.	F 323	**Measures in place to ensure practice does not recur:** DSD, RN Supervisors and or Designees shall continue to perform routine rounds frequently to ensure safety of the residents.. • Facility had implemented a nurse monitoring program 16 hours a day to monitor and supervise residents to ensure safety of the residents. **Monitoring system to make sure solutions are sustained.** • Director of Nurses and or Designee shall report findings outcome at the end of the month to the QAA committee for further review. This plan of correction will be integrated into our Quality Assurance process through a review of the Plan of Correction and findings specific to sustaining compliance with reference to the threshold of incidents as determined by the QA committee X3 months and review by the QA committee with recommendations.	

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F 323	Continued From page 3 A review of Resident 1's care plan titled "Cognitive Loss," dated June 27, 2017, indicated the resident had periods of forgetfulness. The staff interventions included to monitor for changes in mental status and report to the physician and to provide the resident with reality orientation. A review of Resident 1's initial plan of care, dated June 27, 2017, indicated the resident required supervision and was to be observed frequently to ensure safety. A review of Resident 1's care plan titled, "Dementia/Alzheimer's," dated June 30, 2017, indicated the facility would establish and maintain a consistent daily routine for the resident. A review of Resident 1's nurses' note, dated July 11, 2017, and timed at 5 p.m., indicated the resident received her breathing treatment and encouraged to rinse her mouth with water. At 7:15 p.m., on July 11, 2017, the nurses' note indicated that Resident 1 was found unconscious with a small cut to her right upper lip and swelling to her right cheek on another resident's bed. On July 18, 2017 at 10:38 a.m., during an interview, Registered Nurse 1 (RN 1) stated that, on July 11, 2017, Resident 1 would not wake up after her chest was rubbed. RN 1 stated Resident 1's oxygen level was 90 percent (%) (normal reference range [NRR] is 95-100%). RN 1 stated the resident was breathing as if she was asleep and observed with secretions in her mouth that	F 323	Completion Date: 2/26/18	

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F 323	Continued From page 4	F 323		

required suctioning. RN 1 stated Resident 1's pupils (eyes) were constricted (small) and not reactive to light (size should change when light is shined on them). According to RN 1, the physician stated Resident 1 might have had a seizure (uncontrolled electrical activity in the brain, which may produce a physical convulsion [a sudden, violent, irregular movement of a limb or of the body]) or a stroke (sudden loss of brain cells due to lack of oxygen). RN 1 stated that Resident 1 was not on any narcotics (pain medicine that causes drowsiness).

On July 18, 2017, at 5:15 p.m., during an interview, the Director of Nursing (DON) stated that, on July 11, 2017, a certified nursing assistant (CNA) observed Resident 1 putting a pen in her mouth, in front of the nursing station, while the CNA was talking with another resident.

On July 18, 2017, at 5:30 p.m., during an interview, the Administrator was asked about a policy regarding supervision and monitoring in the locked facility. The Administrator stated that the facility had no policy regarding providing monitoring and supervision to residents. The Administrator stated they used a change of condition (COC) notification policy as a guide.

On July 31, 2017 at 9:35 a.m., during an interview, Resident 1's family member (FM 1) stated the resident had increased confusion and combativeness ever since the incident on July 11, 2017 occurred.

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F 323	Continued From page 5 On October 19, 2017 at 1:18 p.m., during an interview, CNA 1 stated that the staff assigned to the hallway was responsible to monitor residents to prevent accidents and to attend to their needs. CNA 1 stated that if she had to attend to a resident, she would have another staff monitor the other residents. On October 19, 2017 at 1:21 p.m., during an interview, Licensed Vocational Nurse 1 (LVN 1) stated residents were monitored every 30 minutes for safety. LVN 1 stated residents who wandered could not be prevented from wandering, but the staff were supposed to redirect them. On October 19, 2017 at 2:32 p.m., during an interview, the Administrator stated that residents were assessed upon admission and if at risk for wandering, the interdisciplinary team ([IDT] group of disciplines working together towards a common goal of a resident) would determine what the staff would do to prevent triggers and injuries to the residents. On October 19, 2017 at 2:49 p.m., during an interview, CNA 3 stated that he took care of Resident 1 during the morning shift, the day she was found unconscious (July 11, 2017). According to CNA 3, the resident would always wander into other residents' rooms and the staff was required to supervise and redirect the resident. CNA 3 stated that Resident 1 was fine throughout his shift.	F 323		

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F 323	Continued From page 6 On October 19, 2017 at 2:55 p.m., during an interview, CNA 4 stated he found Resident 1 on a male resident's bed with her head on the foot board with her eyes closed, unresponsive half asleep, and moaning. CNA 4 stated he did not know how long Resident 1 had been in that room. According to CNA 4, he last saw the resident approximately 30-40 minutes prior to being found unresponsive. CNA 4 also stated that the resident was observed earlier biting on a pen. On October 19, 2017 at 3:20 p.m., during an interview, CNA 4 stated that Resident 1 looked "drugged down" and that he asked the nurse if Resident 1 had been medicated. CNA 4 stated the resident looked stiff and unresponsive. On October 19, 2017 at 3:38 p.m., during an interview, RN 1 stated, on July 11, 2017, upon assessment, Resident 1 was snoring, unresponsive to voice, tactile/painful stimuli and pupils were non-reactive to light. RN 1 also stated that the resident was also seen by a physician who stated that Resident 1 might have had a seizure. According to RN 1, Resident 1 was observed with a small cut on her right upper lip and RN 1 stated that the resident might have bit her lip. The resident's oxygen (O2) level was low according to RN 1 and she administered 4 liters (4L) of supplemental oxygen through a nasal cannula (tube used to administer oxygen) to Resident 1 and her O2 increased to 99-100%. RN 1 stated some residents at the facility had pens and pencils and sometimes would ask staff for papers to write on. RN 1 stated that some residents used the pens to write poems to the staff and that the staff was supposed to assess if	F 323		

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F 323	Continued From page 7 residents should have pens because pens could be dangerous in the facility. On October 19, 2017 at 3:46 p.m., during an interview, LVN 2 stated that she was Resident 1's nurse the day of the incident (July 11, 2017) and that the resident's lip was a little bit swollen when she was found unconscious. LVN 2 stated that Resident 1 might have gone to another resident's room due to confusion. According to LVN 2, the CNA in charge of the hallway might have been busy with another resident, but was supposed to delegate another staff to monitor the hallway. On October 20, 2017 at 10:02 a.m., during an interview, the DON stated that most of the residents were ambulatory (capable of walking) and that the staff could not see residents every minute. A review of the facility's social services assessment, dated July 1, 2017, indicated Resident 1 was alert, confused, and forgetful, but was able to make needs known. It also indicated that resident was to be monitored and assisted with her needs. A review of Resident 1's progress note, dated July 18, 2017, indicated the resident did not fall or have an altercation with another resident and that there was no screaming or yelling heard anywhere in the facility; prior to finding the resident unconscious on July 11, 2017. It also indicated the resident was observed by a CNA biting on a pen while at the nurses' station and	F 323		

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F 323	Continued From page 8 that Resident 1 became agitated when the CNA asked the resident to give him the pen. A review of Resident 1's general acute care hospital (GACH) Emergency Department (ED) note, dated July 11, 2017, indicated at 7 p.m., on the same day, the resident was brought in confused, with pinpoint, fixed, and dilated pupils, and unresponsive with oral trauma present. The physician indicated that Resident 1 was lethargic (lack of energy, sluggish) and able to respond to painful stimuli. The note indicated Resident 1 had a large hematoma (localized swelling filled with blood) to the right jaw and a laceration (deep cut) to the upper lip measuring 0.5 centimeters (cm). According to the ED note, Resident 1 was administered Narcan (used to reverse opioid [pain reliever] medications in hopes to improve breathing) at the nursing home prior to arriving the hospital. A review of Resident 1's GACH note, dated July 12, 2017, indicated the resident was restless, intubated, and unable to follow commands, withdrew to painful stimuli, and had bilateral (both sides) wrist restraints due to restlessness and a high fall risk. A review of Resident 1's care management progress note, dated July 18, 2017, indicated the resident was alert and oriented to her name only, confused, paranoid, and restrained. Another care management note, dated July 22, 2017, indicated Resident 1's family member (FM 1) stated within 14 days of being at the nursing home, the resident had totally changed. FM 1 stated	F 323		

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F 323	Continued From page 9 Resident 1 was striking out and spitting at nurses. A review of Resident 1's chest X-ray, dated July 11, 2017, indicated complete left upper lobe atelectasis (lung collapse) with an elevation of the left hilum (lung roots) and left tracheal (windpipe) shift. A recommendation was made for a computerized tomography [(CT) special X-ray that produces detailed images using X-rays and a computer], of the chest to evaluate for a possible obstruction. The ED note, dated July 12, 2017, indicated Resident 1 was intubated. A review of a "Critical Care Consult," dated July 12, 2017, indicated Resident 1 had acute respiratory failure and a change in mental status likely due to chronic obstructive respiratory failure ([COPD] a recurring chronic and permanent disease of the lungs that restrict normal breathing) and benzodiazepine (class of medications used as a mild tranquilizer). A review of Resident 1's GACH laboratory (lab) results, dated July 11 2017, indicated the resident had a positive urine drug screen for Benzodiazepines. A review of Resident 1's physician orders and the medication administration records (MAR) for June and July 2017, at the nursing home, indicated the resident was not receiving any benzodiazepines.	F 323		

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F 323	Continued From page 10 A review of Resident 1's GACH "Physician Discharge Summary" note, dated July 23, 2017, indicated the resident was admitted to the hospital with acute respiratory failure and during the course of Resident 1's hospitalization, the resident was intubated; extubated (removal of the tube in the trachea), placed on a one to one sitter and had to be restrained. A review of the facility's policy and procedure titled, "Wandering and Elopement," with a revision date of July 2017, indicated that the purpose of the policy was to enhance the safety of residents in the facility and that at admission, residents would be assessed for their wandering/elopement risk. The policy indicated that specific cues to divert the resident from wandering behaviors were to be included in the care plan. A review of the facility's undated policy and procedures titled "Abuse-Prevention Program," indicated the facility did not condone any form of resident abuse, neglect or mistreatment. Neglect, per this policy, was the failure to provide goods and services necessary to avoid physical harm, pain, mental anguish or emotional distress. The policy also indicated the facility maintained adequate staffing on all shifts to ensure that the needs of each resident were met.	F 323		