POC accepted HFEW 28557 10/4/19

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

PRINTED: 09/20/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555004	A. BUILDING _____ B. WING _____	C 09/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAYA DEL REY CENTER	7716 MANCHESTER AVENUE PLAYA DEL REY, CA 90293

(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: CA00647116 Representing the Department of Public Health: Health Facilities Evaluator Nurse ID: 38551, RN This inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility. There were two deficiencies issued for Complaint Number: CA00647116	F 000	Preparation, submission and/or execution of this Plan of Correction does not constitute an admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction is prepared, submitted and/or executed solely because it is required by the provisions of federal and state law. F Tag 689	
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure assisted devices were used for a resident who did not have the ability to sit upright in a wheelchair due to hemiplegia (paralysis [inability to move] on one side of the body) and hemiparesis (weakness on one side of the body) while being pushed in a wheelchair for one of three sampled residents	F 689	CORRECTIVE ACTION(S): Resident 1 fall re- assessment and restraint evaluation related to use of seat belt was completed on 9/25/2019 by MDS nurse and CNE. During assessment evaluation Seat belt found to be unnecessary and not appropriate due to resident safety concerns and behavior . IDT Care plan meeting was held on 7/22/2019 to discussed resident fall causal/risk factors , fall management and current interventions. CNA 1 provided one on one training by Director of Staff Development on how to wheel a patient safely with emphasis on	9/25/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: RN - QMC — (X6) DATE: 9/30/2019

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 689	Continued From page 1 (Resident 1). Resident 1, who was confused and agitated at times, had the tendency of leaning forward in the wheelchair without staff utilizing the footrest and a seatbelt for safety. While being pushed in the wheelchair, Resident 1 fell out of the wheelchair onto the floor and sustained facial injuries. This deficient practice resulted in Resident 1 falling sustaining a laceration (an injury to the skin and the soft tissue underneath it; a cut) over the left eyebrow, an opened wound on the bridge of her nose, swelling to the left upper lip and a slit (a long, narrow cut or opening) in the center of the bottom lip. Resident 1 was transferred to a general acute care hospital (GACH) for evaluation, care and treatment. Findings: A review of Resident 1's Admission Face sheet indicated Resident 1 was admitted to the facility on 11/27/17, with a most recent readmission on 6/30/19. Resident 1's diagnoses included left hemiplegia and hemiparesis, osteoporosis (a disorder that causes bones to become weak and brittle), and dementia (a chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning). A review of Resident 1's "Assessment Outcomes," dated 3/3/18 and timed at 1:47 p.m., indicated Resident 1 was at risk for falls. It also indicated Resident 1 was confused, unable to make significant changes in position independently and required extensive assistance	F 689	the utilization of footrest and seat belt if necessary for residents with diagnosis of Unspecified Dementia with behavioral disturbance on 9/26/2019. HOW TO IDENTIFY OTHER RESIDENTS: The Director of Rehab and MDS nurse completed a review of residents requiring footrest and seat belt on 9/27/2019 . No other residents were affected by the deficient practice. SYSTEMIC CHANGES: Rehab designee and RN supervisor will check all residents with footrest weekly for 3 consecutive months to validate compliance and follow up appropriateness of use . Nurse educator in-serviced all licensed nurses and CNAs regarding Fall Management, Footrest usage for appropriate	9/26/19 9/27/19

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F 689	Continued From page 2 with care. According to this report, Resident 1 used a wheelchair for mobility and had the potential to slide down in a chair. A review of Resident 1's "Morse Fall Risk Screen" (an assessment and screening tool indicating if a resident was at risk for falls), dated 12/13/18 ,indicated Resident 1 had a score or 65 (a score of 45 and above indicated high fall risk). A review of Resident 1's Minimum Data Set (MDS), an assessment and care screening tool, dated 7/7/19, indicated Resident 1's cognition (thought process) was intact. The MDS indicated Resident 1 required a one-person physical assist with bed mobility, dressing, eating, toilet use and personal hygiene. According to the MDS, Resident 1 had a fall in the last two-six months prior to admission and was taking antipsychotic (medication to treat mental disorders) medication. A review of a facility's report titled, "Event Summary Report," dated 7/21/19 and timed at 7 p.m., indicated on 7/21/19 at 6:57 p.m., Certified Nursing Assistant 1 (CNA 1) was wheeling Resident 1 in a wheel chair when Resident 1 placed her foot under the wheelchair's wheel and leaned forward and fell out the wheelchair on her face. According to this report, Resident 1 sustained a laceration over the left eyebrow, an opened wound on the bridge of her nose, swelling to the left upper lip and a slit in the center of the bottom lip. A review of a "Situation Background Assessment and Recommendation (SBAR) Internal Communication Form," dated 7/21/19, indicated Resident 1 had one or more falls.	F 689	residents, restraints use and Proper handling of residents with behavior while wheeling a wheelchair and Accommodation of Resident needs on 9/27/2019. This is a restraint free facility. Medical records designee will audit the Foot rest log daily M-F and findings will be reported to the Center Nurse Executive for correction actions. MONITORING PROCESS: The Center Nurse Executive , Director of Rehab and MDS nurse will track any trends or concerns related to Free of Accidents Hazards /Supervision /Devices . The facility must ensure that each resident receives adequate supervision and assistance to prevent accidents, this will be communicated to the QA committee for further evaluation and recommendation monthly . If it is determined that we have accomplished the objective in the POC above and the results are successful , then the facility will consider the matter resolved. The QA committee will continue to review the deficiency has been proven to be resolved for 3	9/27/19

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F 689	Continued From page 3 A review of Resident 1's "Nursing Home to Hospital Transfer Form," dated 7/21/19 and timed at 10:45 p.m., indicated Resident 1 was transferred to a GACH after a fall incident. On 7/23/19 at 7:05 a.m., during a concurrent observation and interview with Registered Nurse 2 (RN 2), Resident 1 was in bed with no floor mats next to the bed and the bed side table was not within the resident's reach. Resident 1's left eye was observed swollen and bruised. There were five (5) sterile strips (adhesive skin closures) on Resident 1's left eye lid and one sterile strip on the bridge of the nose. Resident 1's left upper lip and left chin were bruised. RN 2 stated that Resident 1 did not have a floor mat because the resident did not get out of bed. RN 2 stated that Resident 1's bed side table should have been closer to the resident to prevent the resident from stretching and falling. On 7/23/19 at 9:59 a.m., during an interview, CNA 1 stated that on 7/21/19 while wheeling Resident 1 in the hallway, the resident's feet were on the floor, not on the foot rest, and Resident 1 was trying to walk (move her feet as though walking) while the wheelchair was in motion. CNA 1 stated that Resident 1 was confused and agitated (feeling or appearing troubled). CNA 1 stated that she continued to push the wheelchair and did not ask Resident 1 to stop. According to CNA 1, as the wheel chair was moving, Resident 1 suddenly leaned forward and fell on her face onto the floor, slit her lower lip and sustained a laceration to the eye and was bleeding from the injuries. CNA 1 stated she was not sure if placing the resident's feet on the foot rest could have stopped the resident from falling and getting injured.	F 689	consecutive months and/or advised by the QA Committee.	

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F 689	Continued From page 4 On 7/23/19 at 11:15 a.m., during an interview, the facility's Director of Rehabilitation (DOR) stated that Resident 1 was unable to walk, was cognitively impaired and had poor safety awareness. The DOR stated that Resident 1's feet should have been placed on the foot rests when someone was pushing the wheelchair because Resident 1 was erratic (unpredictable) and had a tendency of sliding out of the wheelchair. According to the DOR, placing Resident 1's feet on the foot rest would have prevented the fall with injuries. On 7/23/19 at 11:48 a.m., during a telephone interview, Licensed Vocational Nurse 1 (LVN 1) stated that Resident 1 was agitated, confused and had a tendency of standing up abruptly while in the wheelchair. LVN 1 stated that while CNA 1 was wheeling Resident 1 she leaned forward, fell on her face and sustained injuries. On 7/23/19 at 12:20 p.m., during an interview, Registered Nurse 1 (RN 1) stated that on 7/21/19 after dinner, CNA 1 was wheeling Resident 1 from the dining room. Resident 1, who was very confused, put her foot by the wheel of the wheelchair while being pushed and fell face down. RN 1 stated that the resident was bleeding from the eye brow and nose and her dentures and food fell out of her mouth to the floor. RN 1 stated that using a wheel chair with a seat belt around Resident 1's waist could have prevented the fall. RN 1 stated since Resident 1 was agitated and confused, CNA 1 should have pushed the wheelchair with one hand and supported the resident's shoulder with another hand to prevent the fall. A review of the facility's policy with a revision date	F 689		

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F 689	Continued From page 5 of 5/27/15 and titled, "Accidents and Incidents," indicated the purpose of the policy was to provide a safe and healthy environment to residents, visitors and employees. A review of a facility's policy titled, "Falls Management," with a revision date of 3/15/16, indicated the purpose of the policy was to reduce risk for falls and minimize the actual occurrence of falls. The policy also indicated that injury and providing care for a fall would be addressed such as identifying residents fall risk status to caregivers, develop an individualized care plan, review, and revise care plans regularly if a fall incident occurred.	F 689		

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	CA910000069	A. BUILDING: _____ B. WING _____	C 09/20/2019

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B 000	Initial Comments The following reflects the findings of the Department of Public Health of a Complaint investigation during an Abbreviated Standard Survey. Complaint number: CA00647116 Representing the Department of Public Health: Health Facilities Evaluator Nurse ID: 38551, RN The inspection was limited to the specific Complaint investigation and does not represent the findings of a full inspection of the facility. There were two deficiencies issued for CA00647116	B 000	Preparation, submission and/or execution of this Plan of Correction does not constitute an admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction is prepared, submitted and/or executed solely because it is required by the provisions of federal and state law. B4835 CORRECTIVE ACTION(S): Resident 1 fall re- assessment and restraint evaluation related to use of seat belt was completed on 9/25/2019 by MDS nurse and CNE. During assessment evaluation Seat belt found to be unnecessary and not appropriate due to resident safety concerns and behavior . IDT Care plan meeting was held on 7/22/2019 to discuss resident fall causal/risk factors , fall management and current interventions. Resident 1 fall incident was documented in the Risk Management system; Risk Management notifies the user	9/25/19
B4835	T22 DIV5 CH3 ART5-72541 Unusual Occurrences Occurrences such as epidemic outbreaks, poisonings, fires, major accidents, death from unnatural causes or other catastrophes and unusual occurrences which threaten the welfare, safety or health of patients, personnel or visitors shall be reported by the facility within 24 hours either by telephone (and confirmed in writing) or by telegraph to the local health officer and the Department. An incident report shall be retained on file by the facility for one year. The facility shall furnish such other pertinent information related to such occurrences as the local health officer or the Department may require. Every fire or explosion which occurs in or on the premises shall be reported within 24 hours to the local fire authority	B4835		

Licensing and Certification Division
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: RN - CNE — (X6) DATE: 9/30/2019

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B4835	Continued From page 1 or in areas not having an organized fire service, to the State Fire Marshal. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to report a fall incident to the Department of Health Services (DHS), for one of three sampled residents (Resident 1), who fell and sustained a laceration over the left eyebrow, an open wound on the bridge of the nose, swelling to the left upper lip and a slit in the center of the bottom lip. This deficient practice placed Resident 1 and other residents in the facility at risk for neglect or further injuries. Findings: A review of Resident 1's Admission Face sheet indicated Resident 1 was admitted to the facility on 11/27/17, with a most recent readmission on 6/30/19. Resident 1's diagnoses included left hemiplegia and hemiparesis, osteoporosis (a disorder that causes bones to become weak and brittle), and dementia (a chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning). A review of Resident 1's Minimum Data Set (MDS), an assessment and care screening tool, dated 7/7/19, indicated Resident 1's cognition (thought process) was intact. The MDS indicated Resident 1 required a one-person physical assist with bed mobility, dressing, eating, toilet use and personal hygiene. According to the MDS, Resident 1 had a fall in the last two-six months prior to admission and was taking antipsychotic (medication to treat mental disorders) medication.	B4835	whether an incident is a reportable offense or not, in this case no such warning was given. CNA 1 provided one on one training by Director of Staff Development on how to wheel a patient safely with emphasis on the utilization of footrest and seat belt if necessary for residents with diagnosis of Unspecified Dementia with behavioral disturbance on 9/26/2019. HOW TO IDENTIFY OTHER RESIDENTS: The Center Nurse Executive , MDS nurse and RN Supervisor completed a review from 9/23/2019-9/27/2019 on residents had fall incidents from 8/1/2019 to 9/01/2019. No other residents were affected by the deficient practice. SYSTEMIC CHANGES: Nurse educator in-serviced all licensed nurses and CNAs regarding Unusual Occurrences and proper reporting to appropriate agencies. on 9/27/2019.	9/26/19 9/27/19 9/27/19

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B4835	Continued From page 2 A review of Resident 1's "Assessment Outcomes," dated 3/3/18 and timed at 1:47 p.m., indicated Resident 1 was at risk for falls. It also indicated Resident 1 was confused, unable to make significant changes in position independently and required extensive assistance with care. According to this report, Resident 1 used a wheelchair for mobility and had the potential to slide down in a chair. A review of a facility's report titled, "Event Summary Report," dated 7/21/19 and timed at 7 p.m., indicated on 7/21/19 at 6:57 p.m., Certified Nursing Assistant 1 (CNA 1) was wheeling Resident 1 in a wheel chair when Resident 1 placed her foot under the wheelchair's wheel and leaned forward and fell out the wheelchair on her face. According to this report, Resident 1 sustained a laceration over the left eyebrow, an opened wound on the bridge of her nose, swelling to the left upper lip and a slit in the center of the bottom lip. A review of the facility's policy titled, "Accidents and Incidents," with a review date of 5/2/18, indicated the purpose of the policy was to meet regulatory requirements for analyzing and reporting accidents and incidents. Under the sub heading titled, "Reporting," the policy indicated the facility would notify the State of reportable events and the facility would verify that a reporting occurs within required timeframes and via appropriate method or reporting.	B4835	Medical records designee will audit the change of condition daily M-F and findings will be reported to the Center Nurse Executive during stand up meeting and clinical for correction actions and will review the incident if it is reportable or not. MONITORING PROCESS: The Center Nurse Executive and Administrator will track any trends or concerns regarding proper reporting to appropriate agencies of any Unusual Occurrences in the facility. This will be communicated to the QA committee for further evaluation and recommendation monthly . If it is determined that we have accomplished the objective in the POC above and the results are successful , then the facility will consider the matter resolved. The QA committee will continue to review the deficiency has been proven to be resolved for 3 consecutive months and/or advised by the QA Committee.	