Poc Accepted 9/11/2020

41852

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056206	A BUILDING _____ B WING _____	07/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY PARK HEALTHCARE CENTER	230 E Adams Blvd, Los Angeles, CA 90011-1426 LOS ANGELES COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETE DATE
	The following reflects the findings of the Department of Public Health during a Complaint Investigation visit: CLASS A CITATION -- PATIENT CARE 92-2181-0016002-F Complaint(s): CA00691108 Representing the Department of Public Health: Surveyor ID # 2181, HFEN The inspection was limited to the specific facility event investigated and does not represent the findings of a full inspection of the facility. F580 §483.10(g) (14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)		University Park healthcare center submits this response and Plan of Correction as part of the requirements under the State and Federal Law. The Plan of Correction is submitted in accordance with specific regulatory requirements. It shall not be construed as admission of any alleged deficiency cited or any liability. The provider submits this plan of correction with the intention that it is inadmissible by any third party in any civil, criminal action or proceedings against the provider of its employees, agents, officers, directors, or shareholders. The provider reserves the right to challenge the cited findings if at any time the provider determines that the disputed findings are relied upon in a manner adverse to the interest of the provider either by the governmental agencies or third party. Any changes to provider policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the federal rules of evidence and California evidence code section 1151 and should be in any proceeding on that basis. F 580 F 684 -Corrective action(s) Resident 1 no longer resides in the facility. -Identification of other resident affected and corrective action. Interim Director of nursing reviewed all other residents who may be affected by this deficient practice. No other resident noted with similar deficient practice.	08/14/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE MARIANNE B. MEADE TITLE RN, BSN, MSN (X6) DATE 08/31/2020

By signing this document, I am acknowledging receipt of the entire citation packet. Page(s) 1 thru 9

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. Except for nursing homes, the findings 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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	(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). F-684 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. § 72311. Nursing Service - General. (a)Nursing service shall include, but not be limited to, the following (1) Planning of patient care, which shall include at least the following: (B) Development of an individual, written patient care plan which indicates the care to be given, the objectives to be accomplished and the professional		- Measures adopted for systematic changes Starting August 07, 2020, Interim DON and DSD in-serviced licensed nursing regarding following physician's orders with emphasis on administration of proper medications when a resident is noted with fever and reporting to the primary physician as ordered. These in-services were completed on 08/14/2020. On August 08/07/2020 through 08/14/2020, Interim DON and DSD in-serviced CNAs regarding proper reporting a resident abnormal vital signs to a licensed nurse using STOP AND WATCH format. Starting August 07, 2020, Interim DON and DSD in-serviced licensed nursing how to use PCC to check assigned residents vital signs PCC and any warning report from CNAs. Licensed nurses directed to perform this check at least 30 minutes before end of each shift and address any warning reports and abnormal VS if any information wasn't addressed and acted on during a shift. In-services were completed on 08/14/2020. If CNAs identify abnormal VS, a CNA will immediately report to assigned charge nurse and complete STOP AND WATCH report. Charge nurses will act according to nursing practice standards and physician's order and if warranted will report RN supervisor.	

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	discipline responsible for each element of care. Objectives shall be measurable and time-limited. § 72523. Patient Care Policies and Procedures. (a) Written patient care policies and procedures shall be established and implemented to ensure that patient related goals and facility objectives are achieved. An unannounced visit was made to the facility on 6/9/2020 to investigate a complaint of quality of care resulting in death. Based on interview and record review, the facility failed to notify the physician when Resident 1 developed fever (elevated body temperature), as indicated in the facility's policy and plan of care. On 5/30/2020 at 1:28 p.m., Resident 1 developed a fever of 100.5 degrees Fahrenheit (°F - normal range from 97 °F to 99 °F) and the change of condition was not reported to Resident 1's attending physician for medical interventions, including finding out the source of the fever (possible infection) through laboratory tests, frequent checks of the resident's temperature, pharmaceutical and non-pharmaceutical interventions. As a result, on 6/2/2020, at 9:29 a.m., Resident 1, a 69 year old male, was transferred to General Acute Care Hospital 1 (GACH 1) where he was found with an elevated body temperature of 106.3 °F and hemodynamically unstable (abnormal or unstable blood pressure, which can cause inadequate blood flow to organs). Resident 1 expired on 6/3/2020 at		Charge nurses will perform quick audit using PCC to identify abnormal VS by the end of each shift daily and act accordingly. Registered Nurse supervisors during their shift will monitor compliance daily and address any noncompliance issues and report to DON. -Quality Assurance Performance Improvement Monitoring of Corrective Action. DON and/or designee will monitor compliance weekly via performing VS audit and validating that physicians' orders are followed. The Director of Nursing/designee will provide a summary trend analysis of findings to the monthly QAPI committee meeting for review and recommendations. If there are no negative findings reported after 3 months, issue is considered resolved.	

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	11:23 p.m. A review of Resident 1's Admission Record (Face Sheet) indicated a readmission dated on 1/18/2018 with diagnoses including gastrostomy tube (GT - a tube surgical inserted through the abdominal wall into the stomach for the purpose of administration of food, hydration, and medication), heart failure (the heart is unable to provide adequate blood flow to other organs), and cerebrovascular attack (CVA - occurs when blood flow to a part of the brain is stopped either by a blockage or the rupture of a blood vessel) with left hemiparesis (weakness on one side of the body). A review of Resident 1's Physician's Orders for Life Sustaining Treatment (POLST) dated 8/12/2019, indicated Resident 1 was to receive full treatment. A review of the Care Plan developed on 1/2/2020 indicated Resident 1 had a risk of dehydration (dangerous loss of body fluid caused by illness, sweating, or inadequate intake). The care plan interventions included to observe for contributing factors (such as elevated temperature [fever]) and notify the physician as needed. A review of Resident 1's Minimum Data Set (MDS - standardized assessment and care-screening tool) dated 3/5/2020, indicated Resident 1's cognition (mental processes involved in gaining knowledge and comprehension) was moderately impaired (decision poor, supervision required). Resident 1 needed limited assistance with one-person physical assist with activities of daily living (ADLs – such as			

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	transfers, toileting, and personal hygiene). A review of Resident 1's Physician's Order dated 3/3/2020, indicated to administer Resident 1 acetaminophen syrup 650 milligrams (mg - unit of measurement) through the GT every six hours as needed (PRN) for temperature greater than 100°F, and to notify the physician. According to a review of the facility's contact line listing (surveillance, tracing of an infection) for COVID-19 (Coronavirus disease 2019, a highly contagious viral infection that is spread from person-to-person causing respiratory complications requiring in many cases hospitalization and may result in death) dated 5/26/2020, Resident 1 was tested for COVID-19. A review of Resident 1's Change of Condition/SBAR (Situation – Background – Assessment – Recommendation) form dated 5/29/2020 indicated Resident 1's temperature was 98.8 °F, the blood pressure at 146/92 millimeters of mercury (mmHg – unit of measure , the normal adult blood pressure is below 120/80 mmHg), and had pain but was unable to rate the pain. A review of Resident 1's Vital Signs log (measurement of the body's most basic functions such as respiratory and cardiac rate, blood pressure, and body temperature) indicated that on 5/30/2020 at 1:28 p.m., Resident 1's temperature was 100.5 °F, on 6/1/2020 at 9 p.m., the temperature was 99.2 °F, on 6/2/2020 at 8:22 a.m., the temperature was 104 °F.			

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	A review of Resident 1's COVID-19 test result dated 5/31/2020 indicated Resident 1 was positive for COVID-19. According to a review of Resident 1's Medication Administration Record (MAR) dated 5/30 and 6/2/2020 acetaminophen was not given to Resident 1, as per physician's order. A review of Resident 1's medical record indicated no change of condition was conducted on 5/30/2020 after the elevated temperature were identified. There was no documentation the physician was informed. A review of Resident 1's Change of Condition / SBAR form dated 6/2/2020 indicated Resident 1 had a body temperature of 104 °F, was shaking and was possibly having seizures. Resident 1 was transferred to GACH 1 for high body temperature of 104 °F. A review of Resident 1's Nursing Notes dated 6/2/2020 indicated Resident 1 was transferred to GACH 1 for high temperature, altered mental status and shortness of breath via paramedics (emergency medical team). According to a review of the Paramedics' Report dated 6/2/2020, Resident 1 was lying in bed shaking and able to follow commands. Facility staff stated (to paramedics) Resident 1 had a fever and was shaking all morning. The resident was not given any medication for fever. Resident 1 was transported to the GACH 1 at 9:29 a.m. for fever.			

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	A review of GACH 1's Emergency Department (ED) Documentation dated 6/2/2020, indicated Resident 1 arrived at the ED from the facility with reports of chills starting Friday (5/29/2020), with a high fever of 106.3 °F, and was hemodynamically unstable requiring vasopressors (medicines that constrict [narrow] blood vessels, increasing the blood pressure. They are used in the treatment of extremely low blood pressure, especially in critically ill patients). Resident 1 was hypotensive (low blood pressure), hypoxic (deprived of adequate oxygen supply) and was intubated (a tube is inserted into the windpipe [trachea] for ventilation [breathing] and airway protection). Resident 1 had a heart rate of 110 beats per minute, respiration rate of 18 breaths per minute, blood pressure of 100/66 mmHg. Resident 1 was admitted to the cardiac care unit for further management. A review of GACH 1 Death Summary indicated Resident 1 was febrile 101.7 °F, maxed on four vasopressors, increasing blood pressure. Resident 1 with no urine elimination (anuria), worsening acidosis (buildup of acid in the bloodstream due to kidneys and lungs failure). Resident 1 was extubated (the tube to the airway was removed) on 6/3/2020 and was placed on comfort care measures. Resident 1 expired on 6/3/2020 at 11:23 p.m. During an interview on 7/14/2020 at 3:45 p.m., the Director of Nursing (DON) stated Resident 1 had a body temperature of 100.5 °F on 5/30/2020 and confirmed the physician was not notified and			

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	Resident 1 was not given medication for fever and no other interventions such as cooling measures were provided. During an interview on 7/15/2020 at 7:30 a.m., LVN 3 stated she was taking care of Resident 1 on 5/30/2020. LVN 3 stated she was not informed of Resident 1's temperature of 100.5 °F on 5/30/2020. LVN 3 stated she did not give acetaminophen to Resident 1 or notified the physician because she did not know Resident 1's temperature was 100.5 °F. On 7/15/2020 at 3:15 p.m., during an interview, Certified Nursing Assistant 1 (CNA 1) stated on 5/30/2020, she took Resident 1's temperature at around 1:30 p.m. and it was 100.5 °F. CNA 1 stated she informed Registered Nurse 1 (RN 1) and RN 1 told her he would take care of it. On 7/21/2020 at 2 p.m., during an interview, RN 1 stated he was the RN Supervisor on 5/30/2020 morning shift (7 a.m. to 3 p.m.) and CNA 1 did not inform him of Resident 1's elevated temperature. A review of the facility's policy and procedure titled, "Change in a Resident's Condition or Status," revised on 3/3/2017, indicated the nurse will notify the resident's attending physician or physician on call when there has been a significant change in the resident's physical/emotional/mental condition. A significant change of condition is a major decline or improvement in the resident's status that will not normally resolve itself without intervention by staff or by implementing standard disease- related clinical interventions (is not self-limiting), or impacts more			

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	than one area of the resident's health status. The nurse will record in the resident's medical record information relative to changes in the resident's medica/mental condition or status. Based on interview and record review, the facility failed to notify the physician when Resident 1 developed fever (elevated body temperature), as indicated in the facility's policy and plan of care. On 5/30/2020 at 1:28 p.m., Resident 1 developed a fever of 100.5 degrees Fahrenheit (°F - normal range from 97 °F to 99 °F) and the change of condition was not reported to Resident 1's attending physician for medical interventions, including finding out the source of the fever (possible infection) through laboratory tests, frequent checks of the resident's temperature, pharmaceutical and non-pharmaceutical interventions. As a result, on 6/2/2020, at 9:29 a.m., Resident 1, a 69 year old male, was transferred to General Acute Care Hospital 1 (GACH 1) where he was found with an elevated body temperature of 106.3 °F and hemodynamically unstable (abnormal or unstable blood pressure, which can cause inadequate blood flow to organs). Resident 1 expired on 6/3/2020 at 11:23 p.m. The above violations presented either an imminent danger that death or serious harm would result or a substantial probability that death or serious physical harm would result.			

LESSON PLAN

Facility: University Park Healthcare center	
In-service Title: licensed nursing how to use PCC to check assigned residents' vital signs PCC and any warning report from CNAs	

OBJECTIVES	CONTENT	METHOD OF TEACHING	METHOD OF EVALUATION
By the end of this presentation the participant will be able to: 1. The importance of checking PCC dashboard for abnormal VS and Clinical Alerts every shift	1. Any abnormal VS should be promptly reported to a primary physician. 2. After taking VS CNAs must document data in PCC using IPODs 3. After verbal report completed CNA must complete Clinical Alert in PCC using IPAD and STOP AND WATCH format. 4. PCC will create abnormal VS warning report and Clinical Alert reports, which can be accessed using PCC dashboard and running VS reports. This system specifically being placed to ensure that all abnormal findings will be address timely and reviewed. 5. Each charge nurse must check PCC for abnormal VS and Clinical Alerts at least 30 minutes before end of her/his shift, to ensure that no findings went unnoticed.	1. Demonstrated how to check VS and Clinical Alerts using PCC 2. Discussion	1. Return demonstration

LESSON PLAN

Facility: University Park Healthcare center	
In-service Title: following physician's orders with emphasis on administration of proper medications when a resident noted with fever and reporting to the primary physician as ordered	

OBJECTIVES	CONTENT	METHOD OF TEACHING	METHOD OF EVALUATION
By the end of this presentation the participant will be able to: 1. The importance of following physicians' orders. 2. Understand the importance of promptly reporting resident's abnormal vital signs to physician.	1. Any abnormal VS should be promptly reported to primary physician including fever. 2. Elevated body temperature can be indicator for catastrophic failure of a body system and must be reported to physician immediately. Reporting nurse should solicit new order from a physician. 3. If a resident has order for abnormal VS, them nurse must comply with this order and administer ordered medication right away. Delay may cause rapid deterioration and have devastating effect for a resident.	1. Examples such as order for PRN Tylenol for elevated body temperature. 2. Discussion	1. Return demonstration

LESSON PLAN

Facility: University Park Healthcare center	
In-service Title: proper reporting a resident abnormal vital signs to a licensed nurse using STOP AND WATCH format by CNAs.	

OBJECTIVES	CONTENT	METHOD OF TEACHING	METHOD OF EVALUATION
By the end of this presentation the participant will be able to: 1. The importance of following promptly reporting abnormal VS to a charge nurse 2. Understand the importance of using PCC clinical Alert system when reporting abnormal VS.	1. Any abnormal VS should be promptly reported to a charge nurse including fever. 2. Elevated body temperature can be indicator for catastrophic failure of a body system and must be verbally reported to an appropriate charge nurse immediately. Reporting CNA must ensure that charge nurse received message by soliciting verbal confirmation. 3. After verbal report completed CNA must complete Clinical Alert in PCC using IPAD and STOP AND WATCH format. 4. PCC Clinical Alert report will alert every nurse who assigned to the resident and IDT team regarding abnormal findings. This system specifically being placed to ensure that all abnormal findings will be address timely and reviewed.	1. Demonstrated how to create Clinical Alert using PCC IPADS 2. Discussion	1. Return demonstration

INSERVICE TRAINING REPORT

FACILITY: UNIVERSITY PARK HCC /FACILITY CODE: DATE: 8/7/2020

CONDUCTED BY: Dahna Neal DSD/IP LENGTH OF SESSION: 1 hour

TOPIC: Proper use of Hoyer lift with assist, Reporting injury of unknown origin SHIFT:

NAME IN ATTENDANCE (PRINT)	SHIFT	SIGNATURE	DATE
Jessica Chuffard	7-3	LVN	8/7/20
Olivia Rocha	7-3		8.7.20
Edson Torres RN	3-11		8/7/20
Jacqueline Mitchell CNA	3-11		8-7-2020
Kimberly Funes CNA	3-11		8-7-2020
Maria Guardado CNA	3-11		8-7-20
Imelda Campos	3-11		8-7-20
VALDA. MORRIS.	3-11	CNA	8-7-20
Mary Mumuni	3-11	LVN	8-7-20
GLORIA GOMEZ	3-11	CNA	8-7-20
Alicia N Torres	3-11	Alicia N Torres	8-7-20
CATHERINE FONTENOT	3-11		8-7-20
Victor Espinoza	11-7		8/7/20
Martha Figueroa	11-7	LVN	8/7/20
Laura Arriola	11-7		8-7-20
Felicia Trahan	11-7		8-7-20
Rose Davis	11-7		8/7/20
Fernando Tellez	11-7	Fernando Tellez	8/7/20
Silvia Adam	11-7		8/07/20

INSERVICE TRAINING REPORT

FACILITY: UNIVERSITY PARK HCC /FACILITY CODE: DATE:

CONDUCTED BY: Dahna Neal DSD/IP LENGTH OF SESSION: 1 hour

TOPIC: Proper use of Hoyer lift with assist, Reporting injury of unknown origin SHIFT:

NAME IN ATTENDANCE (PRINT)	SHIFT	SIGNATURE	DATE
Silvia Adams	11-7	Silvia D Adams	8/07/20

INSERVICE TRAINING REPORT

FACILITY: UNIVERSITY PARK HCC /FACILITY CODE: DATE: 8/7/2020

CONDUCTED BY: Dahna Neal DSD/IP LENGTH OF SESSION: 1 hour

TOPIC: Medication Administration with V/S, Reporting abnormal Vital signs, Stop and Watch

SHIFT:

NAME IN ATTENDANCE (PRINT)	SHIFT	SIGNATURE	DATE
Jessica Schuffert LVN	7-3		8/7/20
Ujella Kochar LVN	7-3		8.7.20
Edson Torres RN	3-11		8/7/20
Jacqueline Mitchell CNA	3-11		8-7-2020
Kimberly Funes CNA	3-11		8.7.2020
Maria Luisa Linares CNA	3-11		8-7-20
Imelda Campos CNA	3-11		8-7-20
VALDA. MORRIS.	3-11		8-7-20
Mercy Muturi	3-11	LVN	8-7-20
Gamez Gloria	3-11	CNA	8-7-20
Alcira N Torres	3-11		8.7.20
[illegible]	3-11		8-7-20
Victor Espinoza	11-7		8/7/20
Martha Figueroa	11-7	LVN	8/7/20
LAURA Arriola	11-7		8-7-20
FELICIA TRAYLOR	11-7		8-7-20
Rose Davis	11-7		8/7/20
Fernando Tellez	11-7		8/7/20

INSERVICE TRAINING REPORT

FACILITY: UNIVERSITY PARK HCC /FACILITY CODE: _____ DATE: _____

CONDUCTED BY: Dahna Neal DSD/IP _____ LENGTH OF SESSION: 1 hour

TOPIC: Medication Administration with V/S, Reporting abnormal Vital signs, Stop and Watch

SHIFT: _____

NAME IN ATTENDANCE (PRINT)	SHIFT	SIGNATURE	DATE
ASIA Spells LVN	7/3		8/7/20

INSERVICE TRAINING REPORT

FACILITY: UNIVERSITY PARK HCC /FACILITY CODE: DATE: 7/9/2020

CONDUCTED BY: Dahna Neal DSD/IP LENGTH OF SESSION: 30 minutes

TOPIC: POC CNA and EMAR Licensed nurse charting SHIFT:

NAME IN ATTENDANCE (PRINT)	SHIFT	SIGNATURE	DATE
B Dowdell	7-3	Brenda Dowdell	7-9-20
Genesis Sanchez CNA	7-3		7.9.20
Ana Vigil CNA	7-3	Ana Vigil	7-9-2020
Asia Spears	7-3		7/9/20
Analuz Morales	CNA/RNA 7-3	Analuz Morales	7/9/20
Mikel Salone	7-3 CNA		7-9-20
C Lofs	7/3 am	C Lofs	7/9/20
	3/11 CNA pm		9/9/20
Alicia N Torres	3-11		7/9/20
Lourdes Giron	7-3		7-9-20
Mercy M	3-11		7-9-20
Jacqueline M	3-11	J Mitchell	7-9-2020
VALDA. MORRIS	3-11	Valda. Morris	7-9-20

UNIVERSITY PARK
— HEALTHCARE CENTER —

230 East Adams Boulevard
Los Angeles, Ca. 90011-1426

Tel 213-748-0491
Fax 213-7483299

2567 – A Citation for Plan of Correction dated 09/09/20

Supporting Documentation

1. Vital Sign – Q Shift Audit Log / DON Weekly Audit
    a. August 31
    b. September 2020 – Station 1 and Station 2
2. 08/13/20 – QA Notice of G Deficiency POC (QA every 2nd Thursday of the Month)
3. 09/10/20 – QA Notice and QAPI Performance Improvement Plan
4. QAPI-PIP

Thank you,

Marco D. Cantoreggi, NHA
Administrator

University Park Healthcare

Vital Sign Check Q SHIFT

August 2020

All charge nurses are required to initial each shift verifying that they completed a Vital Sign Audit at least 30 minutes befor the end of their shift

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
7a-3p																															
3p-11p																															
																															et.
11p-7a																															

DON WEEKLY AUDIT	DON WEEKLY AUDIT	DON WEEKLY AUDIT	DON WEEKLY AUDIT
Signature:	Signature:	Signature:	Signature:
Date:	Date:	Date:	Date:

Station 1

University Park Healthcare

Vital Sign Check Q SHIFT

September 2020

All charge nurses are required to initial each shift verifying that they completed a Vital Sign Audit at least 30 minutes befor the end of their shift

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
7a-3p	AS	AS	AS	AS			AS																							
						DM																								
3p-11p	CT	CT		LO			CT	CT																						
	CT																													
11p-7a	VE	VE	CT	VE	VE	VE	VE																							
				VE																										

DON WEEKLY AUDIT	DON WEEKLY AUDIT	DON WEEKLY AUDIT	DON WEEKLY AUDIT
Signature:	Signature:	Signature:	Signature:
Date: 09/08/22	Date:	Date:	Date:

Station 1

University Park Healthcare | **Vital Sign Check Q SHIFT** | **September 2020**

All charge nurses are required to initial each shift verifying that they completed a Vital Sign Audit at least 30 minutes befor the end of their shift

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
7a-3p																														
	TB	TB	CR	[illegible]	CR	CR	JS	JS	DH																					
3p-11p																														
	MM	CS	ET	MM	JC	LB		ET	LO																					
11p-7a	MM			MM	MM	MM	MM		-																					
	MF	MT	[illegible]	[illegible]	GT	SC	SC	RBJS																						

DON WEEKLY AUDIT	DON WEEKLY AUDIT	DON WEEKLY AUDIT	DON WEEKLY AUDIT
M. McAfee MSN RN			
Signature: [signature]	Signature:	Signature:	Signature:
Date: 09/08/21	Date:	Date:	Date:

Station 2

FACILITY: University Park Healthcare Center | CQI Meeting Date: 09/10/20 12:30pm

QAPI - PIP

INDICATOR: Vital Sign Monitoring Compliance with Plan of Correction for 2567 A Citation dated 8/31/20 As evidenced by no medication given for fever	CQI - Reporting Month – 08/2020

GOAL To: Monitor the plan of correction related to VS Q-Shift Monitoring to insure 100% compliance	TARGET DATE: 08/14/20
Acknowledge G Deficiency delivery 8/1/20 and A Citation delivered 8/31/20	

Action Steps as a Result of the Root Cause Analysis Performed (please be specific with each step) Note: Break down the solution or proposed solution into as many specific action steps as possible *after* the root cause analysis is completed.	Person(s) Responsible	Items Necessary to Complete the Action Step (equipment, time, staff, supplies, money, etceteras)	Action Step Date Due	Comments/Updates
APPROACHES: Steps that will be necessary to achieve the goal	**Responsible Person(s)**			**Evaluation Statement-At Least Monthly**
1. Inservice Licensed staff on all shifts related to how to perform vital sign checks via PCC and how to identify Stop and Watch reporting from CNA as well as following physician orders as it relates to Fever and reporting to MD requirements. Inservice CNA on identifying Resident abnormal vital signs, reporting to charge nurse and utilizing Stop and Watch	DON/DSD		08/14/20	N/A – New Hires will be inserviced and presented to CQI
2. Daily Audits Q Shift at least 30 minutes before the end of shift	Licensed Nurses	Audit Tool implemented effective 8/31/20 – Located at Station 1 and 2	Daily/ ongoing	Submit monthly vital sign audit for 3 months as per POC
3. DON to conduct weekly audits of VS to ensure compliance	DON	DON completes her audit weekly on the audit form	Weekly/ ongoing	Submit monthly vital sign audit for 3 months as per POC

Desired Outcome (be specific): The Facility will be in 97% compliance

Note: Action Plans should be presented and discussed at all appropriate Committees the facility holds and become part of the Committee Meeting Minutes: Continuous Quality Improvement Committee, Infection Control Committee, Restraint-Reduction Committee, Psychotrophic and/or Pharmacy Committee, Resident Falls Committee, Weight Variance Committee, Patient Care Policy Committee (a Title 22 requirement), Safety Committee, Recruitment and Retention Committee, Dining Committee, Resident Council Committee (if appropriate), Family Council (if appropriate), etceteras.

Please do not hesitate to use more than one page when action planning if necessary.

Signatures:

Team Leader: Marco Centeggi **Date:** 9/10/20

Members:

Manuel Agapito DON

Samantha Byers, ID

Gina Flores, MDS

Alex DOR

Patricia Patterson, SED

Dr. Fadak - Panelist

Mary Carpenter, AD

Dr. Hadad - MD

Daya Dasgal, MR

Dr. Kumar - Panelist