POC Accepted 4/25/19

PRINTED: 03/18/2019
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056244	A. BUILDING _____ B. WING _____	C 03/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND PARK CONVALESCENT HOSPITAL	2312 WEST 8TH STREET LOS ANGELES, CA 90057

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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during the investigation of a complaint. Complaint number : CA00619230 Representing the Department of Public Health: Health Facilities Evaluator Nurse ID: 38469 The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility. A deficiency was issued for complaint number CA00619230.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable	F 656	F656 a. On March, 9, 2019 the IDT reviewed Resident 1's activity current activity assessment and plan of care. The activities Director completed a new activity assessment in conjunction with physical therapy to complete a comprehensive care plan. Upon review of current interventions and residents current physical abilities the IDT team determined that resident only wants to attend activities of choice. Resident frequently goes out with family, he returns tired and only attends activities	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Saul Izaguirre Saul Izaguirre RN
TITLE: R.O.N
(X6) DATE: 3/20/19

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 656	Continued From page 1 physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to develop a comprehensive person-centered activities care plan for one of three sampled residents (Resident 1, 2 and 3). This deficient practice resulted in failure in promoting and providing an activity that reflects the choices and interests of Resident 1. Findings:	F 656	of choice. no change to current interventions was warranted. No ill effects noted. b. On march 9, 2019 the Director of Nurses and Assistant Director of Nurses along with the IDT team members conducted a review of all residents comprehensive care plans and assessments to ensure timely completeness and accuracy. Also to ensure all devices and interventions identified for current use are in place and updated on the plan of care. No other residents were found to be affected. c. It is the responsibility of the IDT to ensure that all comprehensive assessments and care plans reflect the resident's current condition,	

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F 656	Continued From page 2 A review of the Face Sheet (Admission Record) indicated Resident 1 was admitted to the facility, on 1,2,19, with diagnoses including hypertension (high blood pressure), pneumonia (infection that inflames air sacs in one or both lungs, which may fill with fluid) and Type II diabetes mellitus (a chronic condition that affects the way the body processes blood sugar [glucose]). A review of the Minimum Data Set (MDS, a standardized assessment and care-screening tool), dated 1/9/19, indicated Resident 1's cognitive skills (mental action or process of acquiring knowledge and understanding for daily decision-making) were intact. The MDS indicated Resident 1 required extensive assistance for dressing, toilet use, and personal hygiene. The MDS indicated Resident 1's activity preferences were to keep up with the news, to do things with group of people, to go outside to get fresh air when weather was good, and to participate in religious activities. On 2/26/19, at 8:52 a.m., during an interview in Resident 1's room, Resident 1 stated he was a certified public accountant and it felt like he was incarcerated at the facility. Resident 1 stated he had nothing to do except lie longer in bed and watch the television. A review of the care plans and activity attendance logs, for the months of January, February, and March 2019, with the Assistant Director of Nursing (ADON), indicated there was no activity care plan developed for Resident 1. The activity attendance log for the month January 2019 (admission date was 1/2/19), indicated Resident 1 attended activity on 1/15, 1/21, and 1/25/19. For February 2019, the attendance log indicated	F 656	and have measurable goals that are realistic. It is also the responsibility of the IDT to ensure review and update if appropriate interventions that will be used in obtaining the set goals. Any changes in resident's condition will be addressed and reflected in an updated plan of care as they occur. The IDT will meet and invite the resident or responsible party at a minimum of every 3 months to review and update a resident's plan of care. d. On a daily basis the license vocational nurse will review orders for any changes and ensure that the plan of care is reflecting all interventions ordered and warranted to maintain the residents safety and are appropriate in obtaining there goal. The ADON and	

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F 656	Continued From page 3 Resident 1 attended activity on 2/11, 2/13, 2/18, 2/19, and 2/22/19. For March 2019, Resident 1 had not attended activities from 3/1 to 3/6/19. On 3/6/19, at 3:38 p.m., the ADON stated and acknowledged the absence of an activity care plan and the entries in the activity attendance logs. A review of the facility's policy titled, "Activity Evaluation," revised May 2013, indicated that in order to promote the physical, mental, and psychosocial well-being of residents, an activity evaluation was conducted and maintained for each resident. The activity evaluation was used to develop an individual activities care plan that would allow the resident to participate in activities of his/her choice and interest. Each resident's care plan shall relate to his/her comprehensive assessment and should reflect his/her individual needs. A review of the facility's policy titled, "Comprehensive Assessments and the Care Delivery Process," revised December 2016, indicated comprehensive assessments would be conducted to assist in developing person-centered care plans. A review of the facility's policy titled, "Care Planning- Interdisciplinary Team," revised September 2013 indicated the facility's Care Planning/Interdisciplinary Team was responsible for the development of an individualized comprehensive care plan for each resident. A comprehensive care plan for each resident was developed within seven (7) days of completion of the resident assessment (MDS). A review of the facility's policy titled, "Using the	F 656	DSD on a weekly basis will make round and randomly check that all devices and restraints and interventions are being used as ordered. And review admitted residents charts no later then 7 days after comprehensive MDS has been completed to ensure that the RAI process has been completed timely and to ensure accuracy of the comprehensive plan of care. Findings of these reviews will be reported to the QA committee quarterly for review and recommendations. All nurses and IDT were in serviced on Comprehensive care planning and delivery process.by the DSD and ADON on March 10, ,2019.	3/20/19

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F 656	Continued From page 4 Care Plan," revised August 2006, indicated the care plan should be used in developing the resident's daily care routines and would be available to staff personnel who have responsibility for providing care or services to the resident.	F 656		