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

POC Reviewed + accepted 7.13.17 05089

PRINTED: 06/29/2017
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
	055764	A. BUILDING _____ B. WING _____	C 06/[illegible]/17

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEA REHABILITATION HEALTHCARE	7716 S PICKERING AVENUE WHITTIER, CA 90602

(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 California Department of Public Health during the investigation of one complaint during an Abbreviated survey. Complaint No: CA00522865 Representing the Department of Public Health: Health Facilities Evaluator Nurse ID: 36526 The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility. Three deficiencies were written as a result of complaint number CA00522865.	F 000	The signing of this plan of correction is not an admission or agreement by this facility of the truth of the facts alleged on this statement of deficiency and plan of correction. In fact, this plan of correction is submitted exclusively to comply with state and federal law. This Plan of Correction serves as the credible allegation of compliance.	
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (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);	F 157	F-157] Corrective Action for residents found to be affected by the deficient practice. On 1/5/17 Residents number 1 was transferred to the acute hospital for evaluation. Procedure for Identifying Potentially Affected Residents No other Residents have been affected by this deficient practice. Medical Records designee reviewed the last two months of	7/14/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 7/7/17

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 167	Continued From page 1 (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)(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). This REQUIREMENT is not met as evidenced by: Based on interview, and record review, the facility failed to notify a family member/ Power of Attorney (POA) of a change of condition (COC) and a transfer to a General Acute Care Hospital (GACH) for one of one sample resident (Resident 1), in accordance with the facility's policy and procedure.	F 167	discharges to acute hospitals for family notification and change of condition alerts. Corrective Action/ Systemic Changes to Ensure the Deficient Practice Does Not Recur On 6/30/17 through 7/5/17 the License Nursing Staff and Medical Records Staff were in-serviced on the policies related to the Change of Condition notification and responsible family notification of resident condition and transfer locations. Measures Adopted for Systemic Change And Quality Assurance On a monthly basis, for six weeks under the supervision of the Administrator, the Director of Nursing or designee and the Medical Records designee will conduct medical chart reviews of five current and /or discharged resident's	

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F 157	Continued From page 2 This deficient practice resulted in the family member not being aware of the resident's health status and whereabouts. Findings: A review of admission record (Face Sheet) indicated Resident 1 was admitted to the facility on 10/11/16, with diagnoses that included cognitive communication deficit, type 2 diabetes (high levels of sugar in the blood), and thrombosis of unspecified deep veins (DVT) of lower extremities (occurs when a blood clot forms in a vein located deep inside your body). A review of Resident 1's Minimum Data Set (MDS - a resident assessment and care planning tool), dated 11/7/16, indicated Resident 1's cognitive skills for daily decision-making were intact. The MDS indicated Resident 1 required limited assistance of one staff (resident involved in activity; staff provided support with bearing weight), with most activities of daily living. During an interview and record review on 3/3/17 at 10:25 a.m., the Director of Nurses (DON) stated there was nothing in Resident 1's record to confirm the facility informed the resident's POA regarding the resident's COC and transfer to GACH. The DON stated the facility would only inform the POA when the resident is not self-responsible. During an interview on 3/3/17 at 10:56 a.m. License Vocational Nurse/Treatment Nurse 1 (LVN/TN 1) stated she did not notify the POA of the COC of Resident 1's toe.	F 157	medical file to verify that the correct notifications are documented in the resident's medical record. The results of such audits shall be documented on Quality Assurance form and submitted to the Committee for review and recommendation of further monitors. Addendum July 12, 2017 Procedure for Identifying Potentially Affected Residents. Resident's currently in house as of July 1 2017 Change of Condition monitors have been reviewed by Director of Nursing and Staff Development to ensure proper documentation and notification have occurred. No other residents in house have been affected. Corrective Action/ Systemic Changes to Ensure the Deficient Practice Does Not Recur. Director of Nursing and/or designee will completed Change of Condition Log review	

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F 157	Continued From page 3 A review of the Interdisciplinary Wound Management Care Plan (IDT/WMCP) dated 12/29/16, indicated debridement (medical removal of dead, damaged, or infected tissue to improve the healing potential of the remaining healthy tissue) of the right toe performed by podiatrist. The wound was observed larger in size with tip of right great toe black with surrounding area red/purple in color noted with seropurulent (consisting of a mixture of blood serum and pus) drainage. During a telephone interview on 3/9/17 at 9:28 a.m., Resident 1's POA stated she was not informed regarding Resident 1's COC of the right great toe. POA stated she found out about the right great toe amputation during the resident's hospitalization. A review of the California Advance Health Care Directive, signed 3/14/10, indicated under clause three (3) of page 3 of 8, "Give my agent authority to make health care decisions for me (Resident 1) takes effect immediately when the box is initial). A review of the facility's undated policy titled "Notification of Responsible Party" indicated the responsible party will be notified when there is a change in condition.	F 157	of resident's in house weekly to ensure policy is followed to included timely notification of condition and location of residents to their responsible party . <u>Measures Adopted for Systemic Change And Quality Assurance</u> On a weekly basis for six weeks under the supervision of the Administrator, the Director of Nursing or designee and the Medical Records designee will conduct medical chart reviews of five current resident's files for documentation. The results of such audits shall be documented on Quality Assurance form and submitted to the Committee for review and recommendation of further monitors.	
F 202 SS=D	483.15(c)(2)(ii) DOCUMENTATION FOR TRANSFER/DISCHARGE OF RES (c)(2) Documentation. (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by-	F 202		7/14/17

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F 202	Continued From page 4 [483.15(c)(2)(I) will be implemented beginning November 28, 2017 (Phase 2)] (A) The resident's physician when transfer or discharge is necessary under paragraph 483.15(c)(1)(A) or (B) of this and (B) A physician when transfer or discharge is necessary under paragreph 483.15(c)(1)(I)(C) or (D). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure a discharge order was written by the physician for one of one sampled resident (Resident 1). This deficient practice had the potential to result in for inaccurate discharge. Findings: A review of admission record (Face Sheet) indicated Resident 1 was admitted to the facility on 10/11/16, with diagnoses that included cognitive communication deficit, type 2 diabetes (high levels of sugar in the blood), and thrombosis of unspecified deep veins (DVT) of lower extremities (occurs when a blood clot forms in a vein located deep inside your body). A review of Resident 1's Minimum Data Set (MDS - a resident assessment and care planning tool), dated 11/7/16, indicated Resident 1's cognitive skills for daily decision-making were intact. The MDS indicated Resident 1 required limited assist of one staff with most activities of daily living. A review of the Interdisciplinary Wound	F 202	F-202 . Corrective Action for residents found to be affected by the deficient practice. On 1/5/17 Residents number 1 was transferred to the acute hospital for evaluation. Procedure for Identifying Potentially Affected Residents No other Residents have been affected by this deficient practice. Medical Records designee reviewed the last two months of discharges for written physician discharge order all were present in the medical files. Corrective Action/ Systemic Changes to Ensure the Deficient Practice Does Not Recur On 6/30/17 through 7/5/17 the License Nursing Staff and Medical Records Staff were in-serviced on the Discharge and Transfer policy	

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F 202	Continued From page 5 Management Care Plan (IDT/WMCP) dated 12/29/16, indicated debridement (medical removal of dead, damaged, or infected tissue to improve the healing potential of the remaining healthy tissue) of the right toe performed by podiatrist with wound observed larger in size with tip of right toe black with surrounding area red/purple in color noted with seropurulent (consisting of a mixture of blood serum and pus) drainage. A review of the facility's Transfer Record dated 1/5/17 indicated Resident 1 was transferred to a general acute care facility (GACH) for ischemic (restriction in blood supply) gangrene of the right great toe. During a review of Resident 1's closed record there was no written discharge orders by the Primary Physician (PP), in the medical record. During an interview and record review on 3/3/17 at 10:25 a.m., the Director of Nurses (DON) stated she was not able to locate Resident 1's discharge order in the clinical record. A review of the facility's undated policy and procedure titled "Admission & Discharge," indicated the attending physician is to record in the medical record at the time of admission the anticipated length of stay; provide pertinent instructions to the resident regarding discharge or transfers; and include in discharge the reasons for discharge, date, and type of discharge, and orders for post discharge medications and treatments.	F 202	with emphasis on the requirement for a written physician order prior to discharge. Measures Adopted for Systemic Change And Quality Assurance On a monthly basis, for six weeks under the supervision of the Administrator, the Director of Nursing or designee and the Medical Records designee will conduct medical chart reviews of five discharged resident's medical file to verify that the correct discharge order is documented in the resident's medical record. The results of such audits shall be documented on Quality Assurance form and submitted to the Committee for review and recommendation of further monitors.	
F 309 SS=G	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		7/14/17

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F 309 SS=G	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		

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F 309	Continued From page 6 483.24 Quality of life. Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 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, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to promptly obtain a physician order for	F 309	F-309 Corrective Action for residents found to be affected by the deficient practice. On 1/5/17 Residents number 1 was transferred to the acute hospital for further evaluation. Procedure for Identifying Potentially Affected Residents Medical Records designee reviewed Residents in the facility with current changes in conditions to verify care plan interventions were implemented, primary care physician was notified and resident's responsible party was notified. No other Residents were found to be affected by this deficient practice. Corrective Action/ Systemic Changes to Ensure the Deficient Practice Does Not Recur On 7/1/17 License Nurse number 1	

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F 309	Continued From page 7 medical evaluation and intervention when Resident 1 had worsening condition of a right great toe wound. Resident 1 was at risk for poor circulation, had diagnoses of deep vein thrombosis (DVT- a blood clot that forms in a vein deep in the body) and venous insufficiency (the flow of blood through the veins is inadequate), for one of three sampled residents (Resident 1) by failing to: 1. Implement Resident 1's care plan related to poor circulation of the lower extremities, to observe and report to the attending physician any changes in color, temperature, pain, sensation, or drainage of the affected area. 2. Identify as a change of condition, Resident 1's worsening right great toe wound. 3. Implement the facility's "Change in Condition" policy to ensure the change in condition of a resident's toe wound was handled promptly and to ensure daily assessment of the wound was handled by the Nurse Supervisor under the direction of the Director of Nurses (DON). These failures resulted in Resident 1's delay of 6 days for medical evaluation and intervention for severe right leg arterial occlusive (blockage or narrowing of an artery in the legs) disease. Resident 1 was transferred to the general acute care hospital (GACH) emergency room (ER) on 1/5/17 at 9:27 a.m. for treatment of right great toe gangrene (death of tissue, a dangerous and potentially fatal condition). On January 9, 2017, the resident underwent a surgical a balloon angioplasty (a method of opening a clogged or narrowed blood vessel) and stenting (to place a	F 309	and the Director of Nurses were in-serviced one on one by the Clinical Quality Assurance Consultant Nurse in regards to the Change in Condition Policy. Staff Developer has in-serviced license nursing staff from 6/30/17 through 7/6/17on facilities Change in Condition Policy. New change in condition records will be reviewed daily at Clinical Meeting by Director of Nursing or designee for compliance with implementing facilities Change in Condition Policy. Director of Nursing and designee will attend wound management meeting weekly to review any changes in condition of wound and treatments. <u>Measures Adopted for Systemic Change And Quality Assurance</u> Medical Records will audit records of five random selected residents with change in condition every week for six	

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F 309	Continued From page 8 small, metal mesh tube that keeps the artery open) of the right superficial artery (artery in the thigh) and popliteal artery (artery in the knee and the back of the leg) to treat the right leg ischemia (inadequate blood supply) and right great toe gangrene (decay of flesh). On 1/10/17, Resident 1 required a right great toe amputation (surgically cutting off) for gangrene of the right great toe. Findings: During a telephone interview on 3/1/17 at 7:44 a.m., Resident 1's Power of Attorney (POA-a responsible party for Resident 1), stated the facility notified her about the resident's right great toe problem (gangrene) on 1/5/17, when Resident 1 had been transferred to the GACH. The POA stated the resident had an amputation of the right toe and later had progressed to include an amputation of his right foot. A review of admission record (Face Sheet) indicated Resident 1 was admitted to the facility on 10/11/16, with diagnoses that included cognitive communication deficit (disorders of communication affected by disruption of mental processes), type 2 diabetes (high levels of sugar in the blood), and thrombosis of unspecified deep veins (DVT) of the lower extremities. A review of Resident 1's care plan titled "Resident at risk for poor circulation due to lower extremities related to diagnosis of DVT", dated 10/19/16, indicated the intervention included, staff will observe and report any changes in color, temperature, pain, sensation edema (swelling), and inflammation (part of the body becomes reddened, swollen, hot, and often painful), or drainage of affected area to physician as	F 309	weeks then quarterly to ensure compliance continues with implementing Change in Condition Policy. The findings of audits shall be documented on Quality Assurance form and submitted to the Committee for review and recommendation of further monitors. Addendum: July 12, 2017 Procedure for Identifying Potentially Affected Residents Current residents with medical conditions putting them at risk for poor circulation of extremities were assessed by treatment nurse, nursing supervisors and Q.A. nurse on 7/11/17. No other residents were identified to be affected by this practice. Corrective Action/ Systemic Changes to Ensure the Deficient Practice Does Not Recur Preventative treatment will consist of weekly skin sweeps by treatment nurses and staff developer. Wound Physician Group will be notified weekly to address and view any	

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F 309	Continued From page 9 indicated. A review of Resident 1's Minimum Data Set (MDS - a resident assessment and care planning tool), dated 11/7/16, indicated Resident 1's cognitive skills for daily decision-making were intact. The MDS indicated Resident 1 required limited assistance of one staff (resident involved in activity; staff provided support with bearing weight) to ambulate with a walker with most activities of daily living. A review of Resident 1's "Wound Progress Report," dated 12/16/16, indicated the resident developed redness to the tip of the right great toe. The report indicated to treat the right great toe as follows: cleanse with normal saline (salt water), pat dry, apply Venelex (an ointment used to promote wound healing), cover with dry dressing every day. A review of Resident 1's the Interdisciplinary Wound Management Care Plan (IDT/WMCP) dated 12/16/16, indicated the tip of the resident's right great toe was blanchable (skin loses redness with pressure), and was ordered a podiatrist (specialist dedicated in disorders of the foot) consult. A review of Physician Orders dated 12/16/16 at 11:32 a.m., indicated Resident 1 was to see an in house podiatrist (the order did not indicate when the resident was to see the podiatrist). A review of Resident 1's the Interdisciplinary Wound Management Care Plan (IDT/WMCP) dated 12/23/16, indicated the tip of the resident's right great toe continued to be red/purple in color and appears to have increased in size and had a	F 309	new or continued concerns. Wound Care Specialist provided in-service on Proper Assessment of Etiology of Wounds on 7/11/17. Follow up training to be attended by Treatment Nurses on August 17, 2017 refer to attachment. Certified Nurses will conduct skin checks weekly during showers or hygiene care and report finding to immediate supervisor for treatment and follow up documentation. Training was conducted on 7/11/17 by Wound Care Specialist. Measures Adopted for Systemic Change And Quality Assurance Director of Nursing or designee will review binders of skin sweeps and shower checks weekly to ensure system remains intacted. Follow up review of documentation of Wound Care Physician Group by Director of Nursing to ensure proper documentation has been completed. The findings of audits shall be documented on Quality Assurance form and submitted to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055764	A. BUILDING _____ B. WING _____	C 06/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEA REHABILITATION HEALTHCARE	7716 S PICKERING AVENUE WHITTIER, CA 90602

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F 309	Continued From page 10 dry scab at tip of the toe with surrounding area dark purple in color extending. The note indicated waiting for an "In-house podiatrist to see the resident". A review of the IDT/WMCP dated 12/29/16, indicated debridement (medical removal of dead, damaged, or infected tissue) of the right toe was performed by the podiatrist. The IDT/WMCP indicated the wound was observed larger in size, the tip of the right toe was black, with surrounding area of red/purple in color noted with seropurulent (consisting of a mixture of blood serum and pus) drainage. A review of Resident 1's Treatment Record, Multidisciplinary Progress Notes, Licensed Progress Notes and Wound Management Updates dated 12/23/16 to 12/29/16, did not indicate the resident was assessed for the change of condition of the right great toe wound promptly, as indicated in the facility policy. There was no documentation of daily assessments of the right toe wound handled by the Nurse Supervisor under the direction of the DON, as indicated in the facility policy. A review of Resident 1's, Treatment Record, Multidisciplinary Progress Notes, Licensed Progress Notes and Wound Management Updates dated 12/23/16 to 12/29/16, did not indicate the licensed nurse notified the physician of the resident's worsening right great toe condition or requested a medical evaluation and intervention, as indicated in the care plan, when the resident's right great toe wound increased in size, and was dark purple in color and was extending on 12/23/16 or when the resident's right great toe wound tip was black in color and	F 309	the Committee for review and recommendation of further monitors.	

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

PRINTED: 06/29/2017
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
	055764	A. BUILDING _____ B. WING _____	C 06/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEA REHABILITATION HEALTHCARE	7716 S PICKERING AVENUE WHITTIER, CA 90602

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F 309	Continued From page 11 had seropurulent drainage on 12/29/16. During an interview on 3/3/17 at 10:56 a.m., Licensed Vocational Nurse/Treatment Nurse (LVN/TN) 1 stated she did not notify the MD of the changes in Resident 1's right great toe wound, because she was cleaning the wound daily, and she did not know it was a change of condition. LVN/TN 1 stated she did not follow up with Resident 1's physician order (dated 12/16/16), for the podiatrist. During an interview with the Director of Nurses on 3/3/17 at 11 a.m., she stated she did not know of Resident 1's right great toe wound. A review of the Lower Extremity Wound Assessment dated 1/4/17; (6 days after the resident's right great toe wound worsened), indicated Resident 1 had dusky erythema (reddening of the skin) and acral (body parts such as fingers and toes) desiccation (the process of drying out) moving down the toes. The resident was seen for follow up on ischemia gangrene - death of tissue due to insufficient blood flow) of the right hallux (big toe). The resident was ordered a vascular consult (a person who has a surgical subspecialty in diseases of the arteries and veins) stat (immediately). A review of the facility's transfer form dated 1/6/17, no time specified, indicated Resident 1 was transferred to a GACH for ischemic (restriction in blood supply) gangrene of the right great toe. Angiographic Procedure (an x-ray to see your blood vessels), report dated 1/9/17, by the GACH vascular surgery physician, indicated Resident 1	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056784	A. BUILDING _____ B. WING _____	C 06/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEA REHABILITATION HEALTHCARE	7718 S PICKERING AVENUE WHITTIER, CA 90602

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F 309	Continued From page 12 had a successful balloon angioplasty (a procedure in which a narrowed section of an artery is widened), and percutaneous stenting (a procedure that improves blood flow) of the right superficial femoral artery (a blood vessel in the thigh), and popliteal artery (a blood vessel above the knee). A review of the GACH Operative Report dated 1/10/17, indicated Resident 1 had gangrene of the right great toe, and required a right great toe amputation on 1/10/17. The report indicated Resident 1 recently developed right foot pain with right toe gangrene, due to right leg arterial ischemia (deficient supply of blood to a body part due to obstruction of the inflow of arterial blood). A review of the facility's undated policy and procedure titled, "Change in Condition" indicated all changes in condition shall be handle promptly. Daily assessments of condition changes shall be handled by the Nurse Supervisor under the direction of the DON.	F 309		

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