POC accepted 8/31/17 #36385

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

PRINTED: 06/27/2017
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
	056143	A. BUILDING _____ B. WING _____	C 03/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OSAGE HEALTHCARE & WELLNESS CENTRE	1991 SOUTH OSAGE AVE INGLEWOOD, CA 90301

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(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 an investigation of an Entity Reported Incident (ERI) during an Abbreviated survey. ERI Number: CA00523914 - Substantiated. Representing the Department of Public Health: Surveyor ID: 36385, RN, HFEN The inspection was limited to the specific complaint and does not represent a full inspection of the facility. One deficiency was issued for ERI Number: CA00523914.	F 000	**Preparation, submission and/or execution of this Plan of Correction does not constitute 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 provision of federal and state law.**	
F 223 SS=D	483.12(a)(1) FREE FROM ABUSE/INVOLUNTARY SECLUSION 483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. 483.12(a) The facility must- (a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary	F 223	**F223** **CORRECTIVE ACTION(S):** Resident 1 was physically assessed by the Director of Nursing and RN 1 on 2/23/2017. No actual noted. Social Service Director interviewed Resident 1 for any emotional impact associated by treatment of CNA 1 on 2/23/2017. No sign and symptom of anxiety and low self-esteem noted. **HOW TO IDENTIFY OTHER RESIDENTS:** Facility rounds are done by the Administrator and Director of Nursing regarding Abuse. No other residents were affected.	2/23/17 2/23/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 7/28/17

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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OSAGE HEALTHCARE & WELLNESS CENTRE	1001 SOUTH OSAGE AVE INGLEWOOD, CA 90301

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F 223	Continued From page 1 seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure one of three sampled residents (Resident 1) was not slapped on the back of the head by a certified nurse assistant (CNA). This deficient practice had the potential to result in serious injury. Findings: During an unannounced facility visit on 2/28/17 at 1:50 p.m. regarding a certified nurse assistant 1(CNA 1) hitting a resident (Resident 1) in the back of the head, observed resident sitting on a wheelchair in the facility lobby. Resident 1 was alert and oriented to person, and place and time but stated could not recall the incident. A review of Resident 1's admission records indicated she was admitted to the facility on 10/4/15 and re-admitted on 4/28/16 with diagnoses that included end stage renal disease (kidney failure), muscle weakness, hypertension (high blood pressure), dementia (brain disease that affects behavior, thinking and memory) without behavioral disturbance and diabetes mellitus (abnormally high blood sugar). A review of Resident 1's Minimum Data Set (MDS- a standardized assessment and care screening tool) dated 1/1/17 indicated the resident had moderately impaired cognitive function. The resident required extensive assist	F 223	**SYSTEMIC CHANGES:** Director of Nursing and IP nurse will provide in-service to staff regarding the policy and procedure of Abuse Prevention Program, and Abuse Reporting/Investigations on 7/18/2017-7/21/2017. **MONITORING PROCESS:** Findings from daily stand up meeting will be presented to QA Steering Committee monthly for further resolutions and recommendations. **Addendum as of 8/30/17:** **CA00523914** 1. Exhibit 1- Social service note 2. Exhibit 2- Nursing notes and COC 3. Exhibit 3- Facility rounds by the DON and administrator/ stand up records 4. Exhibit 4- CNA suspension and termination records.	7/18/17 – 7/21/17 8/30/17

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F 223	Continued From page 2 with transfers, dressing and was totally dependent on staff for bathing. During an interview on 2/28/17 at 2:15 p.m., the Certified Nurse Assistant 2 (CNA 2) stated on 2/23/17, she was standing in the lobby and observed Resident 1 was sitting in her wheelchair when CNA 1 came out of Room 3, walked pass Resident 1 and hit the resident on the back of the head. Resident 1 head fell forward and she stated "Aw, why did you have to hit me?". During an interview on 2/31/17 at 10:35 a.m., Licensed Vocational Nurse (LVN 1) stated that she was standing in the lobby with CNA 2 on 2/23/17, observed Resident 1 was also in the lobby sitting in her wheelchair when CNA 1 walked behind Resident 1 and slapped her on the back of the head with her bare hand. LVN 1 stated CNA 1 did not apologize to the resident, but continued walking away. LVN 1 stated that she immediately reported the incident to the Director of Nursing (DON). During an interview on June 26, 2017 at 2:30 p.m., the DON stated CNA 1 was suspended on 2/23/17 and terminated on 2/27/17. A review of the facility's revised policy and procedure dated on November 2016 and titled "Abuse Prevention Program" indicated the facility promoted an environment free from abuse and mistreatment. Physical abuse definition included hitting, or slapping.	F 223		