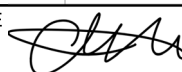


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/01/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055104		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/28/2023	
NAME OF PROVIDER OR SUPPLIER SUNSET MANOR CONV HOSP				STREET ADDRESS, CITY, STATE, ZIP CODE 2720 NEVADA AVENUE EL MONTE, CA 91733			
(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 two complaints. Complaint Numbers: CA00847773 and CA00848063 Representing the Department: Health Facilities Evaluator Nurse(s): 45064 The inspection was limited to the specific complaints investigated and does not represent the findings of a full inspection of the facility. No deficiencies were identified for the complaint number: CA00847773 Two deficiencies were identified for the complaint number: CA00848063 (Refer to F656 and F698) and one State deficiency.			F 000			
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §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			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



TITLE

Admin

(X6) DATE

08/01/23

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. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop a plan of care with individualized approaches for one of two sampled residents (Resident 2) who required hemodialysis (HD, process of removing excess water, solutes, and toxins from the blood in people whose kidneys	F 656			

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F 656	<p>Continued From page 2</p> <p>could no longer perform these functions) and had pressure injuries (PI, painful wounds caused as a result of pressure or friction).</p> <p>These failures had the potential to result in inconsistent implementation of Resident 2 ' s care plan and had the potential for a delay or lack of care and services.</p> <p>Cross reference F698</p> <p>Findings:</p> <p>During a review of Resident 2 ' s Admission Record indicated the facility admitted the resident on 1/4/2023 and readmitted Resident 2 on 6/6/2023 with diagnoses that included respiratory failure (failure of the lungs to meet the oxygen demand of the body that results in difficulty breathing), dependence on renal dialysis treatments (medical procedure that filters the blood of waste products), generalized edema (swelling), and multiple pressure ulcers (injury to the skin caused as a result of pressure or friction).</p> <p>During a review of Resident 2 ' s Order Summary Report (OSR), dated 6/6/2023, the OSR indicated Resident 2 required HD three times a week on Tuesday, Thursday, and Saturday.</p> <p>During a review of Resident 2 ' s Minimum Data Set (MDS- a standardized assessment and care planning tool), dated 6/13/2023, the MDS indicated Resident 2 had severe impaired cognitive skills (ability to think and process information) for daily decision making.</p> <p>During a concurrent interview and record review</p>	F 656			

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F 656	<p>Continued From page 3</p> <p>on 7/7/2023 at 12:53 PM with Licensed Vocational Nurse 3 (LVN 3), LVN 3 stated there was no dialysis care plan for Resident 2. LVN 3 stated Resident 2 needed a care plan for dialysis specific to the resident 's goals, treatment, and interventions.</p> <p>During a concurrent interview and record on 7/28/2023 at 9:40 AM with LVN 2, LVN 2 stated there was no pressure injury care plans for Resident 2. LVN 2 stated Resident 2 needed a care plan for pressure injury specific to the resident 's goals, treatment, and interventions for the following pressure injuries:</p> <ol style="list-style-type: none"> 1. Stage 3 PI (full-thickness skin loss) to Resident 2 's left and right upper back. 2. Unstageable (obscured full-thickness skin and tissue loss) PI to Resident 2 's left hip. 3. Unstageable PIs to Resident 2 's left and right ischium (forms the lower and back region of the hip bone). 4. Stage 4 PI (full-thickness skin and tissue loss) to Resident 2 's Sacrococcyx (tail bone). <p>During a review of the facility 's policy and procedure titled, "Comprehensive Care Plans," dated 12/19/2022, indicated, "It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident 's medical, nursing, and mental and psychosocial needs that are identified in the resident 's comprehensive assessment."</p>	F 656			

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F 656	Continued From page 4 During a review of the facility ' s policy and procedure titled, "Pressure Injury Prevention and Management," dated 12/19/2022, indicated, "the interdisciplinary team shall develop a relevant care plan that includes measurable goals for prevention and management of pressure injuries with appropriate interventions."	F 656			
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(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 ensure one of two sampled (Resident 2), who required hemodialysis (HD, process of removing excess water, solutes, and toxins from the blood in people whose kidneys could no longer perform these functions) received HD care and services as indicated in the Hemodialysis policy and procedure by failing to: 1. Ensure Resident 2 received HD on 6/24/2023 (Saturday). This deficient practice had the potential to place Resident 2 at risk for fluid overload (condition in which the liquid portion of the blood [plasma] is too high). Cross Reference with F656 Findings:	F 698			

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F 698	Continued From page 5 During a review of Resident 2 ' s Admission Record indicated the facility admitted the resident on 1/4/2023 and readmitted Resident 2 on 6/6/2023 with diagnoses that included respiratory failure (failure of the lungs to meet the oxygen demand of the body that results in difficulty breathing), dependence on renal dialysis treatments (medical procedure that filters the blood of waste products), generalized edema (swelling), and multiple pressure ulcers (injury to the skin caused as a result of pressure or friction). During a review of Resident 2 ' s Order Summary Report (OSR), dated 6/6/2023, the OSR indicated Resident 2 required HD three times a week on Tuesday, Thursday, and Saturday. During a review of Resident 2 ' s Minimum Data Set (MDS- a standardized assessment and care planning tool), dated 6/13/2023, the MDS indicated Resident 2 had severe impaired cognitive skills for daily decision making. During a review of Resident 2 ' s Other Orders, dated 6/24/2023, timed at 1:56 am, indicated Medical Doctor 1 (MD 1) ordered for the facility to transfer Resident 2 to a General Acute Care Hospital (GACH) for severe fluid overload. The Other Orders indicated Resident 2 needed dialysis asap (as soon as possible). During an interview on 7/6/2023 at 2:35 pm, with Registered Nurse Supervisor 1 (RNS 1), RNS 1 stated Resident 2 missed dialysis on 6/24/2023 due to transportation because Resident 2 required a certified Respiratory Therapist (RT). RNS 1 stated RT was not available to go with	F 698			

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F 698	Continued From page 6 Resident 2 on 6/24/2023. RNS 1 stated, if Resident 2 did not receive dialysis as scheduled, Resident 2 had the potential for physical harm and declined in health condition by fluid overload and/or shortness of breath. During a review of the facility ' s policy and procedure (P&P) titled, "Hemodialysis," with a revised date of 6/5/2023, the P&P indicated, "The facility will coordinate and collaborate with dialysis facility to assure that the resident ' s needs related to dialysis treatments are met ...the facility will assure that arrangements are made for safe transportation to and from the dialysis facility."	F 698			



SUNSET MANOR

CONVALESCENT HOSPITAL

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.

F656- Develop/Implement Comprehensive care plan

1. Corrective action for residents found to have been affected by this deficiency:

Resident readmitted on 7/30/23

-On 7/30/23 a care plan for dialysis for resident 2 was developed that included to resident's goal, treatment and interventions

-On 7/30/23 care plan for stage 3 pressure injury on bilateral upper back, unstageable pressure injury on left hip, bilateral ischium and Sacro coccyx were completed by treatment nurse

2. Identification of other residents that maybe affected by this deficiency:

- DON and designees review medical records of residents with pressure injury. No missing care plans were identified on 8/4/23

3. Systemic Changes that will be put into place to ensure that this deficiency does not recur:

- On 07/31/2023 DON provided In-service for licensed staff regarding dialysis transportation & appointments and care plan for Dialysis.

-On 08/03/23 DON provided in-service to treatment nurses on completing care plan for each wound site

-IDT will check for care plan during wound care meeting to ensure they were completed and revised as needed

4. Monitoring the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:

- The DON will report findings of missing care plan for wounds to the QA committee for discussion and further recommendations. The QA will continue monitoring for a minimum of three months or until substantial compliance is achieved.

Completion Date 08/10/2023



SUNSET MANOR

CONVALESCENT HOSPITAL

F698 Dialysis

1. Corrective action for residents found to have been affected by this deficiency:

-Resident 2 was readmitted on 7/30/23

2. Identification of other residents that maybe affected by this deficiency:

DON and designee reviewed medical records of other dialysis residents, no missing dialysis sessions were identified on 8/4/23

3. Systemic Changes that will be put into place to ensure that this deficiency does not recur:

Facility will have back up vendors on stand by for dialysis residents and will follow physician orders regarding missed dialysis sessions. AM West Contact: Manny Noble 626-367-1099

DON provided In-service on 07/31/2023 for licensed staff regarding dialysis transportation , appointments and care plan for Dialysis.

DON provided In-service done on 8/3/23 for staff regarding resident care of dialysis.

4. On 8 /7/23 IDT started monitoring the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:

The Administrator and / or designee will report problem with transportation for dialysis resident with ventilator to the QA committee for discussion and further recommendations. The QA will continue monitoring for a minimum of three months or until substantial compliance is achieved.

Completion Date: 08/07/2023

Admin