accepted 2/19/21
POC 11912

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

PRINTED: 02/12/2021
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
	555004	A. BUILDING _____ B. WING _____	C 02/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAYA DEL REY CENTER	7716 MANCHESTER AVENUE PLAYA DEL REY, CA 90293

(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 facility-reported incident. Facility-Reported Incident: CA00715455 Representing the California Department of Public Health: Surveyor 42200 and 40737, Health Facility Evaluator Nurse The inspection was limited to the specific facility-reported incidents investigated and does not represent the findings of a full inspection of the facility. Two deficiencies were written as a result of facility-reported incident: CA00715455	F 000	Playa Del Rey Center submits this response and Plan of Correction as part of the requirements under 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 employee, 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 interests of the provider either by the governmental agencies or third party.	
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation 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 medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion: This REQUIREMENT is not met as evidenced	F 600		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 2/18/21

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 600	Continued From page 1 by: Based on interview and record review, the facility failed to ensure protection from abuse for one of 2 residents (1) by: 1. Failing to monitor Resident 1 before and after an altercation and failed to escort Resident 1 away from the altercation. 2. Failing to call for assistance during the altercation. These deficient practices resulted in Resident 2 being hit by Resident 1. Findings: A review of the Admission record for Resident 1, indicated the resident was admitted on 9/18/2020 and readmitted on 11/9/2020, with diagnoses of schizophrenia (disorder that affects a person's ability to think, feel, and behave clearly) and traumatic hemorrhage of cerebrum (bleeding in or around the brain). A review of the Minimum Data Set ([MDS] a comprehensive standardized assessment and care screening tool) dated 10/7/2020, indicated Resident 1 had moderate cognitive skills (ability to learn, reason, remember, understand and make decisions) and exhibited physical behavioral symptoms directed towards others (i.e. hitting, kicking, pushing, scratching, grabbing, abusing others sexually). On 1/14/2021 at 12:41 p.m., during an interview Certified Nurse Assistant (CNA 1)) stated that Resident 1 had been aggressive and had hit her on two occasions; once during patient care and once after being asked not to eat left over food off	F 600	F 600 Free from Abuse and Neglect A. Immediate Corrective action for Resident identified as being affected. The facility must ensure that residents are free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical and chemical restraint not required to treat the resident's medical symptoms. There were no other resident to resident altercations after 12/4/2021 B. Process of identifying other residents with potential to be affected. The Director of Nursing (DON) reviewed on 2/15/2021, all other resident to resident incidents in the last 3 months. No other deficient practice was identified.	

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F 600	Continued From page 2 trays of other residents on the food cart. On 1/14/2021 at 12:56 p.m., during an interview Licensed Vocational Nurse (LVN 1) stated Resident 1 wanders around the facility and goes into other resident's rooms and if re-directed the resident becomes angry. On 1/14/2021 at 1:11 p.m., during an interview LVN 2 stated she was having lunch when she saw Resident 1's arm coming down towards Resident 2. Resident 1 was trying to hit Resident 2 again, LVN 2 stopped Resident 1 and separated the two residents. LVN 2 said there was no other staff on the patio and instructed Resident 1 to go to his room. LVN 2 left Resident 2 on the patio and went and got the administrator (ADM) and Director of Nursing (DON). When asked if assistance was called to the patio LVN 2 stated no. On 1/14/2021 at 2:41 p.m., during an interview LVN 3 stated she saw Resident 1 going to his room. LVN 3 was not aware of the altercation between Resident 1 and 2 and LVN 2 did not asked for assistance. On 1/14/2021 at 2:58 p.m., during an interview Registered Nurse (RN 1) stated that Resident 1 was in the hallway by his room after the altercation walking around by himself. RN 1 said no one was assigned to monitor the resident. On 1/14/21 at 4:47 p.m. and 1/26/2021 at 3:44 p.m., during an interview, DON stated that if a staff member is by him/herself when an altercation occurs, procedure is to separate the two residents and ensure they are safe and call for help. DON said it is important to call for help to	F 600	C. Systemic measures to prevent recurrence. On 2/15/2021, the Administrator, DON and DSD conducted an in-service to all nursing staff and IDT that in a resident to resident incident, it is important for staff to separate the residents, remove the aggressor from the scene and escort/ accompany the aggressor to a place where the aggressor can no longer harm anyone, then immediately call for help. These will be documented in the resident's clinical chart. D. How system changes will be monitored Medical Records will conduct daily audits for documentation of all resident to resident incidents if the aggressor was removed from the scene and was escorted / accompanied to a place where he can no longer harm others, and then immediately call for help. All findings will be reported to the DON and Administrator on the daily operations meeting. The DON and Administrator will track any trends or concerns regarding documentation of all resident to resident incidents if the aggressor was removed from the scene	

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F 600	Continued From page 3 ensure more eyes, ears and hands are available to take care of the situation. DON said there should had been someone escorting Resident 1 back to his room to ensure the safety of the other residents. DON said Resident 1 had prior physical aggression and hit a staff member on 11/3/2020. During a concurrent record review of Resident 1's care plan created on 10/2/2020, resident exhibits or has the potential to exhibit physical behaviors related to psychiatric disorders: schizoaffective disorder was initiated on 11/9/2020. DON said the care plan was carried over on 11/9/2020 (readmission) A review of the facility's policy and procedure titled, "Behaviors: Management of Symptoms" last revised on 11/1/19, indicated that if the behavior escalates to the point of being dangerous to self or others, immediate measures to protect the safety of patients and staff by calling for assistance and removing the resident from the source of frustration.	F 600	and was escorted / accompanied to a place where he can no longer harm others, and then immediately call for help. This will be communicated to the QA committee for further evaluation and recommendation monthly. If it is determined that we have accomplished the objective in the POC above and the results are successful, then the facility will consider the matter resolved. The QA committee will continue to review the deficiency has been proven to be resolved for 3 consecutive months and/or advised by the QA Committee E. Date deficiency was corrected: 2/15/2021	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to– (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the	F 657	F 657 Care Plan Timing and Revision A. Immediate Corrective action for Resident identified as being affected. The facility must ensure the timeliness of each resident's person-centered, comprehensive care plan, and to ensure that the comprehensive care plan is reviewed and revised by an interdisciplinary team composed of individuals who have knowledge of the	

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F 657	Continued From page 4 resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to revise and individualized a care plan for 1 of 2 residents (1) who exhibited continued physical aggression This deficient practice resulted in Resident 1 being hit by Resident 2. Findings: A review of the Admission record for Resident 1, indicated the resident was admitted on 9/18/2020 and readmitted on 11/9/2020, with diagnoses of schizophrenia (disorder that affects a person's ability to think, feel, and behave clearly) and traumatic hemorrhage of cerebrum (bleeding in or around the brain). A review of the Minimum Data Set ([MDS] a comprehensive standardized assessment and care screening tool) dated 10/7/2020, indicated	F 657	resident and his/her needs, and that each resident and resident representative, if applicable, is involved in developing the care plan and making decisions about his or her care Resident 1's individualized care plan was revised by the IDT on 2/15/2021 B. Process of identifying other residents with potential to be affected. The Director of Nursing (DON) reviewed on 2/15/2021, all other resident to resident incidents in the last 3 months to check if the resident's individualized care plan was revised. No other deficient practice was identified. C. Systemic measures to prevent recurrence. On 2/15/2021, the DON and DSD conducted an in-service to all licensed nurses and IDT that in a resident to resident incident, the plan of care of the resident should be revised to identify personalized interventions pertinent to the resident's current condition.	

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F 657	Continued From page 5 Resident 1 had moderate cognitive skills (ability to learn, reason, remember, understand and make decisions) and exhibited physical behavioral symptoms directed towards others (i.e. hitting, kicking, pushing, scratching, grabbing, abusing others sexually). On 1/14/2021 at 4:47 p.m. and 1/26/2021 at 3:44 p.m., during an interview DON stated that Resident 1 had prior physical aggression and hit staff on 11/3/2020. During a concurrent record review of Resident 1's care plan created on 10/2/2020, resident exhibits or has the potential to exhibit physical behaviors related to psychiatric disorders: schizoaffective disorder was initiated on 11/9/2020. DON said the care plan was carried over on 11/9/2020 (readmission) and there was no care plan to address the resident's wandering behavior. DON said the care plan should have been revised and include triggers for the physical behaviors. DON said the importance of revising care plans is to update the interventions for what is relevant to the resident's problems and it is important to individualize the care plan to address specific resident needs. A review of the facility's policy and procedure titled, "Person-Centered Care Plan" last revised on 7/1/19, indicated the care plans must be customized to each individual patient's needs and would be reviewed and revised to reflect response to care changing needs and goals.	F 657	D. How system changes will be monitored Medical Records will conduct daily audits on revisions on resident's individualized care plans of all resident to resident incidents. All findings will be reported to the DON and Administrator on the daily operations meeting. The DON and Administrator will track any trends or concerns regarding documentation of all resident to resident incidents if the aggressor was removed from the scene and was escorted / accompanied to a place where he can no longer harm others, and then immediately call for help. This will be communicated to the QA committee for further evaluation and recommendation monthly. If it is determined that we have accomplished the objective in the POC above and the results are successful, then the facility will consider the matter resolved. The QA committee will continue to review the deficiency has been proven to be resolved for 3 consecutive months and/or advised by the QA Committee E. Date deficiency was corrected: 2/15/2021	