POC Accepted
8/16/2021
41852

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

PRINTED: 08/04/2021
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
	056244	A. BUILDING _____ B. WING _____	C 08/04/2021

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

(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 a facility reported incident. Facility Reported Incident CA00739953 Representing the Department of Public Health: Health Facilities Evaluator Nurse ID: 41852 The inspection was limited to the specific facility reported incident investigated and does not represent the findings of a full inspection of the facility. Two deficiencies were issued for facility reported incident CA00739953.	F 000	**F000** This plan of correction constitutes the facilities credible allegation of compliance for the deficiency noted. Grand Park Convalescent Hospital makes its best effort to operate in full compliance with both Federal and State law. Nothing included in this plan of correction is an admission otherwise Grand Park Convalescent Hospital has submitted this plan of correction in order to comply with its regulatory obligation and does not waive any objections to the merits or from any allegations contained herein.	
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to conduct a	F 637	**F – 637** **For the resident identified** On June 18, 2021 the MDSN conducted a comprehensive reassessment for Resident 1 significant change in condition identified on May 07, 2021. Resident 1 was re-assessed by the June, 17 2021 the MD and responsible party was notified of Resident 1 significant change in condition. Resident 1 was not found to be adversely affected by this deficient practice.	8/13/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kimberly Lim RN DON | TITLE | (X6) DATE: 8/13/21

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.

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 08/04/2021

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

(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 637	Continued From page 1 comprehensive assessment after a significant change in condition within fourteen days for one of two Residents (Resident 1). This deficient practice had the potential to negatively affect the delivery of care and services to Resident 1. Findings: A review of Resident 1's admission record indicated the facility admitted the resident on 4/7/2021 with diagnoses of history of falling, unspecified convulsions (seizure disorder - sudden surge of electrical activity in the brain when a person experiences abnormal behavior, symptoms, and sensations, sometimes including loss of consciousness), and abnormalities of gait and mobility. A review of the physical therapy assessment dated 4/8/2021 indicated Resident 1 required maximum assistance for standing. A review of Resident 1's Minimum Data Set (MDS- a standardized assessment and screening tool) dated 4/10/2021 indicated the resident was mildly impaired (some difficulty in new situations), and required extensive assistance with one person assist for activities of daily living (ADL - term used in healthcare to refer to daily self-care activities) such as bed mobility, transfer, and toilet use. The physical therapy assessment dated 5/7/2021 indicated Resident 1 required minimum assistance for gait up to 80 feet. A review of the Interdisciplinary Team (IDT - a group of health care professionals from different	F 637	**For all residents** On June 17,18, and 19, 2021 the MDSN, DON, and ADON conducted charts audits for all resident in the facility. No other resident was identified to be affected by this deficient practice. On June 17, 2021 the DON conducted in-service training to the MDS, PT, and nursing department emphasizing on the importance of proper documentation and conducting comprehensive assessment after identifying a significant change in a resident's condition. **Measures to ensure compliance** The ADON will conduct monthly chart audits indefinitely. This will ensure all identified changes in condition for the facilities residents have received a comprehensive reassessment, ensuring all residents are receiving adequate level of care and services. These finding will be logged in the monthly MDS review summary report. **Monitoring of corrective action** The DON will address any concerns and review the MDS summary report on a monthly basis indefinitely. All findings will be documented on the DON's MDS review summary audit logs and discussed with the Q.A. committee in the next Q.A. meeting for evaluations and recommendations.	

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 08/04/2021

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

(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 637	Continued From page 2	F 637		

fields who coordinate resident care) Care Conference notes dated 5/10/2021 indicated Resident 1 was ambulatory but required assistance for resident safety.

During an interview with Physical Therapist (PT) on 6/16/2021 at 11:35 AM, the PT stated Resident 1 was dependent care upon admission and was independent care with supervision prior to the fall on 6/8/2021. He stated Resident 1 was initially bed bound upon admission on 4/7/2021, but improved significantly. The PT stated he recommended Resident 1 continue independent care with supervision.

During an interview with Minimal Data Set Nurse (MDSN) on 6/16/2021 at 11:42 AM, MDSN stated a comprehensive assessment was conducted on 4/10/2021 for Resident 1 and indicated Resident 1 required extensive assistance with one person assist for activities of daily living. The MDSN stated Resident 1 was bed bound upon admission and improved functionally to independent care with supervision. The MDSN stated this improvement was a significant change in condition and required a revised comprehensive assessment within 14 days of the significant change in condition. He stated he failed to conduct a comprehensive reassessment of Resident 1 after his improvement on 5/7/2021 when Resident 1 was able to walk with minimal assistance.

During an interview with Physical Therapist on 6/16/2021 at 12:25 PM, PT stated on 4/8/2021 Resident 1 was not tested for gait upon admission because resident was bed bound. He stated resident became minimal assist with 1

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 08/04/2021

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

(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 637	Continued From page 3	F 637		

person assist on 5/5/2021 and was able to walk 80 feet on 5/7/2021. The Physical Therapist stated this was a significant change in condition from when resident was bedbound. He stated during the 5/10/2021 Interdisciplinary Team (IDT - a group of health care professionals from different fields who coordinate resident care) he informed the IDT of Resident 1's significant improvement.

During an interview with Director of Nursing (DON) on 6/16/2021 at 3 PM, the DON stated Resident 1 had a significant improvement in functioning/mobility according to PT assessment and IDT care conference on 5/10/2021. She stated PT assessment indicated Resident 1 was minimal assist with the ability to walk 80 feet on 5/7/2021. She stated this is a significant improvement from when Resident 1 was admitted and assessed for maximum assist on 4/8/2021. She stated the facility failed to conduct a significant change in status assessment (SCSA) for Resident 1 within 14 days after the 5/10/2021 care conference. She stated the potential outcome was inappropriate level and delivery of care for Resident 1.

During an interview with Administrator (Admin) on 6/30/2021 at 12:20 PM, Admin stated the facility's policy and procedure on Resident Assessment indicated a significant change in status assessment was completed within 14 days when a resident was deemed to have had a significant change in condition such as an improvement or decline in condition. He stated according to PT assessments and IDT documents, Resident 1 had a significant improvement in functioning in 5/10/2021. He stated the facility failed to conduct

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 08/04/2021

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

(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 637	Continued From page 4 a significant change in status assessment within 14 days for Resident 1. The Admin stated the potential outcome was the inappropriate of level of care delivered to Resident 1. A review of the facility's policy and procedure titled, "Resident Assessment," no revision date, indicated a significant change in status assessment (SCSA) was completed within 14 days of the interdisciplinary team determining that the resident meets the guidelines for major improvement or decline. Examples of improvement from baseline include any improvement of ADL physical functioning where a resident was newly coded as independent, supervision, limited assistance since last assessment.	F 637		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers,	F 880	**F – 880** **For the staff member identified** On June 17-18, 2021 the kitchen department staff were in-serviced by the IP and DSD on infection control emphasizing on the proper use of PPE and hair nets/busboy cap while on duty. The identified staff member/Cook 1 was tested for COVID-19 along with all other staff members as directed by Public Health guidelines. Cook 1 latest COVID-19 PCR test result were negative on June 16, 2021 prior to the incident, with subsequent negative COVID-19 PCR test results on June 25, 2021 and June 30, 2021.	8/13/21

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 08/04/2021

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

(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 880	Continued From page 5 visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F 880	During this time period the facility did not identify any COVID-19 positive cases among the staff or residents. No residents were affected by the deficient practice. **For all residents** On June 17, 2021 the DON, ICP nurse, and department heads made rounds to assess all staff members were using PPE as directed by the latest LACDPH infection control guidelines. No other issues were identified. During the following weeks June 18, 2021 to July 02, 2021 the facility did not identify any COVID-19 positive cases among the staff or residents. No residents were affected by this deficient practice. On June 21, 2021 in-service-training by the Infection Control Preventionist nurse was completed for all staff members. Infection control practices were reviewed and demonstrated to staff emphasizing on hand washing and the proper use of PPE.	

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 08/04/2021

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

(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 880	Continued From page 6 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure 1 of 6 kitchen staff (Cook 1) covered his nose and mouth with a mask, and wear a hair covering or busboy cap (a type of hair covering) to ensure a safe environment and help prevent the spread of infections during the Coronavirus ([COVID-19], an illness caused by a virus that can spread from person to person) crisis and placed the all residents and staff at risk for acquiring respiratory illness. This deficient practice had the potential to result in the spread of infections that could lead to serious harm and/or death to all residents and staff. Findings: During an observation and concurrent interview with Cook 1 (CK 1) on 6/28/2021 at 10:45 AM, CK 1 stated he was preparing lunch and he was not wearing a surgical mask over his nose and mouth, and no hairnet or busboy cap to cover his hair. CK1 stated the surgical mask was below his chin and that he was required to wear a surgical mask and hairnet or busboy cap when in the	F 880	**Measures to ensure compliance** The ICP and DSD will conduct random rounds every week indefinitely through all departments to observe and ensure that infection control practices are being followed. All findings will be logged in the Adherence Monitoring log book and is ongoing. **Monitoring of correction action** Any concerns or trends and patterns will be logged in the weekly infection control adherence audit log form by the DON and discussed with the Administrator on a weekly basis. All finding will be discussed with the QAPI committee in the next QAPI meeting for evaluations and recommendations.	

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 08/04/2021

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

(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 880	Continued From page 7 kitchen. During an interview with Dietary Supervisor Assistant (DSA) on 6/16/2021 at 1:44 PM, DSA stated CK 1 was in the kitchen without a busboy cap and the surgical mask was not covering his nose and mouth. The DSA stated the surgical mask was below his chin and that CK 1 failed to follow facility personal protective equipment (PPE - specialized clothing, like glove, gown, mask, or eye protection, used to protect workers from exposure to potentially infectious materials to avoid injury or disease) policy and procedure of wearing a surgical mask and hair covering in the kitchen. She stated the potential outcome was the spread of infection to all staff and residents. During an interview with Infection Control Preventionist (ICP) on 6/16/2021 at 1:55 PM, the ICP stated the facility kitchen staff were required to wear a surgical mask and a disposable white cap provided by the facility. The ICP stated the Cook 1 failed to follow facility PPE policy and procedures of wearing a surgical mask and hair covering. During an interview with the Administrator (Admin) on 6/30/2021 at 12:20 PM, the Admin stated facility kitchen staff were required to wear surgical masks and facility provided approved hair covering of hairnet or busboy cap. The Admin stated Cook 1 failed to wear surgical mask to cover his nose and mouth and busboy cap in the kitchen. He stated the potential outcome was the spread of infection to all residents and staff. During an interview with Director of Nursing (DON) on 6/30/2021 at 3:30 PM, the DON stated	F 880		

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 08/04/2021

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

(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 880	Continued From page 8 kitchen staff were required to wear surgical masks and hair covering of hairnet or busboy caps. The DON stated Cook 1 failed to cover his nose and mouth with a surgical mask and did not have a hairnet or busboy cap on in the kitchen. She stated the potential outcome was the spread of infection to all residents and staff. A review of the facility's policy and procedure titled, "Food Preparation and Service," no revision date, indicated Food and nutrition services staff wear hair restraints so that hair does not contact food. A review of the facility's policy and procedure titled, "Personal Protective Equipment - Face Masks," no revision date, indicated facility personnel must wear a face mask when performing any tasks that may involve splashing of body fluids.	F 880		