DEFARINGENT OF M	EALTH AND HUMAN SERVICES	THE ACCEPTAGE PRINTERS	
CENTERS FOR MED	CARE & MEDICAID SERVICES	· · · · · · · · · · · · · · · · · · ·): 10/24/2 AAPPROV
TATEMENT OF DEFICIENCIE IND PLAN OF CORRECTION	S (X1) PROVIDER/SUPPLIER/CUA CENTURICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X2) DA), 0938-0: TE SURVEY MPLETED
	555128	B. WING	C
NAME OF PROVIDER OR SUI	PUER	STREET ADDRESS, CITY, STATE, ZIP CODE	<i>1241</i> 2018
DOWNEY COMMUNITY	•.	5425 IOWA STREET DOWNEY, CA 90241	
O(4) ID SUMMA PREFIX (EACH DER TAG REGULATOR	RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL LY OR LOC (DENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION 8 HOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETA DATE
Complaint nun Representing t Health Facilitie	reflects the findings of the Public Health during the fa Complaint Investigation during Standard Survey. The CA00597204 The Department of Public Health: S Evaluator Nurse ID: 39872	admission of agreement by the Provider of the truth of the facts alleged or the conclusion set forth on the Statement of Deficiencies This Plan of Companion	
Complaint inveithe findings of a Two deficiencie CA00597204 Notify of Chang CFR(e): 483.10 \$483.10(g)(14) (i) A facility musiconsult with the consistent with in representative(e) (A) An accident results in injury a physician interve	Natification of Changes. I immediately inform the resident resident's physician; and notify, its or her suthority, the resident) when there is involving the resident which and has the potential for requiring the resident which ind has the potential for requiring the resident which ind has the potential for requiring the resident which ind has the potential for requiring the resident which ind has the potential for requiring the resident which ind has the potential for requiring the potential for requ	CORRECTIVE ACTIONS FOR RESIDENTS FOUND TO BE AFFECTED: RESIDENT I NO LONGER RESIDES AT THE FACILITY	11/16/1

Any deficiency statement ending with an estoriat (") denotes a deficiency which the institution may be excused from correcting providing it is determined that office sufficient protection to the posteria. (Goo instructions.) Except for mining homes, the findings stated above are disclosable \$0 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 clied, an approved plan of correction is requirate to continued program participation.

16E0-8E60 ON BMO FORM APPROVED

if continuation sheet Page 2 of 18

falled to follow its policy and notify the physician Based on interview and record review, the facility under \$483.15(c)(9). This REQUIREMENT is not met as evidenced con changes between its different locations part, and must specify the policies that apply to and O2 saturation. locations that comprise the composite distinct state of essential body functions) te physical configuration, including the various frameerge noiselmbs all ni eaclosib feum (6.884) and blood pressure, that indicate the that is a composite distinct part (as defined in rate, temperature, respiration rate, Admission to a composite distinct part. A facility measurements specifically pulse (31)(9)01.6848 abnormal vital signs (clinical representative(s). condition which include the phone number of the resident physician of resident's change of bne (lieme bne gnillism) esenbbe ent efebqu (iv) The facility must record and periodically on 10/25/18 on notifying the (a)(10) of this section. DON in serviced all licensed nurses State law or regulations as specified in paragraph no larabe Trabhu etright frables in agnard A (B) DOES NOT REOCCUR: as specified in §483.10(e)(6); or TO ENSURE THE DEFICIENT PRACTICE (A) A change in room or roommate assignment MEASURES/SYSTEMATIC CHANGES when there isresident and the resident representative, if any, (III) The facility must also promptly notify the planned. C.O.C are properly assessed and care ent of feeuper noqu bebivorq bns eldslisvs si ensuring any resident at risk for all perlinent information specified in §483.15(c)(2) (14)(I) of this section, the facility must ensure that affected by this deficiency by (ii) When making notification under paragraph (g) residents having the potential to be (II)(1)(0)91.E8+8 DON and RN supervisors will assess resident from the facility as specified in erti egnariosi b vo retanant ot noisiosi A (O) AFFECTED: commence a new form of treatment); or HAVING THE POTENTIAL TO BE treatment due to adverse consequences, or to F 580 | IDENTIFICATION OF RESIDENTS Confined From page 1 P 580 DEFICIENCY (EACH CORRECTIVE ACTION SHOULD BE СКОЗЭ-REFERENCED TO THE APPROPRIETE SUMMARY STATEMENT OF DEFICIENCIES RECULATIONS RECULATIONS RECULENCY MUST BE PRECEDED BY FULL RECULATIONS RECULATORY OR LSC IDENTIFYING INFORMATIONS COMPLETION (X5) OI (KX) XITERY DAT XITERS рясурения рели он совяестом a: DOWNEY, CA 90241 DOWNEY COMMUNITY HEALTH CENTER 8425 IOWA STREET STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 10/24/2018 B. WING 555128 (X3) DATE SURVEY IDENTIFICATION NUMBER: STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (XX) MULTIPLE CONSTRUCTION (X1) PROVIDENSUPPLIENCLIA CENTERS FOR MEDICARE & MEDICAID SERVICES ОЕРА̀КТМЕИТ ОF НЕАLTH AND HUMAN SERVICES PRINTED: 10/24/2018

Facility ID: CA940000057

EVER ID: R2HM11

FORM CMS-2367(02-99) Previous Versions Obsolete

specifically pulse rate, temperature, respiration the abnormal vital signs (clinical measurements, of a resident's change of condition which included

CEN	TERS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES	:			FORM	: 10/24/2018 APPROVED :0938-0391
AND PL	M OF CORRECTION	(X1) PROVIDERSUPPLIERICLIA IDENTIFICATION NUMBER:	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: A. BUILL		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
\	;•	555128	B. WING	3 <u></u>			C
NAME	OF PROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE	10)	24/2018
DOW	NEY COMMUNITY HEALT	i. Na otatro	•		3425 IOWA STREET		•
-	* .	<u> </u>		1	DOWNEY, CA 90241		
(X4) II PRÉFI TAG	SUMMARY STAT X (EACH DEFICIENCY REGULATORY OR LS	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL IC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	DE	COMPLETION DATE
F 58	rate, and blood pres	sure, that indicate the state of	F	580	monnothing:		
·	saturation ([percenta	ions) and oxygen (O2) age of O2 [sat]) level for one sidents (Resident 1).		• .	Daily audits will be conducted for residents with C.O.C for the next		ì
	Resident 1 had a lov	v blood pressure at 85/52			days by medical records director		
	millimeter of mercun	/ (mmHa) (normal reference			designee to ensure that resident		
	range [NNR] = 120/8	0 mmHg) and a low 02 sat			MD are notified of any change of		٠
	of 89 percent ([%] NI	RR= 95-100 %).	. •		condition which include the		
	This deficient practic	e resulted in a delay in					
	diagnosis and treatm	ent for Resident 1 who			abnormal vital signs. Significant	·	
	complained of nause	a/vomiting with stomach		"	finding will be submitted to the D	ON	
	pains and shortness	of breath for two days.		- 1	and will be forwarded to QA	· 1	
•	Resident 1 was trans	ferred to the ceneral acute	•		Committee for trending analysis		
•	care nospital (GACH)), admitted into the hospital,			recommendations and corrective	I	
•	Resident 4 work into	ve care unit (ICU), where	·		actions	.	
	Sion in effective and	cardiac arrest (a sudden normal blood circulation due	· . •		detions		
,	to fallure of the heart	to nimp blood catcagon due	•	· -		. [- 1
	intubated (the insertic	on of a breathing tube into	.		Completion date November 16, 20	18	
	I me trachea), placed o	on a mechanical ventilator				·	Ŧ
	(artificial ventilation [b	preathing used to assist or	•		•	l l	•]
	days later.	breathing) and expired 3	•				. 1
	daya mica.	·				1	
		*				.	* 1
	Findings:			ŀ	:	ŀ	1
		- 6 3 -	•	ŀ	•	- 1	l
,	A review of a GACH's	Adult Assessment, dated		ľ	•	.	
	0/20/18 at 8:03 a.m.,	prior to being admitted to	••		•	ļ	
	i die izcinty. Kesident 1	'S SVStems ware assessed '		- [ŀ	.
	i to be yvul (within defi	ine limits) with negative		ľ		Į	-
	laboratory results for c	cardiovascular respiratory		ļ			1
	no abnomelikee Per	ourinary and the skin all with ident 1's chest x-ray report.		ľ:	••	∤	1
	dated 6/20/18 indicate	d there was no south	. .		•		
	problems prior to the t	ransfer to the facility.				. !	

PRINTED: 10/24/2018 **DEPARTMENT OF HEALTH AND HUMAN SERVICES** FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA **(02) MULTIPLE CONSTRUCTION** DC3) DATE SURVEY **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 555128 10/24/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8425 IOWA STREET DOWNEY COMMUNITY HEALTH CENTER **DOWNEY, CA 90241** SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY Continued From page 3 F 580 A review of Resident 1's Face Sheet (Admission Record) indicated the resident was admitted to the facility on 6/20/18. Resident 1's diagnoses included status-post fall with a right hip fracture (a break in a bone), right elbow fracture, hypertension (high blood pressure) and diabetes (high blood sugar). A review of Resident 1's Minimum Data Set (MDS), a standardized assessment a care screening tool, dated 6/27/18, Indicated Resident 1's Brief interview for Mental Status ([BIMS] mental assessment test]) score was 13 (13-15=cognition intact [thought process]). A review of Resident 1's Nursing Admission Screening/History, dated 6/20/18 and timed at 8:25 p.m., indicated Resident 1 was alert, had normal lung sounds, pulse rate was regular rhythm, bowel sounds present and abdomen soft and non-tender. Resident 1's vital signs, dated 8/20/18 at 9:10 p.m., were as follow: Temperature 98:2 normal reference range (INRR) =97.7-99.5 °F) Pulse 78 (NRR 60-100 beats per minute) Respiration 18 bpm ([breathes per minute] NRR=

12 to 20).

mmHg)

Blood Pressure 130/70 mmHg (NRR=120/80

O2 saturation 98% on room air (NRR 94-99%)

A review of a Nursing Progress Note, dated 7/24/18 and timed at 7:50 p.m. indicated Resident 1 was having episodes of vomiting (forceful expulsion of the contents of the stomach via the mouth or sometimes the nose), constipation (bowel movements that are infrequent or hard to pass) with abdominal discomfort. According to

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

PRINTED: 10/24/2018 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION	(X3) DAT	E SURVEY MPLETED	
		555128	B. WING	B. Wing		1	C 10/24/2018	
	PROVIDER OR SUPPLIER Y COMMUNITY HEAL	TH CENTER	<u> </u>	8	TREET ADDRESS, CITY, STATE, ZIP CODE 425 IOWA STREET FOWNEY, CA 80241	1	242010	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) .	BE	COMPLETION DATE	
F 580	the note, the nurse received an order a labs to be drawn, at	called the physician and t 8:10 p.m., on 7/24/18, for odominal x-ray, medication for a laxative and fleet's	F	580				
	timed at 9:39 a.m., I complaining of naus breathing with a low O2 sat of 89% on rocalled and Nurse Practice I additional responsib care than RN's) called Resident 1's conditional ([N/C])	Note, dated 7/25/18 and ndicated Resident 1 was sea/vomiting and difficulty blood pressure of 86/52 and om air. The physician was ractitioner 1 (NP 1 [an Registered Nurse who has illities for administering patient ad back and was informed of on and ordered oxygen via plastic tube inserted into the ygen) at 2-4 liters per minute ath.	٠.					
	A review of Resident dated 7/25/18 and the the following:	t 1's abdominal x-ray report, med at 2:19 a.m., indicated	•					
	such as air (gas) or in abdomen causing its 2. Possibility of gastromedical condition whithe level of the pylometomach) is not exclus. Follow-up examinated 7/28/18 and time I was made awaind FM 1 requested and FM 1 requested.	ic outlet obstruction (a tere there is an obstruction at us, which is the outlet of the	•					

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

PRINTED: 10/24/2018 FORM APPROVED CMP NO. 0038, 0304

7751415		A MIEDICAID SERVICES .			. 0	MR NO	<u>. 0938-0391</u>
STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILC		E CONSTRUCTION ,	CON	E SURVEY IPLETED
\		555128	B. WING		•	1	C 24/2018
DOWNE	PROVIDER OR SUPPLIER Y'COMMUNITY HEAL			84	TREET ADDRESS, CITY, STATE, ZIP CODE 125 IOWA STREET OWNEY, CA 90241		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(XB) COMPLETION DATE
	A review of Resident dated 7/26/18 and the saturation remained oxygen infusing via A review of Resident dated 7/26/18 and the Saturation of Resident dated 7/26/18 and the Saturation of the GAC by Basic Life Support (over two hours later transfer) emergency of two hours later transfer) emergency of two hours later transfer the resident persistent nausea and A review of the ambiguity p.m. As documented as transfer the facility p.m. As documented as transfer the facility p.m. As documented abnormal respiration of increased effort to saturation of 87%. The complaint was documented to the facility of the saturation of 87%. The complaint was documented to the facility of the saturation of 87%. The complaint was documented to the facility of the saturation of 87%. The complaint was documented to the facility of the saturation of 87%. The complaint was documented to the facility of the saturation of 87%. The complaint was documented to the facility of the saturation of 87%. The complaint was documented to the facility of the saturation of 87%. The complaint was documented to the facility of the saturation of 87%. The complaint was documented to the facility of the saturation of 87% and 18	t 1's Nursing Progress Note, med at 11:40 a.m., the O2 low at 87-90% with 2 liters of N/C with heavy breathing. It 1's nursing progress note, med at 11:52 a.m., indicated the orders to transfer the H. Resident 1 was transferred at ambulance at 2:25 p.m. and not via 911 (immediate to the GACH due to to the GACH due to a danormal lab results. Ulance "Patient Care Report," ted a call was received for a :09 p.m., on 7/28/18 and they over two hours later, at 2:48 d, upon the BLS arrival, l, labored breathing (an characterized by evidence breathe) with an O2 he resident's primary nented as abdominal pain	F	5 80			
18	idequate care, which	included not being bathed he had expressed her					

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 10/24/2018 FORM APPROVED OMB NO. 0938-0391

_			A MEDICAID SERVICES			<u> </u>	MR NO	<u>. บรรช-บรรา</u>	
		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILL		LE CONSTRUCTION	CON	DATE SURVEY COMPLETED	
4			555128 ·	B. WING		•	1	C 24/2018	
		PROVIDER OR SUPPLIER Y COMMUNITY HEAL	TH CENTER		ε	STREET ADDRESS, CITY, STATE, ZIP CODE 8425 IOWA STREET DOWNEY, CA 90,241			
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES . 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	85	(XB) COMPLETION - DATE	
		stated Resident 1 al on both heels in her on both heels in her On 8/16/18 at 4:15 pinterview, the Regis (RN 1) stated he do blood of 85/52 and (progress notes on 7 called the NP and w condition would nee nurse, but since he not reported further. On 9/5/18 at 12:55 pinterview, NP 1 state the facility's nursing abnormal lab values report for Resident 1 the nursing staff that physician and togeth facility to see the resulting staff did not the resident was in a blood pressure and I had transferred the resident 1 to the GA the delay in transport were given to transfer he nurses called 911 condition.	lai worker, staff and NP. FM 1 lso developed pressure sores short stay. p.m., during a telephone tered Nurse Charge Nurse 1 cumented the resident' low 02 Sat of 89% on the nursing /25/18. RN 1 stated he also as told the resident's d to be reported to the charge was the charge nurse, it was come, during a telephone at she received a call from staff on 7/26/18 with and an abdominal x-ray l. NP 1 stated she informed the would discuss with the per they would go to the sident. NP 1 stated the give her the information that any distress or had a low had she known she would	F	580				
	10	AHA) website, on 10	1/12/18, indicated "Unlike						

PRINTED: 10/24/2018 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 555128 B. WING 10/24/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8425 IOWA STREET DOWNEY COMMUNITY HEALTH CENTER **DOWNEY, CA 90241** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (XS) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY) F 580 Continued From page 7 F 580 symptoms were shortness of breath. nausea/vomiting. The AHA indicated calling 911 was almost always the fastest way to get lifesaving treatment." https://www.heart.org/en/health-topics/heart-failur e/warning-signs-of-heart-failure A review of GACH emergency department (ED) record, dated 7/26/18 and timed at 3:18 p.m., indicated Resident 1 presented with shortness of breath, abdominal pain, NV and ulcers to bilateral feet. Resident 1's Lab results were as follows: 1. Glucose level 175 (NRR=74-108) 2. Blood Urea Nitrogen ([BUN] indicator of kidney function) 89 (NRR=7-18) kidney function 3. Creatinine (indicator of kidney function) 42 (NRR=0.5-1.5) 4. Albumin (indicator of liver and kidney function, and malnutrition) 3.0 (NRR=3.8-5.2) 5. Brain natriurectic peptide ([BNP] indicator of

of cardiac failure

(NRR=3.50-10.60)

heart function) 50089 (NRR=<450)

7. White blood count (WBC)16.90

elevation=congestive heart failure/heart attack 6. Troponin 20.300 (NRR=0.000-0.045) indicative

8. Hemoglobin (a protein inside red blood cells that carries oxygen from the lungs to tissues and organs in the body and carries carbon dioxide back to the lungs) 9.4 (NRR=12.0-16.00) 9. Liver enzymes; Aspartate aminotransferase (AST) 2076 (NRR=15-37) and Alanine aminotransderase (ALT) 3362 (NRR=12-78)

The GACH ED record indicated Resident 1 was admitted to ICU with diagnoses of acute MI ([myccardial infarction] heart attack), CHF

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/24/2018 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING C 555128 10/24/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8425 IOWA STREET DOWNEY COMMUNITY HEALTH CENTER **DOWNEY, CA 90241** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION . ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (XS) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY F 580 Continued From page 8 F 580 (congestive heart failure), sepsis (a life-threatening condition that arises to the response of infection caused in injury to its own tissues and organs), pneumonia (inflammation of one or both lungs, with dense areas of lung inflammation), and urinary tract infection (infection of the kidney, ureter, bladder, or urethra). A review of GACH's Discharge Summary, dated 8/16/18 Indicated Resident 1 was admitted to GACH on 7/26/18 and expired on 7/29/18, after a cardiac arrest (heart stoppage) and multi-organ failure. The resident was made a do not resuscitate ([DNR] withhold of cardiopulmonary resuscitation [CPR/ procedure to revive the heart and lungs) or advanced cardiac life support [ACLS]), and multi-organ failure. A review of Resident 1's Death Certificate indicated the date of death was 7/29/18 and the cause of death was listed as sensis (life-threatening response to infection, which can lead to tissue damage, organ failure and death) and non-systemic elevation myocardial infarction (MI/heart attack). On 10/18/18 at 10:15 a.m., during a telephone interview, the DON stated if it was just a "normal" change in condition the nurse could call BLS, but in this case, the nurse should have called 911 and not even wait to call the physician. The DON stated they should have called him if they were not sure, especially since the resident was a new

called 911.

admit and they were not that familiar with the resident. The DON stated they did not have a policy regarding when to call BLS or 911, but stated when in doubt the nurse should have

CEN	ERS FOR MEDICAR	H AND HUMAN SERVICES E & MEDICAID SERVICES	14		FOR	D: 10/24/2018 M APPROVED
STATEM AND PLA	NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A BUILDIN	PLE CONSTRUCTION	OMB NO: 0938-039 OMB NO: 0938-039 COMPLETED	
NAME (of provider or supplier	555128	B. WING_		4	C 0/24/2018
DOWN	EY COMMUNITY HEAI	LTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 8425 IOWA STREET DOWNEY, CA 80241	1.	
(X4) IO PREFI) TAG	SUMMARY ST. (EACH DEFICIENC REGULATORY OR I	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SO IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFISIENCY)	TON HLD BE OPRIATE	COMPLETION DATE
F 58	- Total pe		F 580		······································	
F 684	Protocot, Indicated all changes of a re- included vital signs of changes, recent	Illy's policy and procedure Ition Changes-Clinical I the staff would report any and Ident to the physician, which conset, duration and severity labs and pain level.				
SS=G	CFR(s): 483.25 § 483.25 Quality of Quality of care is a applies to all treatm facility residents. Be assessment of a re-	care fundamental principle that ent and care provided to sed on the comprehensive sident, the facility must ensure to treatment and care in	F 684	CORRECTIVE ACTIONS FOR RESIDENTS FOUND TO BE AFFEC Resident #1 no longer resides in facility.		11/16/18
`	practice, the compre- care plan, and the re This REQUIREMEN by:	ressional standards of phansive person-centered person-centered person-centered person continued in the continued person cont	•	IDENTIFICATION OF RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED:		
1	services were provided included sending the a change in condition basic life support am hours for one of three	and record review, the facility to necessary care and led to a resident, which resident to the hospital after ryla 911 emergency, and not- bulance, which took over two e sampled residents	•	All resident have the potential to affected by the practice.	be be	·
	contains for two day at 85/62 (normal refe 120/80) and a low ox percent ([%] NRR# 9 comitting with stomac eyel of care, but was acute care hospital (c and when sent, it was	nt 1, who had a change in swith a low blood pressure rence range [NNR] = ygen (O2) saturation of 89 8-100 %) and nausea and hipain, needed a higher not sent to the general PACH) timely for two days, not by 911 (Immediate) (crossed referenced to		· ·	÷ .	

CENTE	RS FOR MEDICARE	AND HUMAN SERVICES				FORM): 10/24/2018 MAPPROVED): 0938-0391	
ISTATEMEN	IT OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		555128	B. WING			C 10/24/2018		
1	PROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·			STREET ADDRESS, CITY, STATE, ZIP CODE		12412018	
DOWNE	Y COMMUNITY HEALT	TH CENTER .			1425 IOWA STREET DOWNEY, CA 90241		Ì	
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	iD.		PROVIDER'S PLAN OF CORRECTION		F 5 mm	
PREFIX TAG	REGULATORY OR LE	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)) RF	COMPLETION DATE	
F 684	Continued From page 5580).	ge 10	Fe	384	License Nurses have been in ser on October 25, 2018 by the DON		•	
	diagnosis and treatn	ce resulted in a delay in nent for Resident 1 who		;	conditions that may warrant tra to the acute level of care via 911	-	:	
	complained of nausea/vomiting with stomach pains and shortness of breath for two days.				emergency response and those			
•	Resident 1 was trans	sferred to the GACH.			conditions that may be transferr			
	admitted into the hos	spital, transferred to intensive	ļ.,		using basic life support services.		<u> </u>	
	cardiac arrest (a sud	re Resident 1 went into Iden stop in effective and			conditions requiring transfer to		[]	
	nomal blood circula	tion due to failure of the heart	•	` `	acute level will be clarified with	the	1	
	to pump blood), was	intubated (the insertion of a ne trachea [tube-like portion			physician or designee giving the			
Į	of the respiratory trace	ct allowing for the passage of I			order for transfer to specifically address the type of transport			
1	airj), placed on a me ventilation [breathing	chanical ventilator (artificial J used to assist or replace ng) and expired 3 days later.	í : .		necessary.	:		
. [,	<i>o,</i>	•		MEASURES/SYSTEMATIC CHANGE	S		
	Findings:		•		TO ENSURE THE DEFICIENT PRACT			
	` .	•	:	ŀ	DOES NOT REOCCUR:		. 1	
		1's Face Sheet (Admission			DON will monitor all change of	:		
•	Record) indicated the lbe facility on 6/20/19	resident was admitted to		ı	condition and transfer to the	÷		
- 11	included status-post	fall with a right hip fracture (a l		ĺ	hospital for 3 months to ensure th	at		
[1	break in a bone), righ	it elbow fracture.	•	-	the license nurses are using the			
. [(high blood sugar).	ood pressure) and diabetes		ľ	correct type of Ambulance service	•		
	A soview of Docident	dia Nilaina ann Data Gat			Significant findings will be forward	ed		
16	MDS), a standardize	1's Minimum Data Set d assessment a care			to the QA committee for trending			
8	screening.tool, dated	8/27/18, indicated Resident			analysis, recommendations and			
	rs Brief Interview for nental assessment to	Mental Status ([BIMS]	••	ŀ	corrective actions.			
10	13-15=cognition Inta	ct [thought process]).	· ·		Completion the co]	.	
	review of Resident	1's Nursing Admission ted 6/20/18 and timed at	÷		Completion date November 16, 201	8		

CENTE	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES		•		FORM	D: 10/24/2018 MAPPROVED D: 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		PLE CONSTRUCTION G	(X3) DA	TE SURVEY MPLETED
		555128	B. WINC	3		10	C //24/2018
NAME OF	PROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE	<u></u>	
DOWNE	Y COMMUNITY HEALT	TH CENTER		1	8425 IOWA STREET DOWNEY, CA 90241		
(X4) ID PREFIX TAG	i (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	DX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ALD BE	(05) COMPLETION DATE
	normal lung sounds rhythm, bowel sound and non-tender. Rea within normal limits A review of a physic indicated for one lite (intravenous [into ve 80 ml an hour. On 6 liters at 70 ml/hour (intravenous [into ve 80 ml an hour. On 6 liters at 70 ml/hour (intravenous [into ve 80 ml an hour. On 6 liters at 70 ml/hour (interestation ordered at via IV at 70 ml an hour limited at 10 for dehy not enough water tail. A review of a physicil after admission to the timed at 1:40 p.m., is member (FM 1) was care and requested a (skilled nursing facility. A review of a Nursing facility and timed at 4 facility's social worker concerns/grievances.	Resident 1 was alert, had pulse rate was regular ds present and abdomen soft sident 1's vital signs were all (WNL). Jan's order, dated 6/28/18 or (1000 ml [milititer]) of IV lins]) .5 normal saline (NS) at /29/18, another .5 NS two 2000 ml). On 7/2/18, the nother liter (1000 ml) of .5 NS was dration (too much water lost, ken in). Jan's progress note, 15 days a facility, dated 7/5/18 and indicated Resident 1's family not happy with the resident's a transfer to another SNF by). Progress Note, dated 1:25 p.m., and signed by the rindicated FM 1 would email to her. Worker Note titled, "Resident"	F	384	,		
. !! !	Grievance/Complainindicated an attached on concerns about Rehereof and dietary is A review of a Nursing 1/24/18 and timed at Resident 1 was having	t Form," dated 7/9/18, I letter from FM 1 in regards esident 1's care or lack sues. Progress Note, dated 7:50 p.m., indicated ig episodes of vomiting					
10	forceful expulsion of la the mouth or som	the contents of the stomach					

		AND HUMAN SERVICES & MEDICAID SERVICES	•				FORM	10/24/2018 APPROVED 0938-0391	
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING					(X3) DATE SURVEY COMPLETED	
		555128	B. WING				· C 10/24/2018		
NAME OF	PROVIDER OR SUPPLIER			-	STREET ADDRESS, CITY, STAT	E, ZIP CODE			
DOWNE	Y COMMUNITY HEALT	TH CENTER			8426 IOWA STREET DOWNEY, CA 90241				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD TO THE APPROPE	BE	COMPLETION DATE	
	constipation (bowel infrequent or hard to discomfort. According called the physician p.m., on 7/24/18, for x-ray, medication for laxative and fleet's extray, medication for laxative and fleet's extray, medication for laxative and fleet's extray, medication for laxative and fleet's extray fl	movements that are pass) with abdominal ng to the note, the nurse and received an order at 8:10 r labs to be drawn, abdominal r nausea/vomiting, and a greena for constipation. Note, dated 7/25/18 and indicated Resident 1 was ea/vomiting and difficulty blood pressure of 85/52 and om air. The physician was ractitioner 1 (NP 1 [an Registered Nurse who has illities for administering patient and ordered oxygen via plastic tube inserted into the yeen) at 2-4 liters per minute with. It is abdominal x-ray report, med at 2:19 a.m., indicated (occurs when substances, fluid, accumulate in the expansion) is outlet obstruction (a pere there is an obstruction at us, which is the outlet of the yelded atton was recommended.	F	384					
17	7/26/18 and timed at was made aware of F	8:55 a.m., indicated FM 1 - Resident 1's condition and nsfer to the hospital. NP 1							

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/24/2018 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X4) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION A. BUILDING 555128 B. WING 10/24/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8425 IOWA STREET DOWNEY COMMUNITY HEALTH CENTER DOWNEY, CA 80241 **SUMMARY STATEMENT OF DEFICIENCIES** (X4) ID PREFIX TAG ID PROVIDER'S PLAN OF CORRECTION (XS) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG DATE F 684 Continued From page 13 F 684 was notified and called back at 9:15 a.m., on 7/26/18 and stated, "There was no need to transfer the resident right now." A review of a Nursing Progress Note, dated 7/26/18 and timed at 11:40 a.m., the O2 saturation remained low at 87-90% with 2 liters of oxygen infusing via N/C with heavy breathing. A review of Resident 1's nursing progress note. dated 7/26/18 and timed at 11:52 a.m., indicated NP 1 called back with orders to transfer the resident to the GACH. Resident 1 was transferred by Basic Life Support ambulance (transport for patients who do not require extra support or cardiac monitoring) at 2:25 p.m. (over two hours later) and not via 911 emergency. A review of a physician's telephone order, dated 7/26/18 and timed at 11:52 a.m., indicated to transfer the resident to the GACH due to persistent nausea and abnormal lab results. A review of the ambulance "Patient Care Report." dated 7/26/18, indicated a call was received for a basic transport at 12:09 p.m., on 7/26/18 and they arrived to the facility over two hours later, at 2:46 p.m. As documented; upon the BLS arrival. Resident 1 had rapid, labored breathing (an abnormal respiration characterized by evidence of increased effort to breathe) with an O2 saturation of 87%. The resident's primary

complaint was documented as abdominal pain with nausea and vomiting for two days.

On 8/7/18 at 2 p.m., during an interview, FM 1 stated Resident 1 was admitted to SNF for rehabilitation for the hip and elbow fracture, but while in the facility the resident was not given

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

PRINTED: 10/24/2018 FORM APPROVED OMB NO. 0938-0391

	HA COLL WITCH	- A MEDIOVID SELVAIOEO			OMD NO	1. U830-U38
STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DA	TE SURVEY MPLETED C
		555128	B. WING		10	<i>1</i> 24/2018
	PROVIDER OR SUPPLIER Y COMMUNITY HEAL	TH CENTER	8	TREET ADDRESS, CITY, STATE, ZIP CODE 125 IOWA STREET OWNEY, CA 90241		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 684	adequate care, whiregularly, for which concerns to the soc stated Resident 1 a on both heels in he	ch included not being bathed she had expressed her sail worker, staff and NP. FM 1 also developed pressure sores r short stay.	F 684			
·	interview, Registered 1) stated he docume of 85/52 and O2 Sa progress notes on 7 called the NP and woondition would need to the NP and would need to the	p.m., during a telephone of Nurse Charge Nurse 1 (RN ented the resident low blood at of 89% on the nursing 1/25/18. RN 1 stated he also was told the resident's of to be reported to the charge was the charge nurse, he did				
	interview, NP 1 state the facility's nursing abnormal lab values report for Resident the nursing staff that physician and toget facility to see the requiring staff did not the resident was in a	p.m., during a telephone ed she received a call from staff on 7/28/18 with a and an abdominal x-ray 1. NP 1 stated she informed t she would discuss with the her they would go to the sident. NP 1 stated the give her the information that any distress or had a low had she known she would resident sconer.				
	in-person interview a she was not aware o transfer Resident 1 i aware of the delay in	6/18 at 12:30 p.m., during an and chart review, NP 1 stated of the family's request to to the GACH and was not a transport to the GACH when transfer. NP 1 stated she called 911, given the				
	A review of the Amei	rican Heart Association's				

PRINTED: 10/24/2018 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION O(1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION 0(3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A BUILDING 555128 B. WING 10/24/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8425 IOWA STREET DOWNEY COMMUNITY HEALTH CENTER **DOWNEY, CA 90241** PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (XS) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATIONI TAG TAG DEFICIENCY F 684 Continued From page 15 F 684 (AHA) website, on 10/12/18, Indicated "Unlike men, women's most common heart attack symptoms were shortness of breath. nausea/vomiting. The AHA indicated calling 911 was almost always the fastest way to get lifesaving treatment." https://www.heart.org/en/health-topics/heart-failur e/warning-signs-of-heart-failure A review of GACH emergency department (ED) record, dated 7/26/18 and timed at 3:18 p.m., indicated Resident 1 presented with shortness of breath, abdominal pain, NV and ulcers to hilateral feet. Resident 1's Lab results were as follows: 1. Glucose level 175 (NRR=74-106) 2. Blood Urea Nitrogen (IBUN) Indicator of kidney function) 89 (NRR=7-18) kidney function 3. Creatinine (indicator of kidney function) 42 (NRR=0.5-1.5) 4. Albumin (indicator of liver and kidney function.

of cardiac failure

(NRR=3.50-10.60)

and mainutrition) 3.0 (NRR=3.8-5.2)

heart function) 50089 (NRR=<450)

7. White blood count (WBC)16.90

5. Brain natriurectic peptide ([BNP] indicator of

elevation=congestive heart failure/heart attack 6. Troponin 20,300 (NRR=0,000-0,045) indicative

8. Hemoglobin (a protein inside red blood cells that carries oxygen from the lungs to tissues and organs in the body and carries carbon dioxide back to the lungs) 9.4 (NRR=12.0-16.00) 9. Liver enzymes; Aspartate aminotransferase (AST) 2076 (NRR=15-37) and Alanine aminotransderase (ALT) 3362 (NRR=12-78)

PRINTED: 10/24/2018 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO, 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A. BUILDING_ C 888128 B. WING 10/24/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8425 IOWA STREET DOWNEY COMMUNITY HEALTH CENTER **DOWNEY, CA 90241** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE **DEFICIENCY**) F 684 Continued From page 16 F 684 The GACH ED record indicated Resident 1 was admitted to ICU with diagnoses of acute Mi (myocardial infarction [heart attack]), CHF (congestive heart failure), sepsis (a life-threatening condition that arises to the response of infection caused in injury to its own tissues and organs), pneumonia (inflammation of one or both lungs, with dense areas of lung inflammation), and urinary tract infection (infection of the kidney, ureter, bladder, or urethra). A review of GACH's Discharge Summary, dated 8/16/18 Indicated Resident 1 was admitted to GACH on 7/26/18 and expired three days later. on 7/29/18, after a cardiac arrest (heart stoppage) and multi-organ failure. The resident was made a do not resuscitate ([DNR] withhold of cardiopulmonary resuscitation [CPR/ procedure to revive the heart and lungs or advanced cardiac life support [ACLS]), and multi-organ failure. A review of Resident 1's Death Certificate indicated the date of death was 7/29/18 and the cause of death was listed as sepsis (life-threatening response to infection, which can

([Mi] heart attack).

lead to tissue damage, organ failure and death) and non-systemic elevation myocardial infarction

On 9/6/18 at 3 p.m., during a telephone interview, NP 1 stated she had received complaints from Resident 1's family about care concerns and she had discussed the resident's "substandard care"

On 10/18/18 at 10:15 a.m., during a telephone interview, the DON stated if it was just a "normal"

with the Director of Nurses (DON).

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

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STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	Toman		ON	OMB NO. 0938-039		
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NNG		(X3) DATE SURVEY COMPLETED		
NAME OF PROPERTY.	555128	B. WING			C		
NAME OF PROVIDER OR SUPPLIED DOWNEY COMMUNITY HEA	LTH CENTER		STREET ADDRESS, CITY, STATE 8428 IOWA STREET DOWNEY, CA 90241	TE, ZIP CODE	<u> 10/24/201</u>	8	
	SUMMARY STATEMENT OF DEFICIENCIES.				E. COMPLE		
not even wait to ca stated they should not sure, especially admit and they wen resident. The DON policy regarding wh stated when in dout called 911. A review of the facili titled, "Acute Condit Protocol," revised 12 report any and all ch physician, which inc	age 17 In the nurse could call BLS, but use should have called 911 and all the physician. The DON have called him if they were a since the resident was a new to enot that familiar with the stated they did not have a en to call BLS or 911, but not the nurse should have the nurse should have all by spolicy and procedure ion Changes-Clinical 2/15, indicated the staff would langes of a resident to the luded vital signs, onset, of changes, recent labs and	Fe					