ACCEPT
10/16/19
36204

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

PRINTED: 10/08/2019
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
	055764	A. BUILDING _____ B. WING _____	C 10/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITTIER PACIFIC CARE CENTER	7716 S PICKERING AVENUE WHITTIER, CA 90602

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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during the investigation of one complaint. Complaint Number: CA641334 Representing the Department: Health Facilities Evaluator Nurse # 40913 The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility. Two deficiencies were written as a result of complaint number CA641334.	F 000	The signing of this plan of correction is not an admission or agreement by this facility of the truth of the facts alleged on this statement of deficiency and plan of correction. In fact, this plan of correction is submitted exclusively to comply with state and federal law. This plan of correction serves as the allegation of compliance.	
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other	F 609	[F-609] Reporting of Alleged Violations Corrective Action: Administrative staff and direct care staff were in-serviced on 10/09/19-10/11/19 in regards to proper policy and procedure of Reporting Accidents and Incidents, with a focus on	10/15/19

ORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 10/15/19

deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that r safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days wing 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 following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ram participation.

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F 609	Continued From page 1 officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to report an injury of unknown origin for one of three sampled residents (Resident 1) to the State Survey Agency (the Department of Health). This deficient practice had the potential for injuries of unknown origin to not be investigated to rule out abuse. Findings: A review of Resident 1's Admission Record indicated the resident was admitted on 4/17/19 with diagnoses that included dementia (a decline in mental ability severe enough to interfere with daily life) and diabetes (high blood sugar). A review of Resident 1's History and Physical dated 5/6/19, indicated the resident did not have capacity to understand and make decisions. A review of Resident 1's Minimum Data Set (MDS - a care and assessment screening tool), dated 4/24/19, indicated the resident usually	F 609	reporting injury of unknown origin within two hours to the State Survey Agency, adult protective services and other appropriate agencies. The facility policy for Reporting of Accidents and Incidents was update on 10/09/19 and was approved by the Medical Director on 10/14/19. <u>Identification of other residents and Corrective action:</u> No other resident were found to have unreported injuries. <u>Measures to prevent recurrence:</u> <u>Corrective Action:</u> Medical records staff will audit resident's medical records and twenty-four hours reports to ensure incidents have been reported to the Director of Nursing. Findings of audit	

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F 609	Continued From page 2 understands most conversation and sometimes can be understood when making concrete requests. The MDS indicated the resident had severe impairment in cognition (ability to think and process information) and was totally dependent with transfers and toilet use and required extensive assistance (resident involved in activity, staff provide weight bearing support) with bed mobility, locomotion on unit and locomotion off unit with one-person physical assistance. A review of Resident 1's Physician Order dated 6/9/19, indicated an order to transfer Resident 1 to a General Acute Care Hospital (GACH) for the left intertrochanteric (thigh) fracture. A review of the radiology report dated 6/9/19, indicated the left hip shows intertrochanteric fracture with varus deformity (an excessive inward angulation). A review of a report, titled "Investigation of Incident/Accident Known/Unknown Origin," dated 6/9/19, indicated Resident 1 complained of left hip pain with slight swelling of the left hip. The report indicated Resident 1 did not have a fall or any incident of falling. The fracture was self-induced, non-traumatic and not a result of abuse or mistreatment. A review of the facility's policy and procedure, titled "Abuse and Mistreatment of Residents," undated, indicated the policy did not include for facility's staff to report injuries of unknown origin to the Stated Survey Agency. On 9/30/19 at 4:01 p.m., during a concurrent interview and a review of the facility's policy and	F 609	will be matched to the incident report for three month. Report findings will be reported to Director of Nursing immediately. Director of Nursing and Administrator will conduct review of incidents and determine if incident is reportable. Monitoring performance and integration into quality assurance system: On a quarterly basis, for two quarters under the supervision of the Director of Nursing or designee, reports on the findings of all incidents shall be documented on the Quality Assurance form. The results of audits shall be submitted to the Quality Assurance Committee for review and evaluation of any further corrective action as necessary.	

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F 609	Continued From page 3 procedure for abuse, the Director of Nurses (DON) stated the policy did not mention injuries of unknown origin. The DON stated injuries of unknown origin do not fall into a category of abuse. On 9/13/19 at 4:06 p.m., during an interview, the administrator stated the hip fracture was not reported to the Department of Health due to there was no indication of trauma. The administrator stated there was swelling and pain on the left hip but there were no bruises.	F 609		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide supervision and ensure the chair alarm was functioning properly to prevent accident for one of three sampled residents (Resident 1). For Resident 1, the resident had an injury of unknown origin that resulted in hospitalization. These deficient practices placed Resident 1 at risk for falls. Findings:	F 689	F 689 Free of Accident Hazards Corrective action: Wheel -Chair and bed alarm pads were put in place and checked for functioning each shift. Daily floor pad is in place on left side of bed for resident 1 when in bed. Floor pads are being kept in his room when resident is out of bed. Supervision is provided every two hours and each time patient care is rendered. Resident is placed in a high traffic area for increased visual monitoring. Identification of other residents and corrective action: A in-service was provided on 10/10/19 10/12/19 promoting safety , bed and chair alarm use for license staff and certified Nursing aid staff. Rounds were made on 10/8/19 to ensure all residents with bed and/or wheel-chair alarms were operational. A listing of residents with orders of wheel -chair and bed alarms has been	10/15/19

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F 689	Continued From page 4 A review of Resident 1's Admission Record indicated and admission to the facility on 4/17/19. Resident 1's diagnoses included dementia (a decline in mental ability severe enough to interfere with daily life) and muscle weakness. A review of Resident 1's History and Physical, dated 5/6/19, indicated the resident did not have a capacity to understand and make decisions. A review of Resident 1's Minimum Data Set (MDS - a care assessment and screening tool), dated 4/24/19, indicated the resident usually understands most conversation. The MDS indicated the resident had severe cognitive (ability to think and process information) impairment and was dependent with transfers, toilet use. The MDS indicated Resident 1 required extensive assistance (resident involved in activity, staff provide weight bearing support) with bed mobility and locomotion with one-person physical assistance. a.) A review of Resident 1's Physician Order, dated 6/9/19, indicated to transfer Resident 1 to a General Acute Care Hospital (GACH) for a left intertrochanteric fracture (fracture of the thighbone). A review of the radiology report, dated 6/9/19, indicated the left hip shows intertrochanteric fracture with varus deformity (an excessive inward angulation of a bone or joint). On 6/21/19 at 4:42 p.m., during an interview, Resident 1 stated he had a fall but he could not remember if he reported to staff regarding the fall.	F 689	generated for each shift to ensure that alarms are functioning and operational. No other resident were found with the same issue alarms were all functioning. Measures to prevent recurrence: The list of the residents who have orders for alarms will be provided to charge nurses every day. It will be part of their rounds to check if alarms are in place for those residents on the list throughout the day. It will be part of the RN supervisors' daily rounds to make certain that the assignments reflect room numbers of residents on alarms and random check to ensure the alarms are working properly.. The list of resident with order for bed and wheel-chair alarms will be updated monthly and as changes occur. Interdisciplinary team members will discuss residents who are on bed and wheel chair alarms during fall committee meeting, to reassess the need to continue the orders. In addition, IDT members shall review other residents who could benefit from having alarms on equipment. Monitoring performance and integration into quality assurance system: Safety meeting is being conducted every month. Attending members will discuss any increase supervision	

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F 689	Continued From page 5 On 8/6/19 at 7:10 p.m., during an interview, Resident 1 stated he broke his hip when he fell from the wheelchair and ended on the floor. Resident 1 stated two staff helped him back to the wheelchair but could not recall their names. Resident 1 stated he had pain at the time of the fall and was transferred to the hospital one to two days after the fall. A review of the facility's "Falls Log" for 2019 indicated Resident 1's name was not on the log. On 8/6/19 at 7:28 p.m., during an observation, Resident 1 was using his hands and his feet propelling the wheelchair around the facility. On 8/9/19 at 10:39 a.m., during a telephone interview, Licensed Vocational Nurse 4 (LVN 4) stated Resident 1 was "very active" and the resident was able to move around the facility by himself on his wheelchair. On 9/13/19 at 6:21 p.m., during an interview, Certified Nurse Assistant 3 (CNA 3) stated Resident 1 always propel his wheelchair around the hallways and other residents' rooms. On 9/16/19 at 2:13 p.m., during a telephone interview, CNA 4 stated on 6/8/19 Resident 1 was going inside other residents' rooms to collect clothes, books and newspapers. On 9/26/19 at 11:16 a.m., during a telephone interview, LVN 4 stated on 6/7/19 and 6/8/19 while she was working during the 11 PM to 7 AM shift, she saw Resident 1 stayed up late went inside other residents' rooms. On 9/26/19 at 4:10 p.m., during a telephone	F 689	recommendations for individual residents. Audit findings will be presented to the Quality Improvement Committee monthly by the director of staff development for recommendations.	

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F 689	Continued From page 6 interview, CNA 5 stated on 9/8/19 during the 3 PM to 1 PM shift, after dinner, Resident 1 was going around and going inside other residents' rooms collecting clothes and blankets. On 9/26/19 at 10:04 a.m., during an interview, CNA 6 Resident 1 as very inpatient, the resident would get up and transfer to the wheelchair by himself without calling for assistance; he would not use the call light or call/yell for assistance. On 9/30/19 at 9:45 a.m., during an interview and review of the Activity Participation Report for the month of June 2019, the activity director stated that Resident 1 could not stay in one place. She stated Resident 1 liked to roam around and went inside other residents' rooms to get the magazines. On 9/27/19 at 1:29 p.m., during a telephone interview and a review of the Care Plan for Wandering Residents, undated, indicated for staff to monitor the resident's location with visual checks as needed. The MDS nurse stated the intervention was for staff to provide visual checks on Resident 1 every two hours. On 10/1/19 at 8:12 p.m., CNA 7 stated there was no specific instructions from the licensed nurses or the DON on how she would monitor the resident. CNA stated she monitored Resident 1 when she saw him and when she was not with other residents. A review of the facility's policy and procedure, titled "Accident/Incident Prevention," indicated the facility strives to prevent accidents by providing an environment that is free from accident hazards, as well as identification of each resident	F 689		

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F 689	Continued From page 7 at risk for accidents and/or falls. b.) On 8/6/19 at 8:34 p.m., during an observation, Resident 1 was in bed with a bed alarm, a chair alarm on the wheelchair, fall mat on the left side of the bed, and a call light within reach. On 8/9/19 at 7:01 a.m., during an observation, Licensed Vocational Nurse 1 (LVN 1) checked the chair pad alarm and the alarm was not working. LVN 1 stated the battery for the alarm needed to be replaced. On 9/27/19 at 1:29 p.m., during an interview, the MDS nurse stated staff needed to check the pad alarm to ensure it work in order to prevent falls. The MDS indicated the sound of the alarm would remind the resident to be careful and to call for assistance. A review of Resident 1's Care Plan, titled "Pad Alarm," indicated to have pad alarm in bed and wheelchair. The plan was to monitor function of pad alarm during the 11 PM to 7 AM shift and as needed. A review of the facility's Policy and Procedure, titled "Personal Alarm," undated, indicated that the facility would use, as indicated, a sensor pad that conveniently sounds an audible alarm when the sensor detects a patient rising out of the bed/wheelchair reminding the resident to return to a safe position while alerting staff to a potential fall. The policy indicated to check the alarm system every day for proper functioning.	F 689		