accepted 6/11/19 JAH

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

PRINTED: 05/23/2019
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
	555071	A. BUILDING _____ B. WING _____	C 05/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYVIEW CARE CENTER	2000 W WASHINGTON BL LOS ANGELES, CA 90018

(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 Department of Public Health during an investigation of a Complaint during an Abbreviated Survey. Complaint Number: CA00630363. Representing the Department of Public Health: Surveyor ID: 34180 RN, HFEN The inspection was limited to the specific Complaint incidents investigated and does not represent the findings of a full inspection of the facility. One deficiency not related/related to original allegation was issued for Complaint CA00630363.	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 in this statement of deficiencies 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.	5/24/19
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility	F 842		

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JUN 03 2019
By _____

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE DON | (X6) DATE 5/31/19

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 842	Continued From page 1 must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law.	F 842	F-842 **Resident-identifiable information** Immediate Corrective Action Charge Nurse performed sweep on residents with accu-check to ensure glucose level was within normal baseline and blood sugar reading number was recorded as per glucometer. Measures to prevent recurrence The Director of Nursing provided in-service / re-education to Nurses on 5/24/2019 on the importance of change of conditions and proper way to perform/ read glucometer per M.D's orders. Residents with Accu-Check orders will be checked as per MD's order by Charge nurse.	

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F 842	Continued From page 2 §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.60. This REQUIREMENT is not met as evidenced by: Based on interview and closed record review, the facility failed to follow its policy and document a significant change for one of 3 sampled residents (Resident 1). Resident 1, who had a hypoglycemic (low blood sugar) episode that required a transfer to a general acute care hospital (GACH), was not doucmented in Resident 1's record as a change in condition (COC). This deficient practice placed Resident 1, and other residents at risk for lack of continuity of care. Findings: A review of Resident 1's Admission Records indicated the resident was initially admitted to the facility on 3/14/19 and last readmitted on 3/25/19. Resident 1's diagnoses included Type I diabetes mellitus (high sugar levels in the blood) and altered mental status (any measure of arousal other than normal). A review of Resident 1's Admission Assessment,	F 842	Identification of other residents and corrective actions Residents with Accu-Check orders have been randomly reviewed by Director of Nursing, and Medical records to ensure those residents with Diabetes are receiving accurate accu-check monitoring and coverage as per MD's order No other residents have been noted without a numerical reading by glucometer. Monitoring performance and integration into quality assurance system Director of nursing will do monthly random medication administration checks to ensure Charge Nurses are performing Accu-Checks as orders and License Nurses are in compliance with Facilities Policy and Procedure on glucose monitoring. Director Of Nursing will present findings to Q.A Team monthly times 90 days.	

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F 842	Continued From page 3 dated 3/15/19, indicated the resident was alert, oriented, readily answers questions and had quick comprehension (understanding). A review of Resident 1's plan of care, dated 3/15/19 and titled, "Diabetes Mellitus" indicated the staff's interventions included to monitor the resident for signs and symptoms of hypoglycemia and perform finger sticks/accuchecks (a blood glucose measuring device) as ordered. A review of a Nurses' Note, dated 3/17/19 and timed at 5 a.m., indicated Resident 1 was found in the bed breathing heavy with a low blood sugar. The note indicated Resident 1 was administered Glutose (an oral glucose gel)15 grams (gm) and 911(emergency services) was called when the resident became unresponsive. A review of Resident 1's COC, dated 3/22/19, indicated the resident had an episode of severe hypoglycemia and the physician was notified. On 4/9/19 at 12:25 p.m., during a concurrent observation and interview, Resident 1 was observed eating lunch with various beverages on his food tray that consisted of a cup of water, coffee and a small can of soda. Resident 1 stated he drinks plenty of water. On 5/20/19 at 3:15 p.m., during a concurrent interview and record review of Resident 1's clinical record, the Director of Nursing (DON) stated a resident's change in condition (COC) was only completed when a resident remains as an inpatient and was not completed when a resident was transferred to the hospital. The DON stated according to the Nurses' Note, dated 3/17/19 and timed at 5 a.m., Resident 1's blood	F 842		

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F 842	Continued From page 4	F 842		

sugar was low, which indicated when a resident had a low blood sugar below of 50 milligram per deciliter ([mg/dL] the normal reference range [NRR] is 70 and 130 mg/dL) or "high" blood sugar level greater than 500 mg/dL the accucheck machine indicated "low" or "high" as a result, but not a numerical value. During a concurrent interview of another record review of Resident 1's change of condition note dated 3/22/19 and timed at 6:40 a.m., indicated the resident's blood sugar was 24 mg/dL and was given glucogan (oral sugar solution). The DON did not provide a verbal response after being asked how does the staff obtain a blood sugar reading of 2 mg/dL.

A review of the facility's policy, dated 1/24/17 and titled, "Change of Condition," indicated a change of condition is a sudden or marked difference in resident's behavior (e.g. a change to lethargic (a feeling of sleepiness, sluggish or lack of energy), agitated (feeling or appearing troubled or nervous), anxiety (a reaction to stress characterized by symptoms of worriedness and panic), and/or non-responsive), level of consciousness and level of functioning. Any major or permanent change of condition shall require a new Resident Assessment Instrument (RAI).

A review of the facility's undated policy, titled "Daily Licensed Nurse's Notes," indicated meaningful and informative notes shall be written by a licensed nurse to reflect the care and treatment, observations and assessments and other appropriate entry.