POC Accepted 4/16/21 #35305

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

PRINTED: 04/12/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	556004	A. BUILDING _____ B. WING _____	C 04/12/2021

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

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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: CA00728749 Representing the California Department of Public Health: 36926, Health Facility Evaluator Nurse The inspection was limited to the specific complaint and does not represent the findings of a full inspection of the facility. One deficiency was written as a result of complaint number CA00728749	F 000	Playa Del Rey Center submits this response and Plan of Correction as part of the requirements under state and federal law. The plan of correction is submitted in accordance with specific regulatory requirements. It shall not be construed as admission of any alleged deficiency cited or any liability. The provider submits this plan of correction with the intention that it is inadmissible by any third party in any civil, criminal action or proceedings against the provider of its employee, agents, officers, directors, or shareholders.	
F 689 SS=G	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 ensure adequate supervision was provided to prevent accidents for one of three sampled residents (Resident 1). Resident 1, who had a high risk for falls and was dependent on staff for total care, was left unattended during care while the Certified Nursing Assistant (CNA 1) reached for care	F 689	The provider reserves the right to challenge the cited findings if at any time the provider determines that the disputed findings are relied upon in a manner adverse to the interests of the provider either by the governmental agencies or third party.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: ARNOLD DELANTAR, RN — TITLE: Director of Nursing — (X6) DATE: 4/16/2021

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 689	Continued From page 1 supplies and Resident 1 rolled off the bed to the floor and sustained injuries. This deficient practice resulted in Resident 1 sustaining a fracture (broken bone) femur (thigh bone), a skin tear (localized injury to the top layer of the skin when the skin is ripped open and peeled back) to the left elbow, and was transferred to a general acute care hospital (GACH). Resident 1 required a surgical repair of the right femur and intramedullary nail insertion (pieces of a broken bone are put into place using screws, plates, sutures, or rods to hold the broken bone together). Resident 1 required hospitalization from 3/10/21 to 3/15/21. Findings: During a review of Resident 1's Admission Record, the record indicated the resident was originally admitted to the facility on 8/24/19 and last re-admitted to the facility on 2/27/2021. Resident 1's diagnoses included: anemia (low number of red blood cells), age-related physical debility (lacking physical strength), dementia (a group of thinking and social symptoms that interferes with daily functioning), disorders of bone density (a low number of bone minerals), muscle weakness, abnormalities of gait and mobility, and a history of falling. During a review of Resident 1's Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 12/1/2020, the MDS indicated Resident 1's cognition (mental capacity to make decisions, ability to remember, learn, and understand) was moderately impaired. The MDS indicated Resident 1 required an extensive assistance with bed mobility, dressing, and total	F 689	F – 689 Free of Accident / Hazards / Supervision / Devices A. Immediate Corrective action for Resident identified as being affected. The facility will ensure that resident environment remains free of accident hazards and each resident receives adequate supervision and assistive devices to prevent accidents. Resident number 1 was readmitted to the facility on 3/15/2021. A fall assessment was done and determined that resident is a fall risk. Interventions in place include preparing all necessary items for ADL care readily available and within reach, proper turning and repositioning and provide continuous supervision of the resident throughout ADL care to ensure resident's safety.	

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F 689	Continued From page 2 assistance with toileting and bathing. According to the MDS, Resident 1 was always incontinent (inability to control) urine and bowels. During a review of Resident 1's Care Plan, dated 3/5/2021, the care plan indicated Resident 1 was at risk for decreased mobility to perform activities of daily living (ADLs), such as bathing, grooming, personal hygiene, bed mobility, transferring and toileting. The care plan indicated Resident 1 had a decline in cognitive function related to dementia and required assistance for mobility related to weakness. During a review of Resident 1's Physical Therapy ([PT], a trained and licensed medical professional with experience in diagnosing physical abnormalities, restoring physical function and mobility, and maintaining and promoting physical function), evaluation, dated 3/5/2021, the evaluation indicated Resident 1 was a fall risk due to age over 80, walk, and cognition, strength and balance impairment, and had impaired strength in both lower legs. The PT evaluation indicated Resident 1 needed moderate to maximum assist with bed mobility and maximum assistance of a two-persons with transfers. During a review of Resident 1's Admission Nursing Documentation, dated 2/27/2021, the nursing documentation indicated Resident 1 had a history of dementia, was confused and only oriented to person. According to the nursing document, Resident 1's decision making skills were severely impaired, had weakness and impairment in both lower legs, and was totally dependent for bed mobility, dressing/personal hygiene, bathing, and toileting.	F 689	B. Process of identifying other residents with potential to be affected. The Director of Nursing (DON) and MDS Coordinator reviewed the MDS 672 on 4/16/2021. A total of 24 residents who require maximum assistance or total dependence for ADLs for falls with major injury in the last 6 months. There were no other falls with major injury noted. C. Systemic measures to prevent recurrence. On 3/10/2021, a one-on-one in-service and competency check on dressing and undressing a resident was done by the Director of Staff Development (DSD) to CNA 1. In-service is on Safe Measures on ADL care which include include preparing all necessary items for ADL care readily available and within reach, proper turning and repositioning and provide continuous supervision of the resident throughout ADL care to ensure resident's safety.	

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F 689	Continued From page 3 During a review of Resident 1's Admission Nursing Assessment Outcomes, dated 2/27/2021, the assessment outcomes indicated Resident 1 was a fall risk. During a review of Resident 1's Bed Rail Evaluation, dated 2/27/2021, the bed rail evaluation indicated Resident 1 was at risk for falls, due to impaired mobility and dementia. The Bed Rail evaluation indicated Resident 1 was not able to move upper and lower extremities and no bed rails were recommended. During a review of Resident 1's Change in Condition (CIC) Evaluation, dated 3/10/2021 and timed at 11:15 a.m., the CIC evaluation indicated Resident 1 "fell from bed to floor and a malalignment (the bone is not aligned/connected with other bones and is not in proper placement) to the right knee was observed." The CIC evaluation indicated Resident 1 complained of 10/10 pain (0 being no pain and 10 being the worst possible pain) to the right leg and an attempt was made to administer pain medication as ordered, however, Resident 1 could not tolerate elevating the head of bed for the administration of the pain medication. The CIC evaluation indicated the X-ray results showed a midshaft (middle of the bone) femur fracture. Resident 1's physician (Physician 1) ordered Resident 1 to be transferred to the Emergency Department via 911 (emergency services). During a review of Resident 1's Prehospital Care Report Summary, dated 3/10/2021 and timed at 11:55 a.m., the Care Report Summary indicated upon arrival, the EMS personnel found Resident 1 lying in bed with a right femur fracture. The Care Report Summary indicated Resident 1 was	F 689	On 4/16/2021, the DSD gave an in-service to all nursing staff regarding Safe measures on ADL care which include preparing all necessary items for ADL care readily available and within reach, proper turning and repositioning and provide continuous supervision of the resident throughout ADL care to ensure resident's safety. D. How system changes will be monitored The DON, ADON, DSD and RN Supervisors will do random checks on CNAs providing ADL care to see if CNAs have all necessary items for ADL care readily available and within reach, proper turning and repositioning and provide continuous supervision of the resident throughout ADL care. Findings will be reported to the Administrator at the daily operations meeting. Administrator will track any trends or concerns and this will be communicated to the QA	

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F 689	Continued From page 4 injured while staff at the facility attempted to change her bedding. During a review of Resident 1's Nursing Progress Notes (NPN), dated 3/10/2021 and timed at 1:16 p.m., the NPN indicated the charge nurse reported Resident 1 had a fall incident, malalignment to right knee and Resident 1 complained of 10/10 pain. The report indicated Physician 1 was in the facility and was made aware of incident, ordered a STAT (immediate) x-ray and to send Resident 1 to a GACH via 911. The report indicated Paramedics (Emergency Medical Personnel) arrived at facility and administered 50 micrograms (mcg) of Fentanyl (a narcotic/controlled substance used to relieve moderate to severe pain) intramuscular ([IM], administered into the muscle) to Resident 1 and transferred Resident 1 to a GACH at 12:15 p.m., on 3/10/2021. During a review of Resident 1's Facility Transfer Form, dated 3/10/2021 and timed at 12:20 p.m., the transfer form indicated Resident 1's transfer to the GACH was unplanned due to a fall. The transfer record indicated Resident 1 was dependent with bathing, dressing, transfers, toileting, and was incontinent of bowel and bladder at the time of the transfer. During a review of Resident 1's Emergency Treatment Record from the GACH, dated 3/10/2021 and timed at 12:28 p.m., the treatment record indicated Resident 1 was transferred from the facility to the Emergency Department (ED), via Emergency Medical Services (EMS) personnel. Resident 1 rolled off the bed onto the floor while the nursing facility staff was changing the resident.	F 689	committee for further evaluation and recommendation monthly. If it is determined that we have accomplished the objective in the POC above and the results are successful, then the facility will consider the matter resolved. The QA committee will continue to review the deficiency has been proven to be resolved for 3 consecutive months and/or advised by the QA Committee. E. Date deficiency was corrected: 4/16/2021	

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F 689	Continued From page 5 During a review of Resident 1's ED provider notes, dated 3/10/2021, the provider notes indicated Resident 1's right leg was internally (facing toward the center of the body) rotated and Resident 1 had diffuse (wide-spread, covering a large area) tenderness to palpation (touching and tapping the skin over an area) over the lateral (side of leg) femur. The ED note also indicated Resident 1 had a skin tear over the top aspect of the elbow with tenderness to palpation. During a review of Resident 1's Inter-Facility Transfer Report from the GACH back to the facility, dated 3/15/2021, the transfer report indicated Resident 1 required surgery while in the GACH, a femoral intramedullary nail insertion on 3/11/2021. During a review of Resident 1's NPN for a Care Plan Meeting, dated 3/11/2021, the care plan meeting notes indicated the interdisciplinary team ([IDT], a group of health care professionals from diverse fields who work in a coordinated fashion toward a common goal for the patient) met to discuss the circumstances in regard to Resident 1's fall on 3/10/2021, which led to Resident 1 being transferred to a GACH. The meeting notes indicated CNA 1 was assigned to Resident 1 and was providing incontinence care. CNA 1 reached for an incontinence diaper and Resident 1 had a sudden movement while laying on her side during care and Resident 1 fell to the floor. During an interview on 3/11/2021 at 2:18 p.m., CNA 1 stated she was providing peri care (cleaning and care of the external genitalia and the anal area, referred to as perineal area) to Resident 1, she (CNA 1) turned to grab a diaper	F 689		

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F 689	Continued From page 6	F 689		

and a sheet from the table and Resident 1 fell to the floor while position on her side on the side of the bed. CNA 1 stated there were no rails on the side of the bed and she was by herself providing care. CNA 1 stated, "I don't know if she let go of the mattress and when I turned, Resident 1 was on the floor."

During an interview on 3/11/2021 at 4:04 p.m., Resident 2 (Resident 1's roommate) stated that she was in the same room as Resident 1 and CNA 1 was providing care to Resident 1 because Resident 1 needed a diaper change. Resident 2 stated she had her back turned to Resident 1 and was facing the closet but heard Resident 1 yell. Resident 2 stated, "It happened so quickly, I just heard her yell for help and then the CNA called for help and the staff came running in the room."

During an interview on 3/15/2021 at 11:51 a.m., CNA 2 stated she was working on 3/11/2021 and CNA 1 was working in Resident 1's room and she heard CNA 1 asking for help. CNA 2 stated she went inside Resident 1's room and saw Resident 1 laying on the floor. CNA 2 stated she stayed with Resident 1 while CNA 1 went to call for the charge nurse. CNA 2 stated when the charge nurse, Licensed Vocational Nurse (LVN 1) came into the room, CNA 1 and the LVN 1 put Resident 1 back into bed.

During an interview on 3/15/2021 at 12:10 p.m., Registered Nurse (RN 1) was asked what was the process she expects CNAs to use when performing pericare and diaper change. RN 1 stated, "You have to make sure the resident was safe." RN 1 stated there should be two nurses to help and one nurse needs to be close to the bedside. RN 1 stated the bed rails can be up if

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F 689	Continued From page 7 they have consent from family members, but not every resident had bed rails. RN 1 stated, "If there are two people available, it's better to use two people." RN 1 stated she was working on 3/11/2021 when Resident 1 fell. RN 1 stated CNA 1 told her the resident was on the floor. RN 1 stated when she arrived to Resident 1's room, the staff had already put Resident 1 back to bed. RN 1 stated LVN 1 was there and said Resident 1 had fallen. RN 1 stated Resident 1 complained of pain and her leg did not look straight. RN 1 stated Physician 1 was in the building, so she told him about Resident 1's fall and Physician 1 instructed her to get a STAT x-ray. RN 1 stated the x-ray technicians were in the building at that time with another resident, so they were able to come to Resident 1's room and do the x-ray. RN 1 stated when Physician 1 saw the x-ray he stated it showed a broken femur. CNA stated she turned the resident and the resident rolled from the bed and she fell on her right side. RN 1 stated Physician 1 instructed her to call 911 and have Resident 1 transferred to the hospital because the bone was broken. RN 1 stated the paramedics came and gave Resident 1 pain medicine and then put Resident 1 in a chair and took her to the hospital. During an interview on 3/15/2021 at 12:18 p.m., Physician 1 stated he was in the building on 3/11/2021 when Resident 1 fell. Physician 1 stated RN 1 came to him and told him Resident 1 had fallen out of bed. Physician 1 stated Resident 1 was having severe pain to her leg and the x-ray showed a right mid-shaft fracture. Physician 1 stated the x-ray technician could only take one view, because Resident 1 was in too much pain to move the leg. Physician 1 stated he observed Resident 1's right leg to be swollen	F 689		

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F 689	Continued From page 8	F 689		

(enlarged beyond normal size) mid shaft and looked broken. Physician 1 stated Resident 1 was alert, pleasant, and would interact, but was demented. Physician 1 stated the resident was 90% bedbound (confined to bed and unable to get out of bed without assistance, due to weakness or illness) and could not sit up in a wheelchair and needed extensive assist. Physician 1 was asked if the facility determined what was the cause of the fall, Physician 1 stated he was told during care, a hand was taken off Resident 1's side. Physician 1 stated, "You should always roll a patient towards you, not away from you." Physician 1 stated he thought the fall could have been prevented and Resident 1 was not very large. Physician 1 stated the resident had a regular bed mattress.

During an interview on 3/15/2021 at 12:28 p.m., with LVN 2, she was asked if the facility had any policies or procedures that indicated how the CNAs were supposed to position the residents during peri care, diaper changes, and/or bed baths, LVN 2 stated he did not know if there was anything specific to bed safety when the resident was in bed. LVN 2 stated, "If not, we can certainly do something like that." LVN 2 stated he would look again at the orientation checklists for CNAs.

During a concurrent observation and interview on 3/15/2021 at 12:40 p.m. of a reenactment of what happened, CNA 1 showed Resident 1's former room where the fall had taken place on 3/11/2021. CNA 1 stated Resident 1 been in the B bed and CNA 1 was standing on the left side of Resident 1 and used the sheet to pull Resident 1 towards her, then rolled Resident 1 onto her right side, towards the door. CNA 1 stated staff were

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F 689	Continued From page 9	F 689		

taught to roll the resident towards them and then face the resident away from them. When asked if there was anything that could have prevented the Resident from falling, CNA 1 stated, "I guess to try and hold the patient and at least use one hand. I had to let go of the resident to reach for the supplies."

During an interview on 3/15/2021 at 12:58 p.m., LVN 1 stated she was working on 3/11/2021 when Resident 1 fell. LVN 1 stated she was in the hallway, when CNA 1 came out of Resident 1's room yelling to her for help. LVN 1 stated she went to Resident 1's room with CNA 1 and saw Resident 1 laying in a supine position (faceup position on her back on the floor) between bed A and bed B. LVN 1 stated she asked Resident 1 if she was in pain and she said she was in pain and yelled, "I fell." LVN 1 stated she asked what happened and CNA 1 told her that she was providing care and she went to turn the resident and that was when the resident fell from the bed to the floor. LVN 1 stated that she, CNA 1 and CNA 2 got Resident 1 up and put her back to bed. LVN 1 stated they tried to lift the resident up in bed, but Resident 1 yelled, "My leg, my leg." LVN 1 stated she asked Physician 1 if she could give Resident 1 something for pain and Physician 1 ordered Tylenol (medication for mild to moderate pain) but stated when she attempted to sit Resident 1 up in order to swallow the medication, Resident 1 screamed. LVN stated Physician 1 and the Director of Nursing (DON) had decided to send the resident out to the hospital. The paramedics came, gave Resident 1 pain medication, and then transferred her to the hospital. When asked if the facility had provided any training on moving residents, LVN 1 stated, "That's standard education we went to school

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F 689	Continued From page 10 for." LVN 1 stated I know we have had inservices. During an interview on 3/15/2021 at 1:24 p.m. the physical therapist (PT 1) stated he had completed an evaluation on Resident 1 at the beginning of 3/2021. PT 1 stated Resident 1 required maximum assist in getting up in bed. During an interview on 3/15/2021 at 2:09 p.m., the Director of Staff Development (DSD), was asked how staff are orientated and trained to move residents during pericare and bed baths, the DSD stated they go over the competency list together and explain they should gather supplies before they close the curtain and make sure the resident was safe in bed. During an interview on 3/15/2021 at 2:12 p.m., with the Administrator (ADM), the ADM stated, the facility determined CNA 1 was changing the resident and during transition, as she reached for a clean diaper, the resident moved and fell to the floor. During a concurrent interview and record review on 3/15/2021 at 2:40 p.m., the DON stated a review of the facility's investigation of Resident 1's fall on 3/11/2021, indicated CNA 1 was working with Resident 1 at the bedside doing a diaper change and she turned to her left to grab a clean diaper and that split second was when the fall happened. The DON stated, "Resident 1 was a fall risk." The DON stated the facility make sure the right number of people (staff) helping the resident are on duty, and the residents' mental and functional status are considered. The DON stated that when the staff position a resident, staff should put the resident flat in bed and when staff	F 689		

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PLAYA DEL REY CENTER	7716 MANCHESTER AVENUE PLAYA DEL REY, CA 90293

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 11 put the resident on their side, staff need to make sure the resident ends up closer to the middle of the bed rather than the edge of the bed. When asked how the resident should be turned when performing care, the DON stated if the nurse turns the resident towards them the nurse would be quicker to respond. Then the DON stated that some nurses work in tandem (in a team of two) and some work alone. When asked if the CNAs should use two persons to turn a resident during pericare or diaper change when there was no side rail, the DON stated that if the staff asks, they can use two people. The DON stated she was not sure if the facility had a policy about working in tandem. During a review of the facility's policy and procedure (P/P), titled, " Falls Management," revised 2/18/2020, the P/P indicated the guidelines were not intended to replace the judgement and professional discretion of individual clinicians. During a review of the facility's job description for Certified Nursing Assistant (CNA), revised 6/27/17, the CNA job description indicated the CNA would deliver efficient and effective nursing care while achieving positive clinical outcomes and patient satisfaction. The job description indicated the CNA would assist patients [residents] with or perform activities of daily living(ADLs), assist residents with ambulation and transfers, and position residents in correct body alignment in and out of bed. The job description indicated the CNA would promote a culture of safety to ensure a healthy practice and living environment.	F 689		