STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055293	A. BUILDING _____ B. WING _____	C 09/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANTA ANITA CONVALESCENT HOSPITAL	5522 GRACEWOOD AVE. TEMPLE CITY, CA 91780

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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during the investigation of a Facility Reported Incident (FRI). Facility Reported Incident Number: CA00861581 Representing the Department: Health Facilities Evaluator Nurse: [redacted] The inspection was limited to the specific Facility Reported Incident investigated and does not represent the findings of a full inspection of the facility. One deficiency was identified for the Facility Reported Incident: CA00861581 (Refer to Ftag 604).	F 000	**Plan of Correction** The facility submits this plan of corrections as a proposal to ensure compliance with findings indicated on October 10, 2023 letter Santa Anita Convalescent – SNF makes its best effort in substantial compliance with both Federal and State Law. Preparation and/or execution of this Plan of Correction, inclusive of pages 1 through 7 of Form 2567 does not constitute an admission or agreement by the provider of the truth to the facts alleged or conclusions set forth in the Statement of Deficiencies. The facility submits this plan of correction is prepared and/or executed solely because it is credible allegation required by provisions of 42CFR 483, et seq., and Health and Safety Code 1280. In response to the Department's findings we submit the following Plan of Correction which shall constitute Santa Anita Convalescent Hospital's credible allegation of compliance.	
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and	F 604	**F 604 Physical Restraints** **How corrective actions(s) will be accomplished for those residents found**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 10/20/2023

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 604	Continued From page 1 any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure Certified Nurse Assistant 1 (CNA1) did not tie a sheet around the neck of one of three sampled Residents (Resident 1) and obtain a consent to place Resident 1 in a geriatric chair (gerichair) . These failures resulted in Resident 1 having difficulty breathing and coughing which had the potential to result in strangulation, entrapment, and injury, and resulted in Resident 1 not being treated with respect and dignity. Findings: A review of Resident 1 ' s admission record indicated Resident 1 was admitted to the facility on 1/21/22 with diagnoses that included seizures (sudden, uncontrolled body movements and changes in behavior that occur because of abnormal electrical activity in the brain), dysphagia (difficulty swallowing), autistic disorder (developmental disability caused by differences in	F 604	**to have been affected by the deficient practice:** 1.The bed sheet tied around Resident 1's neck was removed immediately by the Charge Nurse. 2. Resident 1 was reassessed by the RN Supervisor and resident was not in any respiratory distress. There was no evidence of cyanosis, redness, bruises or skin tear. Vital signs were within normal range and her 02 sat was at 98%. 3. Resident 1's attending physician and responsible party were notified of the incident. Allegation of abuse was reported to the three agencies according to facility's policy and procedure. 4. The care giver that tied the bed sheet around the resident's neck was counseled, educated and was sent home. 5. The attending physician was called and the order for the use of gerichair was clarified to indicate the resident's condition and consent to the use of gerichair was added on 9/25/23. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** 1. Residents in gerichairs are potentially affected by this deficient practice. 2. RN Supervisor and or Designee reviewed residents' clinical records identifying residents on gerichairs. The clinical records were reviewed to include the use of gerichair and the purpose for its use. There were no other residents affected by this deficient practice. '	

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F 604	Continued From page 2 the brain), and schizoaffective disorder (a mental illness that can affect your thoughts, mood, and behavior). A review of Resident 1's Order Summary Report dated 9/22/23, indicated an order dated 11/17/22 that Resident 1 may be up in a gerichair as tolerated. A review of Resident 1 ' s History and Physical Examination, dated 5/8/23, indicated Resident 1 did not have the capacity to understand and make decisions. A review of the Minimum Data Set (MDS, a standardized assessment and care-screening tool), dated 7/26/23, indicated Resident 1 ' s cognition (a mental process of acquiring knowledge and understanding) was severely impaired and Resident 1 was totally dependent on staff for bed mobility, transfers, locomotion off theunit, dressing and toilet use. The MDS further indicated Resident 1 required extensive assistance from staff for walking in the room, eating and personal hygiene and had no use of restraints. A review of Resident 1 ' s Progress Notes, dated 9/20/23 at 6:24 a.m., written by Licensed Vocational Nurse 1 (LVN 1) indicated Resident 1 was observed in the hallway with a bed sheet knotted around her neck and wrapped around her whole face and head, to the point where she was having difficulty breathing with coughing. During an observation on 9/21/23 at 12:10 p.m., in the dining room, Resident 1 was sitting in a gerichair in a reclined position, while she continued to move her arms aimlessly (without	F 604	3. An in-service was provided to licensed staff on 10/16/23 provided by Quality Assurance Nurses (QA) regarding the facility's policy and procedure on Restraints. It was explained to licensed nurses that residents shall be provided an environment that is restraint-free, unless a restraint is necessary to treat a medical condition in which case a less restrictive measure is used. It was also emphasized that a physical restraint is any physical or mechanical device, material, equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. It was also discussed when using a physical restraint will indicate the resident's condition and the purpose for its use. Care plans developed will have interventions that are resident centered. 4. Another in-service was provided to care givers on 10/16/23 by DSD regarding Health Insurance Portability and Accountability Act (HIPAA) emphasizing on protecting sensitive health information. **What measures will be put in place or what systemic changes the facility will make to ensure the deficient practice will not recur:** 1.Under the supervision of the Director of Nursing (DON), licensed nurses during admission, readmission, annually, quarterly, change of condition and as needed will ensure residents are assessed of their medical condition and the use of gerichair.	

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F 604	Continued From page 3 purpose or direction). Resident 1 was able to remove the bib that was placed on her chest. During an interview on 9/21/23 at 1:19 p.m. with LVN 1, LVN 1 stated she observed Resident 1 with a blanket sheet tied on the front and back of her neck. LVN 1 added that Resident 1 was sitting in her gerichair and was in the hallway when this happened. LVN 1 stated that Resident 1 was coughing and appeared bothered after the blanket was untied from her neck. During an interview on 9/21/23 at 2:36 p.m. with CNA 1, CNA 1 admitted that he tied a blanket around Resident 1 ' s back of neck. CNA 1 stated he did it because Resident 1 had the tendency to take off her blanket that was placed on her. CNA 1 stated that he did it to keep Resident 1 covered and warm. During a concurrent interview and review of the video footage of Resident 1 on 9/21/23 at 4:20 p.m. with Registered Nurse 1 (RN 1), of the apparent incident, Resident 1 was observed to have a blanket tied on her. RN 1 stated Resident 1 ' s head was covered with a white sheet and Resident 1 ' s left hand seemed to be grabbing the sheet to remove it. RN 1 stated Resident 1 was in a gerichair, in the hallway when he was summoned to check the incident that was reported to him by LVN 1 on 9/20/23. During an interview on 9/22/23 at 3:55 p.m. with LVN 2, LVN 2 stated he observed Resident 1 with a bed sheet covering her head and tied in the front of her neck. Resident 1 ' s whole head was covered, and the upper chest area had knot on the front. LVN 2 stated that it looked like a bed sheet bib covering the whole body.	F 604	2. The admitting nurse will complete the restraint assessment ensuring the use of physical restraints/gerichair is warranted informed consents are in place, purpose for its use care plans developed with resident centered interventions. 3. The DON/Designee will conduct clinical record reviews of new admissions, readmissions and will conduct a physical observation of residents ensuring the use of gerichair is warranted. Also, he/she will ensure that resident's environment remains as free of accident hazards as is possible, each resident receives adequate supervision and assistance devices to prevent accidents, provide the residents with the necessary care and services to attain or maintain the highest practicable physical, mental, psychosocial well-being, free of physical restraints imposed for purposes of discipline or convenience. 4. The DON/Designee when reviewing clinical records will ensure consents are in place on the use of physical restraints and care plans are developed with interventions that are resident centered. 5. Medical Records personnel when conducting daily audits of residents' clinical records will ensure care plans on change of condition are developed with interventions that are resident centered. 6. The Department Heads during their daily rounds will conduct observations on safety issues, ensuring necessary care and services provided appropriately. 7. The Quality Assurance Nurses during daily rounds will conduct observations of	

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F 604	Continued From page 4 During a concurrent record review of Resident 1's clinical records and interview with RN 1 on 9/22/23 at 4:25 p.m., RN 1 stated Resident 1 ' s use of a gerichair was not a restraint. RN 1 stated Resident 1's use of a gerichair was used for body positioning and to prevent falls. RN 1 stated Resident 1's use of a regular wheelchair was not appropriate for the resident because of her mental disorder, intellectual disabilities, functional impairment and falls. RN 1 was unable to recall if the use of regular wheelchair was attempted in the past. RN 1 stated Resident 1 tends to always crawl on the floor if she was placed on her bed inside the room, Resident 1 being in a gerichair and being in the hallway near the nurse station were one of the solutions that had so far worked in preventing fall incidents. RN 1 stated it was harder for Resident 1 to get out of the gerichair than being in bed. RN 1 stated Resident 1's physician's order for the use of gerichair did not indicate the resident's condition (reason or purpose for gerichair use) and it should have been clarified. RN 1 stated that Resident 1 ' s responsible party consented for device/restraint use of bilateral mats at the bed side to decrease potential injury related to constantly trying to get out of bed unassisted secondary to poor safety awareness. RN 1 stated the gerichair should have been added since the purpose was the same with applying bilateral mats. During an interview on 9/22/23 at 4:50 p.m. with MDS nurse (MDSN), the MDSN stated that gerichair use needs to have a consent. MDSN stated that gerichair is a device that limits movement, and that means it is considered as a restraint.	F 604	gerichairs, assess the residents' use of gerichair if warranted and likewise ensuring necessary care and services are provided to attain or maintain the highest practicable physical mental and psychosocial well-being. She will ensure safety of residents is provided by staff. She will also ensure the purpose of the gerichair's use is in the consent form. She will also ensure care plans are developed for any change of condition with resident-centered interventions. 8. Non -compliance will be discussed during the daily stand-up meeting and during the clinical rounds for a timely resolution. **How the facility plans to monitor its performance to make sure that solutions are sustained:** 1.Beginning 10/20/23, the DON/Designee is responsible for monitoring physician's orders on the use of gerichair will indicate resident's condition and the purpose for its use, consent forms will include its purpose, care plans will be developed with resident centered interventions. He/she will ensure the deficient practice will not be repeated. 2. The DON or Designee will provide the results of audits to the Quality Assurance Committee which in turn will be submitted and discussed during the monthly quality assurance meeting	

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F 604	Continued From page 5 During a concurrent interview and record review with the MDSN of Resident 1 ' s care plan on 9/22/23 at 5 p.m., the MDSN stated the care plan titled "The resident has a psychosocial wellbeing problem (potential) related to alleged physical abuse", initiated on 9/20/23, indicated interventions that included: a. Consult with pastoral care, social service, and psychologist services. b. Encourage participation from resident who depends on others to make own decisions. c. Increase communication between resident/family/caregivers about care and living environment. d. Initiate referrals as needed or increase social relationships. e. Monitor/document resident ' s usual response to problems: Internal - how individual makes own changes, External - expects others to control problems or leaves to fate or luck. f. Monitor/document residents ' feelings relative to isolation, unhappiness, anger, loss). The MDSN stated this was the only care plan initiated related to the incident on 9/20/23. The MDSN stated this care plan was not focused on the incident, and the interventions were not resident centered. The MDSN added that Resident 1 ' s care plan for the incident of alleged abuse on 9/20/23 should had included and indicated 72-hour monitoring for pain and respiratory problems since the change of condition indicated a choking observation from LVN 1. The MDSN also added that Resident 1 ' s care plan should have an intervention of monitoring for skin integrity on the neck area to make the care plan to be resident problem centered care plan.	F 604	for further recommendation and follow-up. 3. The Performance Improvement Committee will monitor the process every month for three months or until compliance is achieved. **Date of Completion: 10/20/23**	