STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056326	A. BUILDING _____ B. WING _____	C 12/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURLINGTON CONVALESCENT HOSPITAL	**845 S.BURLINGTON AVENUE LOS ANGELES, CA 90057**

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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: CA00874755 Representing the Department: Health Facilities Evaluator Nurse: 45455 . 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 number: CA00874755 (Refer to Ftag 689).	F 000	Disclaimer: The signing of this plan of correction is not an admission or agreement of 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 constitutes Facility's written credible allegation of compliance for the deficiencies noted.	
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 interview, and record review, the facility failed to ensure the residents ' environment remained free of accident hazards for one of three residents (Resident 1) by failing to ensure that a box of hand rubber gloves was not left within reach of a resident with a dementia (a decline in thinking skills). On 12/13/2023,	F 689	F689 Free of Accident Hazards/ Supervision/Devices Corrective Action Resident was transferred to the acute hospital on 12/13/23.	

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

Jeffrey Huang | Administrator | 1/19/24

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 Resident 1 developed acute (severe) sudden shortness of breath. This deficient practice resulted in Resident 1 was transferred to the General Acute Care Hospital (GACH 1) and during endotracheal intubation (a medical procedure in which a tube is placed into the windpipe through the mouth or nose) a rubber glove was found intraorally and was removed. Findings: A review of Resident 1 ' s admission record indicated, facility admitted the resident on 12/12/2023 with diagnoses which included urinary tract infection (UTI-infection of the urinary tract), vascular dementia (a decline in thinking skills caused by reduced blood flow to the brain) type 2 diabetes (a condition that affects the way the body processes blood sugar) and chronic kidney (organ that filters waste and excess fluid from the blood) disease (a gradual loss of kidney function). A review of Resident 1 ' s history and physical (H&P) dated 12/1/2023 indicated Resident 1 did not have the capacity to understand and make decisions. A review of Resident 1 ' s Minimum Data Set (MDS-a standardized assessment and care planning tool), dated, 12/5/2023 indicated Resident 1 ' s cognitive (mental ability to make decisions for daily living) was severely impaired and mobility (process for determining how much a patient can move). The MDS indicated Resident 1 required setup or clean up assistance for eating, and partial/moderate assistance for oral hygiene.	F 689	Identification of others at risk The Director of Nursing, the Director of Staff Development, and the RN Supervisor made rounds and checked the bedside of all the residents for gloves at the bedside. No others were affected. Process to prevent recurrence The Director of Nursing, the Assistant Director of Nursing, QA nurse, and Registered Dietician did in-service on 12/13/23, 12/27/23 and 1/10/24 on resident surrounding environment, safety precautions, change of conditions, proper assessment of resident with change of condition with an emphasis on shortness of breath which includes checking oral cavity to ensure nothing occluding resident's breathing. Nursing staff will conduct Q-shift rounds on the residents to ensure that the resident's environment remains as free of accident hazards as is possible.	

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F 689	Continued From page 2 A review of Resident 1 ' s medical record indicated Resident 1 was re-admitted to the facility on 12/12/2023 at 11:10 p.m. from an acute care hospital, Resident 1 was awake, responsive with even and unlabored breathing. Vital signs (measurement of the body ' s basic functions including temperature of 97.4, heart rate (HR) of 77 beats per minute, respirations of 19 breaths per minute, blood pressure (B/P) of 126/72, oxygen saturation (SpO2) of 98% and pain level of 0/10. Resident 1 had no complaints of pain, no discomfort, no facial grimace, no shortness of breath and no distress. A review of Resident 1 ' s nurses notes dated 12/13/2023 at 4:16 am indicated on 12/13/2023 at 3:45am, Resident 1 was observed sitting on the edge of the bed and had difficulty breathing. Resident 1 ' s vital signs were B/P :183/104, HR:111, SpO2: 75, Resident 1 was immediately started on 15 liters (L) of 02 by non-rebreather mask. SpO2 went up 88 but Resident 1 still appeared to have difficulty breathing. 911 (a phone number used to contact emergency services) was called by supervisor (RN2) at3: 59a.m. Paramedics arrived and assessed Resident 1 at 4:05a.m. Paramedic transferred Resident 1 to the Acute care for higher level of care. A review of Resident 1 ' s GACH Emergency Room (ER) admission records dated 12/13/2023, indicated Resident 1 was found to be in respiratory distress, and subsequently taken to the ER. The GACH records indicated that on arrival to the ER patient had a cardiac arrest (heart suddenly and unexpectedly stops beating), when Resident 1 was being endotracheally intubated (a medical procedure in which a flexible	F 689	Monitoring Performance Department heads will conduct CQI room rounds two times a week x 3 months to ensure resident surrounding environment follows proper safety precautions. The recapitulations of the rounds will be presented by the administrator to the monthly QAA committee for review and action as necessary then quarterly until compliance.	1/19/24

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F 689	Continued From page 3	F 689		

tube is inserted through the mouth or nose and into the windpipe to establish and maintain an open airway) a rubber hand glove was found in intraorally (inside the mouth) in the posterior pharynx (back of the throat). After intubation patient had a return of spontaneous circulation (ROSC).

During an interview on 12/14/2023 at 10:20 a.m., Assistant Director of Nursing (ADON) stated, Resident 1 was admitted to the facility on 12/12/2023 at approximately 11p.m. and was transferred out to GACH1 for a higher level of care after developing sudden shortness of breath that could not be corrected with supplemental oxygen. The ADON stated two police officers arrived at the on 12/13/2023 at 8:30 a.m., Police officers asked ADON if an elderly female Resident was transferred by the facility to GACH1, ADON stated she acknowledged to the Police that Resident 1 was transferred to Acute care, Police asked why the Resident was transferred to the hospital, ADON stated she told the Police Resident 1 developed shortness of breath and that is why she was sent to the hospital for higher level of care. ADON states the Police informed ADON that GACH1 reported to the Police that Resident 1 was found with a glove in her mouth when she (Resident 1) arrived and was assessed in the emergency room. ADON stated Police asked to be shown the room where Resident 1 was residing, ADON states she accompanied the Police to Resident 1 ' s room, the Police observed an open hand glove box by Resident 1 ' s nightstand and then the Police left the facility.

During an interview on 12/14/2023 at 10:53 a.m., Director of Nursing (DON) stated Resident 1 had

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F 689	Continued From page 4	F 689		

been a resident at the facility for a long time and had just been re-admitted to back to the facility on 12/12/2023 at 11:10 p.m. from GACH2 where the resident was transferred after a fall and possible fracture on 12/5/2023 for a higher level of care. DON stated Resident 1 was admitted and assessed immediately after re-admission to the facility and was medically stable (conscious and comfortable with vital signs within normal limits). DON stated Resident 1 developed sudden shortness of breath at 3:30 a.m. (4.5 hours after admission) and became hypoxic (low levels of oxygen in the body tissues, causing changes in breathing with oxygen saturation of 75%) normal oxygen saturation is between 95%-100%. Resident 1 was immediately started on supplemental oxygen (a colorless odorless gas used as a safe and standard medical treatment for low blood oxygen), Resident 1 ' s oxygen levels improved slightly to 88% but was not therapeutic enough resolve the effects of low oxygen levels. Emergency services were called, paramedics arrived at the facility and assessed Resident 1 then transferred Resident 1 to GACH 1 for higher level of care.

On 12/14/2023 at 11:30 a.m. during a telephone interview with Registered Nurse 1 (RN1), RN1 stated Resident 1 was re-admitted to the facility at 11:10 p.m. by the supervisor (RN2), RN1 states, Resident 1 seemed confused but was not short of breath, RN1 states Resident 1 spoke to her in their native language stating that she (Resident 1) needed to go to the bathroom despite having a foley catheter (a flexible plastic tube inserted into the bladder to provide continuous urinary drainage), Resident 1 also stated to RN1 that someone was calling her and that she (Resident 1) needed to go home. RN1

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F 689	Continued From page 5	F 689		

states she kept a close watch on Resident 1 because of Resident 1 history of falls and dementia diagnosis. RN 1 stated at 3a.m., she (RN1) and Certified Nurse Assistant (CNA1) helped Resident 1 put on incontinence brief. RN1 gave Resident 1 some water, Resident 1 swallowed the water without difficulty.
RN1 stated at 3:45 a.m. she (RN1) checked on Resident 1 and observed her (Resident 1) seated on the edge of the bed on the left side, Resident 1 looked like she was going to stand up. RN1 assisted Resident 1 back to bed, adjusted her foley catheter, and raised the head of her bed because she observed Resident 1 to be out of breath. RN1 stated Resident 1 had her mouth open, was trying to breath but was not coughing or holding her neck as if to signal she was choking.

RN1 states she called RN2, RN2 placed Resident 1 on 15 liters (l) of oxygen per min (l/min) via a non-rebreather mask (a device used to give oxygen in an emergency) 911 was called. Paramedics arrived, assessed Resident 1, and transferred her to the hospital for a higher level of care.

On 12/19/2023, at 10:27 a.m. during a telephone interview, MD1 stated if a Resident was to develop a sudden onset of acute shortness of breath, he would expect facility to assess vital signs, perform a physical assessment including heart and lungs sounds, assess resident ' s mental status and check oral cavity to ensure there is nothing occluding resident breathing.

On 12/20/2023, at 1:35 p.m. during a telephone interview, MD2 stated Resident 1 was brought to ER via ambulance, upon arrival, MD2 states

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F 689	Continued From page 6 Resident 1 ' s mouth was closed, Resident was not alert, was not coughing, appeared weak and unstable, was unable to speak, Resident 1 ' s blood pressure dropped, Resident 1, became unresponsive, went into cardiac arrest and when she (Resident 1) was being endotracheally intubated, a rubber glove was found intraorally and was removed. After intubation Resident 1 had return of spontaneous circulation (ROSC). MD2 further stated the glove was (off white) opaque in color and was not the rubber kind used in the hospital. A review of the facility's policy and procedure, titled "Safety and Supervision of Resident" revised July 2017 under subtitle "individualized, Resident-Centered Approach to safety" states facility individualized, resident-centered approach to safety addresses safety and accident hazards for individual resident. Policy further states, interdisciplinary care team shall analyze information obtained from assessment sand observations to identify specific accidents hazards or risks for individual residents.	F 689		