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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055744	A. BUILDING _____ B. WING _____	C 07/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLANTIC MEMORIAL HEALTHCARE CENTER	2750 ATLANTIC AVE. LONG BEACH, CA 90806

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F 000	INITIAL COMMENTS The following reflects the findings of the Department of Public Health during a complaint investigation. Complaint Number: CA00443043. Representing the Department of Public Health: HFEN # 33670 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 issued for complaint number CA00443043.	F 000	Preparation and or execution of this Plan of Correction does not constitute admission and/or agreement by Atlantic Memorial Healthcare Center of the facts alleged and/or conclusion set forth on this Statement of Deficiencies. This Plan of Correction is prepared and/or executed because the provisions of Health and Safety Code, Section 1250 and 42 Code of Federal Regulations 405.1907 requires it.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment	F 279	***F 279*** ***Immediate Corrective action(s) for resident(s) found to have been affected by the deficient practice:*** Resident 1 was discharged January 1, 2015. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken;*** Four (4) residents which had the potential to be affected by this deficient practice were reviewed for the presence of care plan and documentation addressing the MD order. Care plan was updated as indicated.	8/2/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 8/3/17

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 279	Continued From page 1 under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop a comprehensive plan of care for one of three sampled residents (Resident 1). This deficient practice resulted in Resident 1 not receiving the necessary respiratory care and treatment. Findings: A review of Resident 1's record titled, "Admission Record," indicated Resident 1 was admitted to the facility on 12/28/14, with diagnoses that included cerebral artery occlusion with infarct (an area of dead tissue in the brain resulting from lack of blood supply) and history of aspiration (breathing foreign materials usually food, liquids, and vomit [stomach contents] into the lungs or airways) pneumonia (infection of the lungs). A review of Resident 1's record titled, "Order Summary Report," dated 12/28/14, at 9:56 p.m., indicated to suction Resident 1 as needed for increased secretions and assess lungs for signs and symptoms of aspiration every shift. A review of Resident 1's record titled, "Care Plan," dated 12/30/14, indicated Resident 1 required tube feeding related to swallowing problem and to prevent aspiration. The interventions included for the facility staff to monitor and report to the physician abnormal breath sounds. There was no plan of care developed to address Resident 1's respiratory	F 279	***What measures and/or systemic changes will be made to ensure that the deficient practice does not recur; process to prevent recurrence:*** The DON/Designee in-serviced the licensed nurses on 7/25/17 regarding care planning and assessments, and respiratory care. The DON/Designee will review new admissions to check for any special care needs in regards to respiratory treatments and/or suctioning five times a week for three month to ensure that appropriate respiratory care plan are in place. "New Admission Audit Form – Special Needs" will be used to ensure compliance with these reviews. ***How the corrective action(s) will be monitored to ensure that solution are sustained and deficient practice will not recur, i.e. POC integration into Quality Assurance Program to evaluate effectiveness:*** Medical Records will conduct 8-day, 15-day and quarterly audit on new residents' records for care plan completion. Deficiencies will be reported to DON/designee weekly for review and completion.	

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F 279	Continued From page 2 care for respiratory assessments and needed suctioning. There was no plan of care to address interventions to be implemented when Resident 1's oxygen saturation (blood oxygen level) decreased and experienced shortness of breath. A review of Resident 1's record titled, "Minimum Data Set (MDS, a resident assessment and care screening tool), dated 1/1/15, indicated Resident 1 was unable to speak, rarely or never able to express ideas, sometimes able to understand others and had severe cognitive (mental abilities) impairment (rarely or never made decisions). The MDS indicated Resident 1 required extensive assistance (resident involved in activity and staff provided weight-bearing support) with one person assistance with activities of daily living. The MDS indicated Resident 1 had limitation in range of motion (the distance and direction a joint can move to its full potential) on all extremities. A review of Resident 1's hospital record titled, "ED Notes," dated 1/1/15, at 10:46 a.m., indicated Resident 1 was brought to the ED by the paramedics with shortness of breath and agonal respiration (gasping for breath) with respiratory desaturation (low oxygen level in the blood) of 70% (normal range 90-100%) and was intubated for respiratory distress/failure and was transferred to the intensive care unit. A review of Respiratory Therapist 1's (RT 1) documentation on the ED Notes, dated 1/1/15, at 1:11 p.m., that during Resident 1's intubation, there was a large amount of thick gelatinous material (secretions) obstructing Resident 1's airway. A review of Resident 1's hospital record titled,	F 279	Results of the special needs audit and Medical Records audit will be reported to the QA&A Committee for review and advisement monthly for three months, and then quarterly for six (6) months. Correction Completion date: 8/2/17	

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F 279	Continued From page 3 "Discharge Summary," dated 1/12/15, indicated Resident 1 was discharged to the subacute facility with diagnoses that included acute respiratory failure secondary to aspiration with very thick semi-solid nasal (nose) oropharyngeal (mouth and throat) secretions with recent stroke and severe dysphagia and was extubated (removed from respirator [machine designed to assist or replace normal breathing]). A review of Resident 1's Nursing Progress Notes, MAR, and care plans for 12/28/14 to 1/1/15, conducted with Registered Nurse 1 (RN 1) on 5/29/15, at 11:50 a.m., RN 1 stated she could not find documentation regarding color and amount of Resident 1's secretions and the quality of breath sounds. RN 1 stated the nursing staff should have assessed Resident 1's breath sounds and suctioned secretions as needed according to the physician's order. RN1 stated she could not find a plan of care for respiratory care to address suctioning and assessing breath sounds. During an interview on 6/15/17, at 2:30 p.m., the Director of Nursing (DON) stated the nursing staff should have assessed Resident 1 for respiratory problem such as listening to the breath sounds, suctioning Resident 1 when necessary, and documenting the amount, color, and thickness of the secretions. The DON stated Resident 1 should have been assessed if secretions were in the upper (from the nose down to the folds of the vocal cord) or lower respiratory tract (from the vocal cord down to the lungs) needing deep suctioning (the use of a smaller suction catheter to reach down into the resident's airway). The DON stated Resident 1's vital signs (heart rate, body temperature, respiration rate, and blood	F 279		

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F 279	Continued From page 4 pressure [the strength of the blood pushing against the sides of the blood vessels]), including the blood oxygenation level should have been assessed. A review of the facility's policy and procedures titled, "Care Planning," dated 5/2007 indicated it is the policy of the facility that the Interdisciplinary Team (IDT, a group consisting of the head of the different departments who work together to discuss a resident's care) develop a comprehensive plan of care for each resident.	F 279		
F 328 SS=G	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide respiratory care by consistently assessing breath sounds and suctioning respiratory secretions every shift from 12/28/14 to 1/1/15, as ordered by the physician and in accordance with facility policy and procedures for one of three sampled residents (Resident 1).	F 328	***F 328*** ***Immediate Corrective action(s) for resident(s) found to have been affected by the deficient practice:*** Resident 1 was discharged January 1, 2015. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken;*** Four (4) residents which had the potential to be affected by this deficient practice were assessed for breath sounds, the presence of care plan and documentation addressing the MD order. Clarification and	8/2/17

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F 328	Continued From page 5 As a result of this deficient practice, Resident 1 was admitted in the emergency department (ED) with acute (sudden) respiratory failure (failure of the lungs to provide adequate oxygen to the body) due to thick semi-solid gelatinous secretions that blocked the airway and required emergency intubation (placement of a tube into the windpipe to maintain an open airway), intensive care (care to manage a life threatening condition) monitoring and hospitalization for 12 days. Resident 1 was discharged to a subacute (a level of care needed by a resident who does not require hospital care, but who requires more intensive skilled nursing care than is provided to the majority of residents in a skilled nursing facility) facility. (Cross reference to F279) Findings: A review of Resident 1's record titled, "Admission Record," indicated Resident 1 was admitted to the facility on 12/28/14, with diagnoses that included cerebral artery occlusion with infarct (an area of dead tissue in the brain resulting from lack of blood supply). A review of Resident 1's record titled, "Order Summary Report," dated 12/28/14, at 9:56 p.m., indicated to suction Resident 1 as needed for increased secretions and assess lungs for signs and symptoms of aspiration (breathing foreign materials usually food, liquids, and vomit [stomach contents] into the lungs or airways) every shift. A review of Resident 1's record titled, "History and Physical," dated 12/29/14, indicated Resident 1 had a large cerebrovascular accident (CVA, the	F 328	revision was done to reflect residents' current plan of care. ***What measures and/or systemic changes will be made to ensure that the deficient practice does not recur; process to prevent recurrence:*** The DON/Designee in-serviced the licensed nurses on 7/25/17 regarding respiratory care and suctioning. The DON/Designee will review new admissions to check for any special care needs in regards to respiratory treatments and/or suctioning five times a week for three months. In addition, the resident's clinical record will be reviewed for respiratory care plan, appropriate documentation and to verify the respiratory orders are being carried out as prescribed. "New Admission Audit Form – Special Needs" will be used to ensure compliance with these reviews. Skills check for licensed nurses will be done upon hire, within 90-days, and annually regarding respiratory care by DON/Designee.	

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F 328	Continued From page 6 sudden death of brain cells due to lack of oxygen supply) with right hemiplegia (unable to move the right side of the body) and dysphagia (difficulty swallowing). A review of Resident 1's record titled, "Physician's Progress Notes," dated 12/30/14, indicated Resident 1 had severe diminished breath sounds at the bases of the lungs and completed seven-day antibiotic therapy for treatment of aspiration pneumonia (infection of the lungs due to aspiration). A review of Resident 1's record titled, "Care Plan," dated 12/30/14, indicated Resident 1 required tube feeding related to swallowing problems and to prevent aspiration. The interventions included for the facility staff to monitor and report to the physician abnormal lung sounds. There was no plan of care developed to address Resident 1's respiratory care for respiratory assessments and needed suctioning. A review of Resident 1's record titled, "Nursing Progress Notes," dated 12/31/14, at 11:02 p.m., indicated Resident 1's breath sounds had rales (breath sounds that indicate presence of fluids or secretions in the lungs); the physician was informed and ordered to increase the frequency of the breathing treatment medication. A review of Resident 1's record titled, "Order Summary Report," dated 12/31/14, at 11:14 p.m., indicated a telephone order to increase Ipratropium-Albuterol solution 0.5-2.5 milligrams/ 3 milliliters, inhale orally every six hours as needed for shortness of breath. A review of Resident 1's record titled, "Minimum	F 328	***How the corrective action(s) will be monitored to ensure that solution are sustained and deficient practice will not recur, i.e. POC integration into Quality Assurance Program to evaluate effectiveness:*** Results of the special needs audit will be reported to the QA&A Committee for review and advisement monthly for three months, and then quarterly for six (6) months. Correction Completion date: 8/2/17	

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F 328	Continued From page 7 Data Set (MDS, a resident assessment and care screening tool), dated 1/1/15, indicated Resident 1 was unable to speak, rarely or never able to express ideas, sometimes able to understand others and had severe cognitive (mental abilities) impairment (rarely or never made decisions). The MDS indicated Resident 1 required extensive assistance (resident involved in activity and staff provided weight-bearing support) with one person assistance with activities of daily living. The MDS indicated Resident 1 had limitation in range of motion (the distance and direction a joint can move to its full potential) on all extremities. A review of Resident 1's Nursing Progress Notes, dated 1/1/15, indicated the following: 1. At 10:15 a.m., Resident 1 had shortness of breath (SOB) and Resident 1's family member (FAM 1) was informed and agreed to provide Resident 1 with oxygen and perform cardiopulmonary resuscitation (CPR, an emergency procedure performed to preserve the brain function and to restore blood circulation and breathing), but no intubation. 2. At 10:45 a.m., Resident 1's physician was informed. 3. At 10:55 a.m., Resident 1 was awake, alert to name with shortness of breath, oxygen saturation (a measurement of oxygen level in the blood, normal blood oxygen level is 90-100 percent [%]) of 82 %. Oxygen was administered using a non-rebreathing mask (mask that provides oxygen at a high rate and high level) at 10 liters per minute (LPM) and the oxygen saturation increased to 98%. FAM 1 was informed of Resident 1's progress and agreed to transfer	F 328		

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F 328	Continued From page 8 Resident 1 to the hospital by 9-1-1 (an emergency phone number). A review of Resident 1's Nursing Progress Notes, dated from 12/28/14, and 1/1/15, did not indicate evidence that Resident 1 was consistently assessed for breath sounds, reassessed for effectiveness of breathing treatments, suctioned for increased secretions, and assessed for character of secretions, amount, color, and thickness. A review of Resident 1's record titled, "Medication Administration Record (MAR)," from 12/28/14 to 1/1/15, there were no nurses' initials to indicate suctioning every shift were provided to Resident 1. A review of Resident 1's hospital record titled, "ED Notes," dated 1/1/15, at 10:46 a.m., indicated Resident 1 was brought to the ED by the paramedics with shortness of breath and agonal respiration (gasping for breath) with respiratory desaturation (low oxygen level in the blood) of 70% (normal range 90-100%) and was intubated for respiratory distress/failure and was transferred to the intensive care unit. A review of Respiratory Therapist 1's (RT 1) documentation on the ED Notes, dated 1/1/15, at 1:11 p.m., that during Resident 1's intubation, there was a large amount of thick gelatinous material (secretions) obstructing Resident 1's airway. A review of Resident 1's hospital record titled, "Discharge Summary," dated 1/12/15, indicated Resident 1 was discharged to the subacute facility with diagnoses that included acute	F 328		

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F 328	Continued From page 9	F 328		

respiratory failure secondary to aspiration with very thick semi-solid nasal (nose) oropharyngeal (mouth and throat) secretions with recent stroke and severe dysphagia and was extubated (removed from respirator [machine designed to assist or replace normal breathing]).

A review of Resident 1's Nursing Progress Notes, MAR, and care plans for 12/28/14 to 1/1/15, conducted with Registered Nurse 1 (RN 1) on 5/29/15, at 11:50 a.m., RN 1 stated she could not find documentation regarding color and amount of Resident 1's secretions and the quality of breath sounds. RN 1 stated the nursing staff should have assessed Resident 1's breath sounds and suctioned secretions as needed according to the physician's order. RN1 stated she could not find a plan of care for respiratory care to address suctioning and assessing breath sounds.

During an interview on 4/11/16, at 10:15 a.m., FAM1 stated she visited Resident 1 every day and she did not see the facility staff suction Resident 1 during her visits and she noticed the container for the suction machine (a machine used to remove respiratory secretions) was always empty.

During an interview on 6/15/17, at 2:30 p.m., the Director of Nursing (DON) stated the nursing staff should have assessed Resident 1 for respiratory problems such as; listening to the breath sounds, suctioning Resident 1 when necessary, and documenting the amount, color, and thickness of the secretions. The DON stated Resident 1 should have been assessed if secretions were in the upper (from the nose down to the folds of the vocal cord) or lower respiratory tract (from the

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F 328	Continued From page 10 vocal cord down to the lungs) needing deep suctioning (the use of a smaller suction catheter to reach down into the resident's airway). The DON stated Resident 1's vital signs (heart rate, body temperature, respiration rate, and blood pressure [the strength of the blood pushing against the sides of the blood vessels]), including the blood oxygenation level should have been assessed. A review of the facility's policy and procedures, dated 5/2007, titled, "Care of Resident with respiratory secretions," indicated it is the policy of the facility to clear the airway of obstructing secretions and prevent aspiration. The facility will evaluate and assess the resident for signs and symptoms of impaired respiratory function, assess breath sounds, significant decrease in oximetry results (a device placed in the finger and detects how much oxygen is in the blood), to call MD (medical doctor) and discuss respiratory changes, and provide suctioning as needed.	F 328		