STATEMENT OF DEFICIENCIES

PRINTED: 07/24/2017 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

IDENTIFICATION NUMBERS PECTIO BUILDINGS TON COMPLETED AND PLAN OF CORRECTION ADMINISTRATION B. WING 055744 07/24/2017 -4 AM STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER RECEIVED. 2750 ATLANTIC AVE. ATLANTIC MEMORIAL HEALTHCARE CENTER LONG BEACH, CA 90806 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES . (X5) COMPLETION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 000 F 000 INITIAL COMMENTS The following reflects the findings of the Department of Public Health during a complaint Preparation and or execution of this Plan of investigation. Correction does not constitute admission and/or agreement by Atlantic Memorial Complaint Number: CA00443043. Healthcare Center of the facts alleged and/or conclusion set forth on this Representing the Department of Public Health: Statement of Deficiencies. This Plan of HFEN # 33670 Correction is prepared and/or executed because the provisions of Health and The inspection was limited to the specific Safety Code, Section 1250 and 42 Code of complaint investigated and does not represent Federal Regulations 405.1907 requires it. the findings of a full inspection of the facility. Two deficiencies were issued for complaint F 279 number CA00443043. 8/2/17 F 279 F 279 483.20(d), 483.20(k)(1) DEVELOP Immediate Corrective action(s) SS=D COMPREHENSIVE CARE PLANS for resident(s) found to have been affected by the deficient A facility must use the results of the assessment practice: to develop, review and revise the resident's comprehensive plan of care. Resident 1 was discharged January 1, 2015. The facility must develop a comprehensive care plan for each resident that includes measurable How other residents having the objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial potential to be affected by the needs that are identified in the comprehensive same deficient practice will be identified and what corrective assessment. action will be taken: The care plan must describe the services that are to be furnished to attain or maintain the resident's Four (4) residents which had the highest practicable physical, mental, and potential to be affected by this psychosocial well-being as required under deficient practice were reviewed for §483.25; and any services that would otherwise the presence of care plan and be required under §483.25 but are not provided documentation addressing the MD due to the resident's exercise of rights under order. Care plan was updated as §483.10, including the right to refuse treatment indicated. LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION

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.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
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	•	055744	B. WING				07/	24/2017
NAME OF PROVIDER OR SUPPLIER ATLANTIC MEMORIAL HEALTHCARE CENTER				2750 ATL	DDRESS, CITY, STATE, ZIP ANTIC AVE. EACH, CA. 90806	CODE .		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x 1. (PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO ROSS-REFERENCED TO TH DEFICIENCY)	ON SHOULD IE APPROPR	BE	(X5) COMPLETION DATE
F 279	Continued From pa under §483.10(b)(4 This REQUIREME	_	F2	chai that not	at measures and/or nges will be made t the deficient prac recur; process to urrence:	to ensu	<u>re</u> es	
	failed to develop a	w and record review, the facility comprehensive plan of care mpled residents (Resident 1).		licen rega	DON/Designee in-sensed nurses on arding care plantessments, and respira	7/25/ <i>*</i> ning ar	17 . nd	
	This deficient practice receiving the nece treatment. Findings:	tice resulted in Resident 1 not ssary respiratory care and		adm care	DON/Designee will raissions to check for a needs in regards to the transfer and/or sucti	any speci respirato	al ry	
	A review of Reside Record," indicated the facility on 12/2 included cerebral a area of dead tissue lack of blood supp	ent 1's record titled, "Admission Resident 1 was admitted to 8/14, with diagnoses that artery occlusion with infarct (an e in the brain resulting from by) and history of aspiration		ensu care Adm Need com	s a week for three ure that appropriate plan are in planission Audit Form ds" will be used pliance with these revertive active active.	respirato ace. "Ne - Speci to ensu- views.	ry w al re	
	and vomit [stomac airways) pneumon	materials usually food, liquids, h contents] into the lungs or ia (infection of the lungs). Int 1's record titled, "Order		be solu defic	monitored to ensition are sustain cient practice will proceed to the process of t	sure the ned an not recu	at d r.	
	Summary Report," indicated to suction increased secretion	dated 12/28/14, at 9:56 p.m., n Resident 1 as needed for ns and assess lungs for signs aspiration every shift.		Assu effect Medi	urance Program to ctiveness: ical Records will concay and quarterly audi	evalua duct 8-day	<u>'e</u>	
	Plan," dated 12/30 required tube feed problem and to preinterventions include monitor and report breath sounds. The	Int 1's record titled, "Care /14, indicated Resident 1 ing related to swallowing event aspiration. The ded for the facility staff to to the physician abnormal ere was no plan of care ess Resident 1's respiratory		resid comp repoi	lents' records for care pletion. Deficiencies writed to DON/designed eview and completion	e plan will be e weekly		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		E CONSTRUCTION .	(X3) DATE SURVEY COMPLETED		
		055744	B. WING		·	07/2	24/2017
NAME OF PROVIDER OR SUPPLIER			•	ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
ATLANTI	IC MEMORIAL HEAL	THCARE CENTER		L	ONG BEACH, CA 90806	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL SE DENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE .	(X5) COMPLETION DATE
F 279	suctioning. There interventions to be 1's oxygen saturat	age 2 y assessments and needed was no plan of care to address implemented when Resident ion (blood oxygen level) perienced shortness of breath.	F:	279	Results of the special needs audi and Medical Records audit will be reported to the QA&A Committee for review and advisement month for three months, and then quarte for six (6) months.	e ily	
·	Data Set (MDS, a screening tool), data 1 was unable to spexpress ideas, sor others and had se impairment (rarely The MDS indicate assistance (reside provided weight-be assistance with accindicated Residen	ent 1's record titled, "Minimum resident assessment and care ated 1/1/15, indicated Resident beak, rarely or never able to metimes able to understand vere cognitive (mental abilities) or never made decisions). It is desident 1 required extensive ent involved in activity and staff earing support) with one person tivities of daily living. The MDS to 1 had limitation in range of			Correction Completion date: 8/2/	17	
	move to its full pot	ce and direction a joint can ential) on all extremities.					
	"ED Notes," dated Resident 1 was br paramedics with s respiration (gaspir desaturation (low of 70% (normal rang	ent 1's hospital record titled, 1/1/15, at 10:46 a.m., indicated ought to the ED by the hortness of breath and agonal ng for breath) with respiratory oxygen level in the blood) of e 90-100%) and was intubated ress/failure and was transferred re unit.					
	documentation on 1:11 p.m., that dur there was a large material (secretion airway.	ratory Therapist 1's (RT 1) the ED Notes, dated 1/1/15, at ing Resident 1's intubation, amount of thick gelatinous as) obstructing Resident 1's					
	A review of Reside	ent 1's hospital record titled,			·		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
•	•	055744	B. WING			07/24	1/2017
NAME OF PROVIDER OR SUPPLIER ATLANTIC MEMORIAL HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE 2750 ATLANTIC AVE. LONG BEACH, CA 90806			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ACTION SHOULD I IO, THE APPROPR	BE	(X5) COMPLETION DATE
F 279	Resident 1 was di	page 3 nary," dated 1/12/15, indicated scharged to the subacute bases that included acute	F 2	279	٠.		
	very thick semi-so (mouth and throat and severe dysph (removed from re	secondary to aspiration with blid nasal (nose) oropharyngeal c) secretions with recent stroke agia and was extubated spirator [machine designed to normal breathing]).					
	MAR, and care pl conducted with R 5/29/15, at 11:50 find documentation of Resident 1's set breath sounds. R should have asset sounds and suction according to the p	ent 1's Nursing Progress Notes, ans for 12/28/14 to 1/1/15, egistered Nurse 1 (RN 1) on a.m., RN 1 stated she could not on regarding color and amount ecretions and the quality of N 1 stated the nursing staff ssed Resident 1's breath oned secretions as needed obysician's order. RN1 stated	-				
	she could not find care to address s sounds.	a plan of care for respiratory uctioning and assessing breath	•				
	Director of Nursin should have asse problem such as suctioning Reside documenting the the secretions. The	w on 6/15/17, at 2:30 p.m., the g (DON) stated the nursing staff ssed Resident 1 for respiratory listening to the breath sounds, ent 1 when necessary, and amount, color, and thickness of the DON stated Resident 1 assessed if secretions were in					
	the upper (from the vocal cord) or low vocal cord down to suctioning (the use to reach down into DON stated Residuals).	ne nose down to the folds of the respiratory tract (from the to the lungs) needing deep to the resident's airway). The dent 1's vital signs (heart rate, the respiration rate, and blood					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			C C		
•		055744	B. WING			1	24/2017
NAME OF PROVIDER OR SUPPLIER ATLANTIC MEMORIAL HEALTHCARE CENTER			27	TREET ADDRESS, CITY, STATE; ZIP CODE 750 ATLANTIC AVE. ONG BEACH, CA 90806			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE ·	(X5) COMPLETION DATE
F 279	pressure [the strer against the sides of	age 4 ngth of the blood pushing of the blood vessels]), including tion level should have been	F2	279			
F 328 SS=G	titled, "Care Plann is the policy of the Team (IDT, a groudifferent department discuss a resident comprehensive plants at 183.25(k) TREATI	ility's policy and procedures ing," dated 5/2007 indicated it facility that the Interdisciplinary p consisting of the head of the ents who work together to 's care) develop a an of care for each resident. MENT/CARE FOR SPECIAL	F	328	<i>F</i> 328		8/2/17
55=0	The facility must e proper treatment a special services: Injections; Parenteral and en	ostomy, or ileostomy care; e;			Immediate Corrective action(s) for resident(s) found to have been affected by the deficient practice: Resident 1 was discharged Janual 1, 2015. How other residents having potential to be affected by same deficient practice will identified and what correct action will be taken;	ary the the be	
	by: Based on intervie failed to provide re assessing breath respiratory secreti 1/1/15, as ordered accordance with fa	eNT is not met as evidenced w and record review, the facility espiratory care by consistently sounds and suctioning ons every shift from 12/28/14 to by the physician and in acility policy and procedures for oled residents (Resident 1).	100		Four (4) residents which had potential to be affected by the deficient practice were assessed breath sounds, the presence of capian and documentation address the MD order. Clarification as	his for are ing	

Facility ID: CA940000007

			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
•		055744	B. WING	<u> </u>	07/24/2017
	ROVIDER OR SUPPLIER	THCARE CENTER	. 2	TREET ADDRESS, CITY, STATE, ZIP CODE 750 ATLANTIC AVE. ONG BEACH, CA 90806	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 328	was admitted in the with acute (sudder the lungs to provid body) due to thick secretions that blo emergency intubat the windpipe to maintensive care (car condition) monitori days. Resident 1 v (a level of care neonot require hospital intensive skilled nut the majority of resifacility) facility. (Cross reference to Findings: A review of Reside Record," indicated the facility on 12/2 included cerebral a area of dead tissue lack of blood suppose A review of Reside Summary Report," indicated to suction increased secretion and symptoms of a materials usually fe [stomach contents every shift. A review of Reside Reside Summary Report," indicated to suction increased secretion and symptoms of a materials usually fe [stomach contents every shift.	deficient practice, Resident 1 are emergency department (ED) of respiratory failure (failure of e adequate oxygen to the semi-solid gelatinous cked the airway and required ion (placement of a tube into aintain an open airway), the to manage a life threatening and hospitalization for 12 was discharged to a subacute eded by a resident who does all care, but who requires more arising care than is provided to dents in a skilled nursing to F279) and 1's record titled, "Admission Resident 1 was admitted to 8/14, with diagnoses that artery occlusion with infarct (and in the brain resulting from	F 328	revision was done to ref residents' current plan of care. What measures and/or system changes will be made to ensigned that the deficient practice donot recur; process to previously. The DON/Designee in-serviced licensed nurses on 7/25 regarding respiratory care a suctioning. The DON/Designee will review in admissions to check for any specare needs in regards to respirat treatments and/or suctioning times a week for three months. addition, the resident's clinical system.	the /17 and lew cial ory five In ical for ate the ied ion be with will ys,
	Physical," dated 12 had a large cerebr	2/29/14, indicated Resident 1 ovascular accident (CVA, the		٠.	·

IDENTIFICATION AND REPER		(X2) MULTIPLE A. BUILDING	(X3) DATE SURVEY COMPLETED		
		055744	B. WING		07/24/2017
NAME OF PROVIDER OR SUPPLIER ATLANTIC MEMORIAL HEALTHCARE CENTER			27	REET ADDRESS, CITY, STATE, ZIP CODE 50 ATLANTIC AVE. DNG BEACH, CA 90806	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD_BE \ COMPLETION
F 328	supply) with right right side of the b swallowing). A review of Resid Progress Notes," Resident 1 had seat the bases of th seven-day antibio aspiration pneum to aspiration inclumonitor and reposounds. There was address Resident respiratory assess A review of Resid Progress Notes," indicated Resider (breath sounds the secretions in the informed and ord of the breathing to A review of Resid Summary Report indicated a teleph Ipratropium-Albut	ent 1's record titled, "Physician's dated 12/30/14, indicated evere diminished breath sounds e lungs and completed tic therapy for treatment of onia (infection of the lungs due ent 1's record titled, "Care 0/14, indicated Resident 1 ding related to swallowing prevent aspiration. The uded for the facility staff to ret to the physician abnormal lung as no plan of care developed to the system of the succession of the lungs due ent 1's respiratory care for sments and needed suctioning. ent 1's record titled, "Nursing dated 12/31/14, at 11:02 p.m., at 1's breath sounds had rales at indicate presence of fluids or lungs); the physician was ered to increase the frequency reatment medication. ent 1's record titled, "Order "dated 12/31/14, at 11:14 p.m., one order to increase erol solution 0.5-2.5 milligrams/e orally every six hours as	F 328	How the corrective action(be monitored to ensure solution are sustained deficient practice will not i.e. POC integration into (Assurance Program to ev effectiveness: Results of the special needs a will be reported to the QA&A Committee for review and advisement monthly for three months, and then quarterly fo (6) months. Correction Completion date: 6	e that and recur, Quality valuate audit
	A review of Resid	ent 1's record titled, "Minimum			

	OF DEFICIENCIES F CORRECTION .	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	G		PLETED
•		055744	B. WING		07/2	; :4/2017
NAME OF PROVIDER OR SUPPLIER ATLANTIC MEMORIAL HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2750 ATLANTIC AVE. LONG BEACH, CA 90806		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROFICIENCY)	DBE ؞ 、	(X5) COMPLETION DATE
F 328	screening tool), da 1 was unable to sp	resident assessment and care ted 1/1/15, indicated Resident teak, rarely or never able to	F 32	28		
	others and had se- impairment (rarely The MDS indicated assistance (reside provided weight-be assistance with ac- indicated Resident motion (the distance	netimes able to understand vere cognitive (mental abilities) or never made decisions). It Resident 1 required extensive in tinvolved in activity and staff earing support) with one person tivities of daily living. The MDS 1 had limitation in range of the ce and direction a joint can	1 •			
	A review of Reside dated 1/1/15, indic	ential) on all extremities. ent 1's Nursing Progress Notes, ated the following: Resident 1 had shortness of				•
	breath (SOB) and (FAM 1) was information Resident 1 with ox cardiopulmonary remergency process	Resident 1's family member med and agreed to provide ygen and perform esuscitation (CPR, an fure performed to preserve the to restore blood circulation and				
·	informed. 3. At 10:55 a.m., name with shortne	Resident 1's physician was Resident 1 was awake, alert to ess of breath, oxygen saturation			4,4	,
	(a measurement of normal blood oxyg of 82 %. Oxygen we non-rebreathing measurement oxygen at a high reper minute (LPM) increased to 98%.	of oxygen level in the blood, then level is 90-100 percent [%]) was administered using a mask (mask that provides ate and high level) at 10 liters and the oxygen saturation FAM 1 was informed of the ess and agreed to transfer			\$ X	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
	•	055744	B. WING		07/24/2017	
NAME OF PROVIDER OR SUPPLIER ATLANTIC MEMORIAL HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2750 ATLANTIC AVE. LONG BEACH, CA 90806		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ACY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION;	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 328	Continued From		F 328	3		
	Resident 1 to the emergency phon	e hospital by 9-1-1 (an e number).				
	dated from 12/28 evidence that Re assessed for bre effectiveness of for increased sec	dent 1's Nursing Progress Notes, 1/14, and 1/1/15, did not indicate sident 1 was consistently ath sounds, reassessed for breathing treatments, suctioned cretions, and assessed for retions, amount, color, and				
	Administration R 1/1/15, there wer	dent 1's record titled, "Medication ecord (MAR)," from 12/28/14 to e no nurses' initials to indicate shift were provided to Resident				
	"ED Notes," date Resident 1 was to paramedics with respiration (gasp desaturation (low 70% (normal ran	dent 1's hospital record titled, at 1/1/15, at 10:46 a.m., indicated brought to the ED by the shortness of breath and agonal ing for breath) with respiratory oxygen level in the blood) of ge 90-100%) and was intubated stress/failure and was transferred are unit.			·	
	documentation of 1:11 p.m., that duthere was a large	iratory Therapist 1's (RT 1) n the ED Notes, dated 1/1/15, at uring Resident 1's intubation, e amount of thick gelatinous ons) obstructing Resident 1's				
·	"Discharge Sumi Resident 1 was o	dent 1's hospital record titled, mary," dated 1/12/15, indicated lischarged to the subacute oses that included acute				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DAT	(X3) DATE SURVEY COMPLETED		
		055744	B. WING_			C 24/2017	
NAME OF PROVIDER OR SUPPLIER ATLANTIC MEMORIAL HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2750 ATLANTIC AVE. LONG BEACH, CA 90806		24/2017	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		ULD BE	(X5) COMPLETION (PATE	
F 328	respiratory failure very thick semi-s (mouth and throa and severe dyspi (removed from re	page 9 e secondary to aspiration with olid nasal (nose) oropharyngeal t) secretions with recent stroke nagia and was extubated espirator [machine designed to normal breathing]).	F 32	28			
	MAR, and care p conducted with F 5/29/15, at 11:50 find documentati of Resident 1's s breath sounds. F should have asse sounds and suct according to the she could not fine	dent 1's Nursing Progress Notes, lans for 12/28/14 to 1/1/15, legistered Nurse 1 (RN 1) on a.m., RN 1 stated she could not on regarding color and amount ecretions and the quality of tN 1 stated the nursing staff lessed Resident 1's breath loned secretions as needed physician's order. RN1 stated d a plan of care for respiratory suctioning and assessing breath					
	FAM1 stated she and she did not s Resident 1 during container for the	ew on 4/11/16, at 10:15 a.m., visited Resident 1 every day see the facility staff suction g her visits and she noticed the suction machine (a machine respiratory secretions) was					
·	Director of Nursing should have assupproblems such a suctioning Resid documenting the the secretions. The should have been the upper (from the secretions).	ew on 6/15/17, at 2:30 p.m., the ng (DON) stated the nursing staff essed Resident 1 for respiratory s; listening to the breath sounds, ent 1 when necessary, and amount, color, and thickness of he DON stated Resident 1 n assessed if secretions were in he nose down to the folds of the ver respiratory tract (from the					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
	•	055744	B. WING _		07/24/2017	
	PROVIDER OR SUPPLIER C MEMORIAL HEALT	HCARE CENTER	.	STREET ADDRESS, CITY, STATE, ZIP CODE 2750 ATLANTIC AVE. LONG BEACH, CA 90806		
(X4) ID PREFIX	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROPROPROPROPROPROPROPROPROPROPROPRO	D BE COMPLETION	
F 328	Continued From pa	-	. F 32	28		
	suctioning (the use to reach down into DON stated Reside body temperature, pressure [the stren against the sides of the blood oxygenal assessed. A review of the facility to clear secretions and pressure into the succession of the facility to clear secretions and pression of the secretion of th	the lungs) needing deep of a smaller suction catheter the resident's airway). The ent 1's vital signs (heart rate, respiration rate, and blood gth of the blood pushing f the blood vessels]), including ion level should have been lity's policy and procedures, I, "Care of Resident with ons," indicated it is the policy of the airway of obstructing went aspiration. The facility will see the resident for signs and	f			
	symptoms of impai assess breath sour oximetry results (a detects how much MD (medical docto	es the resident for signs and red respiratory function, ands, significant decrease in device placed in the finger and oxygen is in the blood), to call r) and discuss respiratory de suctioning as needed.				
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