AOC 4.1.19 Accepted 36356

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

RECEIVED MAR 22 2019 By

PRINTED: 03/20/2019
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
	055744	A. BUILDING _____ B. WING _____	02/26/2019

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

(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 000	INITIAL COMMENTS Addendum 3/20/19 The following reflects the findings of the Department of Public Health during a Recertification survey. Representing the Department of Public Health: Surveyor ID: 36356 RN, HFEN Surveyor ID: 39085 RN, HFEN Surveyor ID: 40168 RN: HFEN Total Population: 79 Sampled Size: 19	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 550 SS=E	Highest Severity and Scope: E Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility	F 550	***F 550*** ***Immediate Corrective action(s) for resident(s) found to have been affected by the deficient practice:*** Resident 286 was observed the whole survey period and no issue was identified. Reeducated regarding utilizing call light use and to call for assistance as needed. Resident 135 was discharged home safely 2/28/2019. Housekeeping department and IDT performed a sweep of facility equipment and bathrooms on 2/19/19 – no other issues was identified.	3/22/19

RECEIVED MAR 22 2019 By

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 3/22/19

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.

PRINTED: 03/20/2019
FORM APPROVED
OMB NO. 0938-0391

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 _____	02/26/2019

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

(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 550	Continued From page 1 must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide respect and protect the dignity for four of 19 sampled residents (67, 69, 286, 135). The facility failed to: 1. Ensure a shower chair, toilet seat, and faucet were free of fecal material (stool) for two residents (Resident 67 and 69). The deficient practice resulted in Resident 69 direct contamination with fecal material which had the potential to spread of disease(s), and it made the resident feel upset, like no one cared, and was that it was degrading. 2. Ensure Resident 286, who was dependent on	F 550	***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken;*** Residents speaking the dominant language have the potential to be affected by this deficient practice. DSD/Designee in-serviced the facility staff regarding use of dominant language and infection control, dated 2/27/19 and 3/1/19. Maintenance Supervisor re-evaluated the deep cleaning schedule for resident's rooms, bathroom and equipment – updated 2/27/19. Maintenance Supervisor/Designee in-serviced housekeeping and clinical staff regarding deep cleaning policies and procedures, schedule and infection control, dated 2/27/19. ***What measures and/or systemic changes will be made to ensure that the deficient practice does not recur; process to prevent recurrence:*** RN Supervisor/Designee in the morning will perform daily rounds to ensure cleanliness in the facility is	

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

PRINTED: 03/20/2019
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
	055744	A. BUILDING _____ B. WING _____	02/26/2019

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

(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 550	Continued From page 2 staff for activities of daily living (ADL), was assisted with incontinent care and the resident was not left with a soiled diaper on. Resident 286 removed the soiled diaper off and threw it in the trash can next to her bed. The deficient practice resulted in Resident 286 changing her soiled diaper and placing it in the restroom trash shared by five other residents, making the resident feel helpless, and undignified. 3. Ensure the facility's staff spoke in a dominant language, when providing care to Resident 135. The deficient practice placed Resident 135 at risk of feeling left out, helpless, disrespectful, undignified and not communicated to. Findings: a. A review of the admission record indicated Resident 67 was readmitted to the facility on 8/4/2017 with diagnoses not limited to depressive (low mood) disorder. A review of the Minimum Data Set (MDS), a standardized assessment and care-screening tool, dated 2/12/18, indicates Resident 286 had no cognitive (ability to make decisions, remember and learn) impairment. During an interview on 2/19/19 at 8:25 a.m., Resident 67 stated "I just came back from the hospital last night and they took me to a men's room to use the toilet and the raised toilet seat had dry poop." Resident 67 further stated "I	F 550	maintained and that any issues will be addressed accordingly. Guardian Angels will also do their rounds weekly – which includes evaluating the cleanliness of the resident rooms and bathrooms. Activity Director will be addressing any issues regarding cleanliness and staff using the dominant language during Resident Council. ***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:*** The Maintenance Supervisor/ Designee will report any findings to QA&A Committee monthly to ensure that the protocols set forth within these corrective measures are followed.	

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

PRINTED: 03/20/2019
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
	055744	A. BUILDING _____ B. WING _____	02/26/2019

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

(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 550	Continued From page 3	F 550		

placed toilet papers on the toilet seat. They don't have toilet seat covers. Another time the toilet seat had urine." Resident 67 stated it is degrading and the facility just did not care. Resident 67 continued to state "it made me upset and feel like no one cares."

During an interview on 2/19/19 at 10:45 a.m., certified nursing attendant (CNA 3) stated "I noticed a stain like poop on the shower chair seat. its from another resident. I was supposed to clean and correct CNA 1. I wont allow anyone to sit me or my loved one on dry poop. That disrespect to the resident and infection control issue."

During an interview on 2/19/19 at 3:39 p.m., Resident 67 stated "look inside the restroom." On a concurrent observation licensed vocational nurse (LVN 2) and maintenance supervisor (MS) observed, a soiled diaper in the trash can, dry black/green smear on the faucet, toilet bowl and commode seat. During a concurrent interview LVN 2 stated "that looks like stool" and LVN 2 had never seen toilet seat covers for the residents. LVN 2 further stated "we have them (toilet seat covers in the staff and visitors restrooms." MS stated "we have toilet seat covers but give them to residents who ask for them." LVN 2 further stated it was Resident 67 who soiled the restroom.

A review of the facility's policy titled "Resident Rights Dignity and Respect" revised 5/2017 indicated all residents be treated with kindness, dignity and respect.

A review of the facility's policy titled "Cleaning and Disinfection of Wheelchairs, Walkers, Shower

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

PRINTED: 03/20/2019
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
	055744	A. BUILDING _____ B. WING _____	02/26/2019

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

(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 550	Continued From page 4	F 550		

Chairs, and Stretchers" revised 3/2009 indicates it is the facility's policy to clean and disinfect wheelchairs, walkers, shower chairs and stretchers when dirty and in between resident use.

b. A review of the admission record indicated Resident 69 was readmitted to the facility on 1/3/19 with diagnoses not limited to cognitive communication deficit for cerebrovascular accident (stroke), aphasia (loss of ability to understand or express speech, caused by brain damage), gait and mobility abnormality.

A review of the Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 1/30/19 indicated Resident 69 has severe cognitive impairment, was dependent on staff for ADLs, and was not able to walk or transfer between surfaces.

During an observation on 2/19/19 at 8:47 a.m., a shower chair smeared with dry brown/black material was observed at Resident 35's bedside. Certified nurse assistants (CNAs 1 and 3) were observed attempting to wake Resident 35 for a shower, but the resident declined. Both CNAs 1 and 3 wheel the same shower chair to Resident 69's bedside. CNA 3 looked at the shower chair seat several times. Both CNAs 1 and 3 transferred Resident 69 on to the same shower chair without prior sanitization. The bedside curtains for Residents 35 and 69 was observed with white, reddish and brown stains.

During an interview on 2/19/19 at 10:45 a.m., CNA 3 stated "I noticed a stain like poop on the shower chair seat. It's from another resident. I was supposed to clean and correct CNA 1. I wont

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

PRINTED: 03/20/2019
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
	055744	A. BUILDING _____ B. WING _____	02/26/2019

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

(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 550	Continued From page 5 allow anyone to sit me or my loved one on dry poop. That disrespect to the resident and infection control issue." During an interview on 2/20/19 at 7:22 a.m., CNA 1 stated there was a yellow stain on the shower chair which looked like urine. CNA 1 continued to state "I transferred the resident (Resident 69) onto the shower chair without first disinfecting it." CNA 1 further stated any resident shared equipment must be sanitized before and after use to prevent spread of infection. During an interview on 2/22/19 at 9:05 a.m., the director of staff development (DSD) stated shared equipments equipment must be disinfected prior to, after, and if visibly dirty (anything that is obvious to eyes use to prevent spread of infection from person to person. A review of the facility's policy titled "Cleaning and Disinfection of Wheelchairs, Walkers, Shower Chairs, and Stretchers" revised 3/2009 indicated it is the facility's policy to clean and disinfect wheelchairs, walkers, shower chairs and stretchers when dirty and in between resident use. c. A review of the admission record indicated Resident 135 was admitted to the facility on 2/1/19 with diagnoses not limited to generalized muscle weakness. The Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 2/8/19 indicated Resident 135 had moderate cognitive impairment. During an ADL observation on 2/22/19 at 7:40	F 550		

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 _____	02/26/2019

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

(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 550	Continued From page 6 a.m., CNAs 2 and 4, while attending to Resident 135's needs, they spoke to each other and in front of the resident, in Spanish which was a non-dominant language. During an interview on 2/22/19 at 8:21 a.m., CNA 2 stated Resident 135 spoke English and a second language. CNA 2 verified both CNAs 2 and 4 spoke in Spanish which was not the dominant language of the facility and Resident 135 understood part of what CNA 2, and 4 discussed. CNA 2 stated English was the official language and "I would feel bad if someone spoke in a language I do not understand." During an interview on 2/22/19 at 10:00 a.m., Resident 135 stated "I only speak English, I would like for the nurses to speak to me in English because I don't speak Spanish." Resident 135 shrugged her shoulders when asked how that made her feel. During an 2/22/19 at 10:26 a.m., the director of nurses stated "we are always reminding staff not to speak in another language unless the resident and or family are not able to speak in facility's preferred language which is English." A review of the facility's policy titled "Official Language Designation" revised 4/2004 indicated the establishment of English as the official language of the company to respect and protect the residents' dignity and rights to communicate and be communicated to, and to decrease the amount of tension and anxiety among residents which can result when multiple languages are spoken in and around patient care area. d. A review of the admission records indicated	F 550		

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

PRINTED: 03/20/2019
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
	055744	A. BUILDING _____ B. WING _____	02/26/2019

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

(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 550	Continued From page 7	F 550		

Resident 286 was admitted on 2/1/19 with diagnoses that included cirrhosis of liver (an end stage liver scarring disease), lack of coordination, diabetes mellitus (irregular blood sugar levels), and peritonitis (inflammation of the abdominal wall).

A review of the Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 2/14/19 indicated Resident 286 was cognitively (ability to make decisions of daily living) intact. MDS indicated Resident 286 did not exhibit any behaviors of rejecting care. The same MDS indicated Resident 286 required extensive assistance in activities of daily living such as dressing, toileting, and personal hygiene.

On 2/19/19 at 8:40 a.m. during a concurrent observation and interview, there was a soiled diaper and bed liner in the trash can next to Resident 286's bed. Resident 286 stated she had summoned for help using her call light. Resident 286 stated however a Certified Nursing Assistant (CNA) had responded to the call light and told her there was no one to help her at the time. Resident 286 stated she took the soiled diaper off and threw it in the trash can by her bed because she did not want to lay in a dirty diaper. Resident 286 stated she felt helpless and undignified.

During an interview on 2/22/19 at 10:42 a.m., CNA 7 stated that it was not good for a resident to remain in a soiled diaper; it could negatively affect the resident's dignity as well as causing skin breakdown.

A review of the facility's policy titled "Residents Rights/Dignity and Respect" revised 5/2017 indicated that residents would be appropriately

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 _____	02/26/2019

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

(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 550	Continued From page 8 dressed in clean clothes arranged comfortably on their persons, and be well groomed.	F 550	***F 558***	3/22/19
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to thoroughly assess one of 19 sampled residents (83) living space and environment for easy access, and navigation safely in to the restroom to minimize the risks for falling. The deficient practice resulted in Resident 83 complaining of inadequate wheel chair and walker access to the restroom, inadequate restroom rails to assist with sitting and getting up, and risk of falling because wall/privacy curtains were of the same color. Findings: A review of the admission records indicated Resident 83 was admitted to the facility on 1/29/19 with diagnoses not limited to hemiplegia and hemiparesis (weakness of one entire side of the body), difficulty walking, emphysema and exacerbation (increase in severity) chronic obstructive airway disease ([COPD] inflammatory	F 558	***Immediate Corrective action(s) for resident(s) found to have been affected by the deficient practice:*** Resident 83 was discharged home safely with family 2/19/19. No fall or any incident was noted during resident's stay in the facility. DOR and Maintenance Supervisor immediately evaluated all rooms in the facility for any similar condition on 2/19/19 – no other rooms have found with restriction of space. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken;*** All in-house residents have the potential to be affected by this deficient practice. Rehab will assess resident's room suitability based on resident's physical capacity and limitations during their admission in the facility. In-service was provided by DON/ Designee to clinical staff, rehab department and IDT members regarding ADL Care and room	

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

PRINTED: 03/12/2019
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
	055744	A. BUILDING _____ B. WING _____	02/26/2019

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

(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 558	Continued From page 9 obstructive airway disease ([COPD] inflammatory lung disease which cause difficulty in breathing), falls, glaucoma (damaged optic nerve with symptoms not limited to blurred vision) and peripheral neuropathy (nerve damage which results in pain, numbness and weakness). A review of the Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 2/5/18 indicated Resident 83 had no cognitive impairment, needed extensive assist with activities of daily living (not steady when moving from seated to standing position), and normally used a walker and or wheel chair as assistive devices. During an interview on 2/19/19 at 8:10 a.m., Resident 83 stated he had difficulty navigating the entrance to the restroom because there was a bed next to the restroom door and his wheel chair or walker could not go past the foot of Bed A. Resident 83 continued to state "I have very bad COPD and I don't need to work that hard to get to the rest room, the privacy curtains are the same color as the wall paint. I almost fell because I was trying to hold onto the wall but held onto the curtain to stabilize myself. I have told them before about my challenges but they don't do anything. Restroom has one pull up bar and toilet seat is low." During interview Resident 83 was observed to be a tall person. During a concurrent observation bed A was close to restroom door and the restroom door was not able to completely be opened. During an interview and observation, Physical Therapy Aid (PTA 1) showed Resident 83 was only provided with one grab bar in the restroom and a low toilet seat. PTA 1 was not able to provide a raised toilet seat for Resident 83's restroom to ensure the resident was safer to	F 558	compatibility for residents based on their capacity & limitations, dated 2/28/19 and 3/1/19. ***What measures and/or systemic changes will be made to ensure that the deficient practice does not recur; process to prevent recurrence:*** Resident will be assessed upon admission by nursing and rehab for room suitability. Resident will be placed in a room accordingly, based on their physical capacity and needs. IDT will discuss with resident and resident representative during Care Conference regarding room feasibility and any adjustments that needs to be done accordingly. Any room changes will be arranged and documented by Social Services Department and nursing. ***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:***	

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

PRINTED: 03/12/2019
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
	055744	A. BUILDING _____ B. WING _____	02/26/2019

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

(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 558	Continued From page 10 sit on the toilet seat. During a witnessed observation on 2/19/19 at 10:45 a.m., Resident 83's wheel chair and oxygen tank at the foot of bed A. The Physical therapy assistant (PTA 1) observed Resident 83 come out of the restroom, complained of shortness of breath (SOB), quickly sat on bed A and asked for oxygen. PTA 1 was observed to assist Resident 83 stand up and transfer onto a wheel chair at the foot of bed A. Resident 83 was then attempted to grab onto the wall and privacy curtains to stabilize self. During a concurrent interview PTA 1 stated "yes, the space between the restroom door and bed A is small and the wheel chair can't go past it. We need to remove bed A." PTA 1 stated Resident 83 does therapy is done in PT room. The director of rehabilitation and physical therapy (DRPT) stated "I can see how the wall and privacy curtains can confuse the resident. We need contrasting colors." During an interview on 2/19/19 at 1:15 p.m., Occupational therapy (OT 1) stated Resident 83 did therapy in physical therapy (PT) room because the room was bigger. OT 1 stated "I did an evaluation at bedside but never in the resident's restroom." During a concurrent observation of the restroom toilet seat, OT 1 stated "yes the toilet is low and the resident can benefit from toilet seat raiser such as a bedside commode. I think the resident is almost 6 feet tall." The responsible party, who was the resident's bedside, also confirmed Resident 83 always did therapy in the therapy room. A review of an undated plan of care on risk for falls indicated Resident 83 had impaired mobility and weakness, will be free from falls, maintain a	F 558	The DON/Designee will report any findings to QA&A Committee monthly to ensure that the protocols set forth within these corrective measures are followed.	

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 _____	02/26/2019

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

(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 558	Continued From page 11 clear pathway free of obstacles and provide a sense of control. A review of the facility's policy titled "Fall Risk Assessment" revised 5/2017 indicated the facility identifies each resident at risk for accidents and or falls, and adequately plans care and implements procedures to prevent accidents.	F 558	***F 584*** ***Immediate Corrective action(s) for resident(s) found to have been affected by the deficient practice:*** Resident 83 was discharged home safely with family 2/19/19. No fall or any incident was noted during resident's stay in the facility. DOR and Maintenance Supervisor immediately evaluated all rooms in the facility for any similar condition on 2/19/19 – no other rooms have found with restriction of space. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken;*** All in-house residents have the potential to be affected by this deficient practice. Rehab will assess resident's room suitability based on resident's physical capacity and limitations during their admission in the facility. In-service was provided by DON/ Designee to clinical staff, rehab department and IDT members regarding ADL Care and room	3/22/19
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(l) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(l)(4) Private closet space in each	F 584		

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 _____	02/26/2019

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

(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 584	Continued From page 12 resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide safe environment by thoroughly assessing one of 19 sampled residents (83) living space and environment to ensure easy access, and navigation safely to minimize risk for falls. The deficient practice resulted in Resident 83 complaining of inadequate wheel chair and walker access to the restroom, inadequate restroom grab bar to assist with sitting and getting up positions, and risk for fall because wall/privacy curtains were of the same color. Findings: A review of the admission record indicates Resident 83 was admitted to the facility on 1/29/19 with diagnoses not limited to hemiplegia and hemiparesis (weakness of one entire side of the body), difficulty walking, emphysema and exacerbation (increase in severity) chronic obstructive airway disease ([COPD] inflammatory	F 584	compatibility for residents based on their capacity & limitations, dated 2/28/19 and 3/1/19. ***What measures and/or systemic changes will be made to ensure that the deficient practice does not recur; process to prevent recurrence:*** Resident will be assessed upon admission by nursing and rehab for room suitability. Resident will be placed in a room accordingly, based on their physical capacity and needs. IDT will discuss with resident and resident representative during Care Conference regarding room feasibility and any adjustments that needs to be done accordingly. Any room changes will be arranged and documented by Social Services Department and nursing. ***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:***	

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 _____	02/26/2019

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

(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 584	Continued From page 13 lung disease which cause difficulty in breathing), falls, glaucoma (damaged optic nerve with symptoms not limited to blurred vision) and peripheral neuropathy (nerve damage which results in pain, numbness and weakness). A review of the Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 2/5/18 indicated Resident 83 had no cognitive impairment, needed extensive assist with activities of daily living, not steady when moving from seated to standing position, and normally used a walker and or wheel chair as assistive devices. During an observation and interview on 2/19/19 at 8:10 a.m., Resident 83 stated he had difficulty navigating the entrance to the restroom because there was a bed next to the restroom door and his wheel chair or walker could not go past the foot of bed A. Resident 83 continued to state "I have very bad COPD and I don't need to work that hard to get to the rest room, the privacy curtains are the same color as the wall paint. I almost fell because I was trying to hold onto the wall but held onto the curtain to stabilize myself. I have told them before about my challenges but they don't do anything. Restroom has one pull up bar and toilet seat is low." During a concurrent observation Bed A was close to restroom door, making the door not completely open up. During an interview Physical Therapy Aid (PTA 1) observed one grab bar in the resident's restroom along with a low toilet seat. On 2/19/19 at 10:45 a.m., during an observation Resident 83's wheel chair and oxygen tank was at the foot of bed A. PTA 1 observed Resident 83 come out of the restroom, complaining of shortness of breath (SOB), quickly sat on bed A	F 584	The DON/Designee will report any findings to QA&A Committee monthly to ensure that the protocols set forth within these corrective measures are followed.	

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 _____	02/26/2019

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

(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 584	Continued From page 14	F 584		

and asked for oxygen. PTA 1 was assisted Resident 83 to stand up and transfer onto a wheel chair at the foot of bed A. Resident 83 attempted to grab onto the wall and privacy curtains to stabilize self. During a concurrent interview PTA 1 stated "yes, the space between the restroom door and bed A is small and the wheel chair can't go past it. We need to remove bed A." PTA 1 stated Resident 83's teaching and therapy was done in PT room. The director of rehabilitation and physical therapy stated "I can see how the wall and privacy curtains can confuse the resident. We need contrasting colors."

During an interview on 2/19/19 at 1:15 p.m., Occupational therapy (OT 1) stated Resident 83 did therapy in physical therapy (PT) room because the room was bigger. OT 1 stated "I did an evaluation at bedside but never in the resident's restroom." On a concurrent observation of the restroom toilet seat, OT 1 stated "yes the toilet is low and the resident can benefit from raised toilet seat such as a bedside commode. I think the resident is almost 6 feet tall." The responsible party who was at the bedside stated, Resident 83 always did therapy in the therapy room.

A review of an undated plan of care on risk for falls indicates Resident 83 had impaired mobility and weakness, will be free from falls, maintain a clear pathway free of obstacles and provide a sense of control.

A review of the facility's policy titled "Fall Risk Assessment" revised 5/2017 indicated the facility identifies each resident at risk for accidents and or falls, and adequately plans care and

PRINTED: 03/12/2019
FORM APPROVED
OMB NO. 0938-0391

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 _____	02/26/2019

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

(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 584	Continued From page 15 implements procedures to prevent accidents.	F 584		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to initiate a plan of care for one of three closed sampled residents (84), when there was a change of condition.	F 657	***F 657*** ***Immediate Corrective action(s) for resident(s) found to have been affected by the deficient practice:*** Resident 84 has passed away 1/4/19. Medical Records reviewed any change in condition from 2/26/19, and no issues were identified. All residents that was noted with change of condition was audited and care plan are in place. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken;*** All residents in-house with Change in condition have the potential to be affected by this deficient practice. In-service was completed with the licensed nurses and the IDT team dated 2/27/19 and 3/15/19, regarding care planning, update and revisions with every resident's change of condition, by the DON.	3/22/19

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

PRINTED: 03/12/2019
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
	055744	A. BUILDING _____ B. WING _____	02/26/2019

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

(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 657	Continued From page 16 The deficient practice had the potential for interrupted and inconsistent care for Resident 84. Findings: A review of the admission records indicated Resident 84 was admitted to the facility on 3/29/11 with diagnoses not limited to dementia (progressive decrease in the ability to think and remember great enough to affect a person's daily functioning). During a record review on 2/26/19 at 7:26 a.m., the progress notes indicated Resident 84 developed: 1. Shortness of breath, crackles (abnormal breath sounds) to both lungs, cough, elevated temperature 99.8 (reference range of 97 to 99) degrees Fahrenheit (F) and oxygen saturation of 91 to 92 (reference range of 94 to 99) percent (%) on room air on 1/2/19 at 9:55 a.m. 2. White blood cell ([WBC] blood cells that aid fight infections) 17.05 (normal range 4.30 to 11.0) and neutrophils (type of WBC that help fight infections) 14.59 (reference range 1.80 to 7.20). 3. Cough, lung crackles and on oxygen 2 liters per min on 1/3/19 at 2:47 p.m. 4. Temperature 101.2 degrees F, heart rate 115 (reference range 50 to 90) per minute. 5. Decreased or unable to eat food and or drink adequate amounts and functional decline.	F 657	***What measures and/or systemic changes will be made to ensure that the deficient practice does not recur; process to prevent recurrence:*** Medical Records/Designee will audit the change of condition daily using the "Change of Condition Audit" form and the licensed nurses Change of Condition lists that's in every nurses' station – which will be reviewed during clinical meeting. All residents with change of condition will be reviewed by the Clinical IDT team daily during clinical meeting to ensure proper interventions, documentations are in place and any concerns will be addressed accordingly. ***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 relay any audits that is not address in the daily clinical meeting to the ADON/ Designee - which will be reviewed weekly. The DON/Designee will report any findings to QA&A Committee	

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

PRINTED: 03/12/2019
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
	055744	A. BUILDING _____ B. WING _____	02/26/2019

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

(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 657	Continued From page 17 During a concurrent interview licensed vocational nurse 5 verified, even though Resident 84 had change of condition, elevated WBC and temperature, and an abnormal lung sounds, there was no care plans developed for the problems identified, which increased the risks based on the identified changes of condition. A review of the facility's policy titled "Care Plan and Care Plan" revised 2/2010 indicated care plan will be initiated based on identified problem and medical change of condition.	F 657	monthly to ensure that the protocols set forth within these corrective measures are followed.	
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care,	F 676	***F 676*** ***Immediate Corrective action(s) for resident(s) found to have been affected by the deficient practice:*** Resident 34's ADL status were re-assessed 3/13/19 and based on reassessment, her status improved from last assessment. Currently resident is supervision with her ADL's, and is fully continent with both bowel and bladder. IDT meeting with Resident 34 on 3/21/19 was done to discuss current plan of care and reeducation to resident regarding safety. Resident 34's care plan was updated accordingly to address resident's needs.	3/22/19

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 _____	02/26/2019

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

(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 676	Continued From page 18 §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide supervision and assistance to one of 19 sampled residents (34), who needed assistance with incontinent care (changing disposable diaper). This failure had the potential for Resident 34 to fall and injure if not supervised and assisted by staff when needing assistance to change a disposable diaper. Findings: During initial rounds on 02/19/19 at 08:05 am, Resident 34 was observed sitting on the wheelchair, in her room, trying to put on a diaper without staff's assistance. Resident 34 was by herself. Resident 34 had bilateral below the knee amputation (cut off) with leg prosthesis (artificial leg) at the bedside. During interview Resident 34 was aware, alert, and oriented. During interview Resident 34 stated "I transferred myself to the	F 676	***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken;*** All other residents who have the ability to toilet independently and with supervision were re-assessed for their safety with this task. Care Plans were updated accordingly. In-service was done by DSD/ Designee with the clinical staff regarding ADL care – which includes reporting any changes to the IDT whether it is an improvement or a decline, to adjust plan of care accordingly. Dated 2/27/19 and 3/15/19. ***What measures and/or systemic changes will be made to ensure that the deficient practice does not recur; process to prevent recurrence:*** Clinical IDT team will check and review any residents with change of condition. Resident's care plan will be updated based on resident's needs.	

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 _____	02/26/2019

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

(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 676	Continued From page 19 wheelchair. I called a nurse assistant earlier and said she'll be back. I did not press the call light again because I know it will take them a while to come. When I cough, I pee on myself. I need to put the diaper on right away." Resident 34 then put the call light on and certified nursing assistant (CNA 6) responded. CNA 6 stated, "Resident 34 only needs assistance with transfer to the wheelchair. The last time she saw the resident was around breakfast." CNA 6 stated "When there is a call light while I'm busy, I tell them first that I'm busy right now and that I'll come back but everyone in the hallway passing by can answer the call light." During an interview with registered nurse 3, who also responded to Resident 34's call, stated "Resident 34 needs staff supervision. A staff should watch her while she is doing her personal care because Resident 34 is at risk for falling." During an interview with occupational therapist (OT 2) on 02/25/19 at 07:49 am regarding Resident 34, stated "She can put on her upper clothing, apply lotion, and eat by herself with set up assistance." OT 2 added, "It was recommended to provide staff supervision when Resident 34 performs self-care, lower body dressing and toileting and requires supervision for functional mobility during activities of daily living. Staff should always be there to observe and make sure she is safe when putting on her diaper and putting on her prosthesis while sitting on the wheel chair. CNA should be helping her putting on diaper and it is never recommended to put on diaper while sitting on wheelchair." OT 2 stated there was a risk of Resident 34 falling. A review of Resident 34's plan of care indicated weakness, decline in functional mobility requiring	F 676	***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:*** Quality Measures will be reviewed by DON monthly with the clinical team to ensure appropriate interventions are provided to the residents accordingly based on their ADLs and capacity. The DON/Designee will report any findings to QA&A Committee monthly to ensure that the protocols set forth within these corrective measures are followed.	

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

PRINTED: 03/12/2019
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
	055744	A. BUILDING _____ B. WING _____	02/26/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATIDN)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 676	Continued From page 20 bilateral lower extremities prosthesis, heart failure, ascites (the accumulation of fluid in the peritoneal cavity, causing abdominal swelling), and anemia (low iron the blood). The care plan indicated Resident 34 was at risk for accidental bowel/bladder incontinence (loss of function) related to history of infections. The care plan interventions for Resident 34 indicated to check as required for incontinence, wash, rinse, and dry the perineum, change clothing as needed if incontinence episodes, resident prefers to use disposable brief at times, change every two to three hours, and provide assistance. A review of the Minimum Data Set (MDS), a standardized assessment and care screening tool, indicated Resident 34 was cognitively intact and needed assistance with ADLs. A review of the facility's undated policy and procedure titled "ADL, Services to Carry Out", indicated it is the policy of this facility that residents are given the appropriate treatment and services to maintain or improve his or her abilities. Any resident who requires assistance will receive necessary services to maintain personal hygiene, toileting and assistance with transfer.	F 676		
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 envlronment 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.	F 689	***F 689*** ***Immediate Corrective action(s) for resident(s) found to have been affected by the deficient practice:*** Resident 83 was discharged home safely with family 2/19/19. No fall or any incident was noted during resident's stay in the facility. DOR and Maintenance Supervisor immediately evaluated all rooms in the facility for any similar condition on 2/19/19 – no other rooms have found with restriction of space.	3/22/19

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

PRINTED: 03/12/2019
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
	055744	A. BUILDING _____ B. WING _____	02/26/2019

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

(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 SHDULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 21 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide safe environment by thoroughly assessing one of 19 sampled residents (83) living space and environment to ensure easy access, and navigation in a safe manner to minimize risk for falls. The deficient practice resulted in Resident 83 complaining of inadequate wheel chair and walker access to the restroom, inadequate restroom grab bar to assist with sitting and getting up positions, and risk for fall because wall/privacy curtains were of the same color. Findings: A review of the admission record indicates Resident 83 was admitted to the facility on 1/29/19 with diagnoses not limited to hemiplegia and hemiparesis (weakness of one entire side of the body), difficulty walking, emphysema and exacerbation (increase in severity) chronic obstructive airway disease ([COPD] inflammatory lung disease which cause difficulty in breathing), falls, glaucoma (damaged optic nerve with symptoms not limited to blurred vision) and peripheral neuropathy (nerve damage which results in pain, numbness and weakness). A review of the Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 2/5/18 indicated Resident 83 had no cognitive impairment, needed extensive assist with activities of daily living, not steady when	F 689	***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken;*** All in-house residents have the potential to be affected by this deficient practice. Rehab will assess resident's room suitability based on resident's physical capacity and limitations during their admission in the facility. In-service was provided by DON/ Designee to clinical staff, rehab department and IDT members regarding ADL Care and room compatibility for residents based on their capacity & limitations, dated 2/28/19 and 3/1/19. ***What measures and/or systemic changes will be made to ensure that the deficient practice does not recur; process to prevent recurrence:*** Resident will be assessed upon admission by nursing and rehab for room suitability. Resident will be placed in a room accordingly, based on their physical capacity and needs. IDT will discuss with resident and resident representative during Care Conference regarding room	

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 _____	02/26/2019

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

(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 22 moving from seated to standing position, and normally used a walker and or wheel chair as assistive devices. During an observation and interview on 2/19/19 at 8:10 a.m., Resident 83 stated he had difficulty navigating the entrance to the restroom because there was a bed next to the restroom door and his wheel chair or walker could not go past the foot of bed A. Resident 83 continued to state "I have very bad COPD and I don't need to work that hard to get to the rest room, the privacy curtains are the same color as the wall paint. I almost fell because I was trying to hold onto the wall but held onto the curtain to stabilize myself. I have told them before about my challenges but they don't do anything. Restroom has one pull up bar and toilet seat is low." During a concurrent observation Bed A was close to restroom door, making the door not completely open up. During an interview Physical Therapy Aid (PTA 1) observed one grab bar in the resident's restroom along with a low toilet seat. On 2/19/19 at 10:45 a.m., during an observation Resident 83's wheel chair and oxygen tank was at the foot of bed A. PTA 1 observed Resident 83 come out of the restroom, complaining of shortness of breath (SOB), quickly sat on bed A and asked for oxygen. PTA 1 was assisted Resident 83 to stand up and transfer onto a wheel chair at the foot of bed A. Resident 83 attempted to grab onto the wall and privacy curtains to stabilize self. During a concurrent interview PTA 1 stated "yes, the space between the restroom door and bed A is small and the wheel chair can't go past it. We need to remove bed A." PTA 1 stated Resident 83's teaching and therapy was done in PT room. The director of rehabilitation and physical therapy stated "I can	F 689	feasibility and any adjustments that needs to be done accordingly. Any room changes will be arranged and documented by Social Services Department and nursing. ***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:*** The DON/Designee will report any findings to QA&A Committee monthly to ensure that the protocols set forth within these corrective measures are followed.	

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 _____	02/26/2019

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

(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 23 see how the wall and privacy curtains can confuse the resident. We need contrasting colors." During an interview on 2/19/19 at 1:15 p.m., Occupational therapy (OT 1) stated Resident 83 did therapy in physical therapy (PT) room because the room was bigger. OT 1 stated "I did an evaluation at bedside but never in the resident's restroom." On a concurrent observation of the restroom toilet seat, OT 1 stated "yes the toilet is low and the resident can benefit from raised toilet seat such as a bedside commode. I think the resident is almost 6 feet tall." The responsible party who was at the bedside stated, Resident 83 always did therapy in the therapy room. A review of an undated plan of care on risk for falls indicates Resident 83 had impaired mobility and weakness, will be free from falls, maintain a clear pathway free of obstacles and provide a sense of control. A review of the facility's policy titled "Fall Risk Assessment" revised 5/2017 indicated the facility identifies each resident at risk for accidents and or falls, and adequately plans care and implements procedures to prevent accidents. A review of an undated plan of care on risk for falls indicates Resident 83 has impaired mobility and weakness, will be free from falls, maintain a clear pathway free of obstacles and provide a sense of control. A review of the facility's policy titled "Fall Risk Assessment" revised 5/2017 indicated the facility identifies each resident at risk for accidents and	F 689		

PRINTED: 03/20/2019
FORM APPROVED
OMB NO. 0938-0391

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 _____	02/26/2019

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

(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 697 SS=D	Continued From page 24 Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to consistently assess the effectiveness of administered pain medication to ensure the resident's lower back pain was under control for one of 19 sampled residents (285). This deficient practice resulted in Resident 285 unnecessarily enduring pain for prolonged periods of time. Findings: A review of the admission records indicated Resident 285 was admitted with diagnosis that included low back pain, intervertebral disc displacement of the lumbosacral region (a painful condition affecting the spine in which a tear in the outer ring of a spinal disc allows the soft, part to bulge out), and hypertension (high blood pressure). A review of an admission note dated 2/18/19 at 4:35 p.m. indicated Resident 285 was status post (S.P.) a revision of laminectomy (a surgical operation to remove the back of one or more vertebrae [joints of the spine], to relieve pressure	F 697 F 697	***F 697*** ***Immediate Corrective action(s) for resident(s) found to have been affected by the deficient practice:*** Resident 285 was discharged home 3/5/19. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken;*** Residents on pain management were reviewed by the IDT and residents were interviewed regarding their pain management on 3/13/19. No other issues were identified. Licensed Nurses were in-serviced by the DON regarding Pain Management principles, dated 2/27/19 and 3/15/19. Which includes assessment, documentation and management. Residents who have frequent PRN pain medication usage shall be evaluated for consideration for routine pain medication with agreement from MD and resident/ resident representative.	3/22/19

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

PRINTED: 03/20/2019
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
	055744	A. BUILDING _____ B. WING _____	02/26/2019

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

(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 697	Continued From page 25 on spinal nerves). A review of the admission (nursing assessment) records dated 2/18/19 4:30 p.m., indicated Resident 285 was alert, oriented, and able to make needs known. The assessment indicated Resident 285 had a lower back surgical incision, measuring 15.5 centimeters (a unit of measure) with reddish/purplish discoloration on the surrounding areas. The admission assessment further indicated Resident 285 showed no behavioral problems such as anxiety, fear, or forgetfulness. A review of a physician order dated 2/18/19 at 4:30 p.m. indicated to monitor Resident 285's pain level using the following scale: 0 = no pain, 1-3 = mild, 4-6 = moderate, 7-10 = severe every shift. A review of Resident 285's physician order dated 2/19/19 at 12:02 a.m. indicated to administer Norco Tablet 10-325 (a medication used to treat moderate to severe pain) one tablet by mouth for moderate pain and 2 tablets for severe pain, every 4 hours as needed. a 1. During a concurrent observation and interview on 2/19/19 at 8:52 a.m. Resident 285 stated his pain level was at an 8/10, and the last pain medication he had received was at around 5 a.m. Resident 285 stated Licensed Vocational Nurse (LVN 4) had administered his morning medications, but did not ask him if he was in any pain. During an interview on 2/19/19 at 11:36 a.m. LVN 4 stated he does not remember if he assessed Resident 285's pain level. LVN 4 stated he would	F 697	In cases of unsuccessful pain management efforts, residents shall be referred to pain management clinic or in-house Pain MD for further evaluation. ***What measures and/or systemic changes will be made to ensure that the deficient practice does not recur; process to prevent recurrence:*** Licensed Nurses will continue to assess for pain level every shift. DON/Designee shall review usage of PRN medications weekly for further monitoring and intervention. The DON/Designee will monitor for continued compliance with assessment and effectiveness of interventions by random review of nursing documentations – which includes the eMAR's. ***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:*** The DON/Designee will report any findings to QA&A Committee monthly to ensure that the protocols set forth within these corrective measures are followed.	

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 _____	02/26/2019

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

(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 697	Continued From page 26 assess Resident 285 for pain right away. A review of the Medication Administration Records dated 2/1/19 thru 2/28/19 indicated Resident 285 was medicated with two Norco 10-325 for pain level of 8/10. During an interview on 2/19/19 at 3:40 p.m. LVN 4 stated he asked Resident 285 if he was ok (during morning medication administration), he did not ask him if he was in pain. LVN 4 stated it is important to assess for pain to ensure that residents are comfortable, and do not get agitated. LVN 4 stated pain was a stressor, and could negatively affect Resident 285's quality of life. a 2. During an interview on 2/26/19 at 11:23 a.m. Resident 285 stated during the past couple of days (2/24/19 and 2/25/19) he had to wait at much as 12 hours to receive pain medication. Resident 285 stated when he asked for pain medication, he was told it was not due yet. Resident 285 stated he was only interested in getting better and going home, he felt being in pain was getting in the way. A review of the MARs dated 2/1/19 thru 2/28/19 indicated Resident 285 received Norco 10-325 mg two tablets on the following days: 2/24/19 at 2:35 a.m. for a pain level of 9 2/24/19 at 7:00 p.m. for a pain level of 7 2/24/19 at 11:09 p.m. for a pain level of 7 2/25/19 at 3:30 a.m. for a pain level of 7 2/25/19 at 9:34 a.m. for a pain level of 8 2/25/19 at 8:25 p.m. for a pain level of 7 2/26/19 at 12:15 a.m. for a pain level of 7 2/26/19 at 9:23 a.m. for a pain level of 8	F 697		

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

PRINTED: 03/20/2019
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
	055744	A. BUILDING _____ B. WING _____	02/26/2019

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

(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 697	Continued From page 27 A review of the interventions for pain indicated in the plan of care dated 2/18/19 indicated: administer analgesia medication as per orders, monitor effectiveness, evaluate the effectiveness of pain interventions, review for compliance, alleviating of symptoms, dosing schedules, and resident satisfaction with results, impact on functional ability and impact on cognition, and follow pain scale to medicate as ordered. During an interview on 02/26/19 at 10:53 a.m. Assistant Director of Nursing (ADON) stated Resident 285 should not have to wait this long to receive pain medication. ADON stated Resident 285's pain should had been relieved by administering the ordered medications. ADON stated if the pain was still not relieved staff should notify the physician about Resident 285 experiencing break through pain. ADON stated not managing his pain can affect Resident 285 negatively with the level of functioning and would not maximize his potential for recovery. A review of the facility's policy titled "Care and Treatment: Pain Management" revised 11/2017 indicated the facility assists each resident with pain to maintain or achieve the highest practicable level of well-being and functioning by: -Screening to determine if the resident has been or is experiencing pain -Comprehensively assessing the pain -Developing and implementing a plan, using pharmacological and /or non-pharmacological interventions to manage the pain and/or try to prevent the pain consistent with the resident's goals.	F 697		
F 698	Dialysis	F 698		

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 _____	02/26/2019

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

(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 697	Continued From page 28 prevent the pain consistent with the resident's goals.	F 697	***F 698***	3/22/19
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure one of 19 sampled residents (64) transportation to and from hemodialysis (purification of blood by a machine) center was not delayed. The deficient practice resulted in Resident 64's transportation delayed for one and half hours late going and three hours late coming back from hemodialysis center, which made the resident becoming very angry, aggravated, and stating "I feel like they don't care." Findings: A review of the admission records indicated Resident 64 was readmitted to the facility on 11/20/18 with diagnoses not limited to end stage renal disease ([ESRD] kidneys no longer working). A review of the Minimum Data Set (MDS), a standardized assessment and care screening	F 698	***Immediate Corrective action(s) for resident(s) found to have been affected by the deficient practice:*** Resident 64's transportation were reviewed since survey, and no delay of service was noted. Resident's insurance is still working on switching transportation provider but resident prefers to stay with current transportation. Since resident's admission to the facility, the resident did not miss any dialysis treatment as scheduled. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken;*** All residents on dialysis have the potential to be affected by this deficient practice. All residents on dialysis were reviewed for their transportation and no other issues were noted with regards to timeliness. ***What measures and/or systemic changes will be made to ensure that the deficient practice does not recur; process to prevent recurrence:***	

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

PRINTED: 03/12/2019
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
	055744	A. BUILDING _____ B. WING _____	02/26/2019

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

(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 698	Continued From page 29 tool, dated 1/15/19 indicated Resident 64 had no cognitive impairment. During an interview on 2/19/19 at 9:55 a.m., Resident 64 stated "they are always late to pick me to and return me from dialysis by one and half hours late going and three hours late coming back. I get very angry and aggravated. I feel like they don't care." During an interview on 2/20/19 at 8:25 a.m., the social services staff (SSS 1) stated she contacts insurance company who designate the transportation company 15 to 30 minutes before a resident's appointment. SSS 1 stated she contacts private transportation company two hours ahead of scheduled appointment if the transportation company can accommodate a resident. SSS 1 further stated "some residents have missed their appointment because the doctor's office can not accommodate them when they are arrive late." SSS 1 stated for two months Resident 64 was picked up to and from dialysis late. SSS 1 stated "I have not discussed transportation concerns with my supervisor. I will try and communicate more with transportation company and the resident's insurance about late transportation." A review of the facility's policy titled "Transportation to Dialysis" revised 5/2017 indicated social service designee will be responsible for arranging the transportation and that requests for transportation be made as far in advance as possible.	F 698	Licensed Nurses and Social Services Department were in-serviced by the DON regarding dialysis transportation, communication and reporting of any delays and changes, which also includes the importance of transportation timeliness, dated 2/27/19. Facility arranged an agreement with secondary transportation company who will be in stand-by to accommodate any delays with transportation. Social Services Dept/Designee will review dialysis residents on a weekly basis to ensure timeliness and identify any issues if there's any noted, and will be addressed accordingly. ***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:*** The Social Services Dept/Designee will report any findings to QA&A Committee monthly to ensure that the protocols set forth within these corrective measures are followed.	
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F 761		

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 _____	02/26/2019

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

(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 761	Continued From page 30 §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation interview and record review the facility failed to ensure the residents were free from potential accidents by leaving medication at the bedside for three of 19 sampled residents (286, 43, 46), and to date a multiple dose vial of purified protein derivative ([PPD] skin test) to detect tuberculosis (lung infection), when it was opened. This deficient practice had the potential for staff not know which medications were taken by Resident 286, 43 and 46, when other residents	F 761	***F 761*** ***Immediate Corrective action(s) for resident(s) found to have been affected by the deficient practice:*** Resident 286 and 46 are still residing in the facility. Both were interviewed by the DON regarding medication administration, they both stated they do not have any problem taking medications in the presence of the nurse upon administration, verbalized understanding. Resident 43 had no concerns regarding medication administration. LN 4 and LN 3 were in-serviced immediately rega2rding medication administration protocol, which includes not leaving the medications at bedside, dated 2/19/19. LN 3 were in-serviced immediately regarding medication storage – which includes ensuring medications are securely stored prior leaving the med cart unattended, dated 2/19/19. DON immediately swept the medication room refrigerator on 2/20/19 for any multi-use vial, to ensure no open viais are left with no labels. No other issues was noted.	3/22/19

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 _____	02/26/2019

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

(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 761	Continued From page 31 had easy access to the meds, other residents experience side effects if taken the medications by mistake, and not dating an opened PPD vial staff may not know its expiration date. Findings: a. A review of the admission record indicated Resident 286 was admitted on 2/01/19 with diagnoses that included cirrhosis of liver (an end stage liver scarring disease), lack of coordination, diabetes mellitus (irregular blood sugar levels), and peritonitis (inflammation of the abdominal wall). A review of the Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 2/14/19 indicated Resident 286 was cognitively (ability to make decisions of daily living) intact. MDS indicated Resident 286 did not exhibit any behaviors of rejecting care. The MDS indicated Resident 286 required extensive assistance in activities of daily living such as dressing, toileting, and personal hygiene. During initial rounds on 2/19/19 at 8:36 a.m. Resident 286 was observed with a container filled with thick white fluid and another container with two white tablets in it. During a concurrent interview Resident 286 stated she was not ready to take all her medications, so her nurse had left Mylanta (medication that treats heartburn and upset stomach), and Semethicone (an anti gas medication) at her bedside so she could take them when she was ready. During an interview on 2/19/19 at 4:14 p.m.	F 761	***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken;*** All residents in-house have the potential to be affected by this deficient practice. Licensed Nurses were in-serviced by the DON/Designee regarding Medication administration and safe storage, dated 2/27/19 and 3/15/19. Licensed Nurses were in-serviced regarding labeling multi-dose vial with "Open Date", dated 2/20/19 and 3/15/19 by the DON. ***What measures and/or systemic changes will be made to ensure that the deficient practice does not recur; process to prevent recurrence:*** ADON/Designee and/or RN Supervisor will be observing charge nurses during their med pass for compliance on policies on medication administration on a weekly basis. Pharmacy Consultant will do med pass observation for any new hires and existing licensed nurses monthly.	

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

PRINTED: 03/12/2019
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
	055744	A. BUILDING _____ B. WING _____	02/26/2019

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

(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 761	Continued From page 32 Licensed Vocational Nurse (LVN 4) stated he had left Mylanta, and Semethicone at the bedside for Resident 286 to take when she was ready. LVN 4 stated Resident 286 had not been assessed for self administration of medications to ensure it was safe to self administer. During an interview on 2/22/19 at 1:37 p.m. Registered Nurse (RN 1) stated the nurse administering medications should visualize Resident 286 when taking the medication before leaving the bedside. RN 1 stated that way the nurse can ensure the right resident got the right medication at the right time. RN 1 stated "This also ensures another resident does not come by and grab it, or accidentally spill it." A review of the facility's undated policy titled "Policy and Procedure for Med Pass" indicated the person who prepares the dose for administration is the person who administers the dose to the resident. Residents are allowed to self-administer medications when specifically authorized by the attending physician and in accordance with procedures for self-administration of medications. b. During medication administration observation on 2/19/19 at 9:49 a.m., licensed vocational nurse (LVN 3) poured the following medications for Resident 43: 1. Amiodarone HCL (to stabilize abnormal heart beat) 200 milligrams (mg) 1 tablet (tab) oral (PO) 2. Sertraline HCL (medication to stabilize mood) 25 mg 1 tab PO 3. Enalapril Maleate (to control abnormal blood pressure) 20 mg 1 tab PO BP 126/68 mmHg 4. Folic Acid (supplement)1 tab PO	F 761	RN Supervisor/Designee will be checking the med room refrigerator for any missing medication labels or date when it was opened. ***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:*** The DON/Designee will report any findings to QA&A Committee monthly to ensure that the protocols set forth within these corrective measures are followed.	

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

PRINTED: 03/12/2019
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
	055744	A. BUILDING _____ B. WING _____	02/26/2019

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

(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 761	Continued From page 33 5. Hydrocortisone 5 mg 1 tab PO 6. Magnesium Oxide (supplement) 400 mg 1 tab PO 7. Rena-Vite (supplement) 1 tab PO 8. Vit B-11 (supplement) tab PO 9. Iron (supplement) 325 mg 1 tab PO 10. Sodium Bicarbonate 650 mg 1 tab PO During observation when asked if she was done checking the medications, LVN stated "Yes." LVN 3 then entered Resident 43's room and left the poured medications on top of the medication cart. LVN 3's back was turned away from the doorway and she did not have direct sight to medication cart. There was staff, a family member and a resident who walked past the medication cart while Resident 43's medications were left unattended. A review of the facility's undated policy titled "Medication Administration General Guidelines" indicated the resident is always observed after administration to ensure that the dose is completely ingested. c. A review of the admission records indicates Resident 46 was admitted to the facility on 10/8/18 with diagnoses not limited to cerebral infarct (stroke) and major depression (abnormal mood). A review of the facility's document titled IDT Care Plan Review V2 dated 1/15/19 indicated Resident 46 was alert and oriented times, but forgetful at times. During an observation on 2/19/19 at 8:04 a.m., seven tablet were observed in a clear plastic cup at Resident 43 over bed table. During an	F 761		

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 _____	02/26/2019

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

(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 761	Continued From page 34 interview Resident 46 stated "I ask the nurse to leave my medications at the bedside because I want to first eat then take them later." During an interview on 2/19/19 at 2:52 p.m., Licensed Vocational Nurse (LVN 3) verified and stated "I administered medications to Resident 46 at around 8:00 a.m." LVN 3 further stated it was important to ensure the resident swallowed the medications before leaving the bedside because of the potential for pocketing, spitting out or have difficulty swallowing the medications. LVN 3 stated she signed the medication administration record (MAR) without verifying Resident 46 swallowed the medications. LVN 3 stated it was not a safe practice to leave medications unattended because of the potential for an unintended person or a resident to gain access and swallow the medications. A review of the facility's undated policy titled "Medication Administration General guidelines" indicated no medications are kept on top of the cart. d. During a medication storage room inspection on 2/20/19 at 11:48 a.m., accompanied by the director of nurses (DON), there was one multiple dose vial of purified protein derivative ([PPD] skin test) which determines if there is tuberculosis (a serious infection, usually of the lungs) was not dated as to when it was opened. During a concurrent interview, the DON stated "the vial is only good for 28 days." A review of PPD manufacturer's insert indicated vials in used more than 30 days be discarded due to possible oxidation and degradation which may affect potency.	F 761		

PRINTED: 03/12/2019
FORM APPROVED
OMB NO. 0938-0391

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 _____	02/26/2019

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

(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 773 SS=D	Lab Srvcs Physician Order/Notify of Results CFR(s): 483.50(a)(2)(i)(ii) §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by: Based on interview, and record review, the facility failed to follow up a test result and to report the findings to the physician for one of 19 sampled residents (34). This failure had the potential to cause complications when not knowing the test results, which could delay treatment plan and care for Resident 34. Findings: On 02/19/19 at 12:30 pm during a record review for Resident 34, a physician order dated 01/14/19 for Hemoglobin A1c ([HbA1c] a test used to determine the average blood sugar control levels over a period of three months in a person with abnormal blood sugar levels) every six months was noted to start on 01/16/19. However, the result of the HbA1c was not found in Resident	F 773	***F 773*** ***Immediate Corrective action(s) for resident(s) found to have been affected by the deficient practice:*** Resident 34's Hemoglobin A1C result was relayed to MD 2/19/19, with no new orders and to continue with Januvia and Insulin per sliding scale. Resident was assessed by DON at bed side and no sign and symptoms of hypo or hyperglycemia, resident was notified of lab results. All laboratory tests that was ordered for Resident 34 were reviewed 3/21/19, no other issues were identified, no labs were reported missing and everything was reported to MD. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken;*** All residents in-house have the potential to be affected by this deficient practice. DON/Designee reviewed lab results from 2/1/19 - 3/13/19, and all the lab orders was reported in the electronic record and was relayed to the primary physician.	3/22/19

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

PRINTED: 03/12/2019
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
	055744	A. BUILDING _____ B. WING _____	02/26/2019

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

(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 773	Continued From page 36 34's paper chart and electronic medical records. A review of Resident 34's clinical records indicated the resident had diagnoses included diabetes mellitus (abnormal blood sugar levels), peripheral vascular disease (blood circulation disorder), anemia (a deficiency of red blood cells or of hemoglobin in the blood resulting in pallor and weariness), chronic kidney disease (gradual loss of kidney function) and cirrhosis of the Liver (a serious degenerative disease that occurs when healthy cells in the liver are damaged and replaced by scar tissue, usually as a result of alcohol abuse or chronic hepatitis). On 02/19/19 at 12:45 pm, a concurrent record review and interview with Registered Nurse (RN 3) was conducted and she was not able to find Resident 34's HbA1c result in the paper chart and in the electronic medical records. There was no documentation in the nurses' notes about the result nor any laboratory test result reported to the physician. When asked, RN 3 stated, "I don't know how this happened. No one followed up on it. The physician must be notified if it's high or low as they might increase the insulin, change the diet or review all the medications, and give orders." RN 3 called the laboratory, the result of HbA1c was faxed with a result of 4.3 percent (%) (reference values 4.8 - 5.6 %). On 02/19/19 at 03:04 pm, an interview with Licensed Vocational Nurse (LVN 2) was conducted. LVN 2 stated "all lab results are important, whether normal or abnormal and must be reported to the physician." LVN 2 stated regarding Resident 34, HbA1c was missed and no one followed up on the results. LVN 2 stated it was the responsibility of all the charge nurses and	F 773	***What measures and/or systemic changes will be made to ensure that the deficient practice does not recur; process to prevent recurrence:*** Licensed Nurses will utilize the "Laboratory Log Sheet" to track all the labs that was drawn and the results that was reported. The DON in-serviced the licensed staff regarding reporting of lab results and documentation, which also includes utilization of the Laboratory Log Sheet, dated 3/15/19. ***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:*** The Laboratory company will be auditing monthly for any missed orders and results. Results of this audit will be relayed to the DON monthly. The DON/Designee will report any findings to QA&A Committee monthly to ensure that the protocols set forth within these corrective measures are followed.	

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 _____	02/26/2019

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

(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 773	Continued From page 37	F 773		

Registered Nurses to follow up a test results and report it to the physician, and if there were abnormal levels, the doctor could possibly make some changes in the orders. LVN 2 stated, "There are risks involved. If it was too high, the resident could have gotten and checked for infection and if it's too low, patient could go into hypoglycemic episode (low blood sugar) and shock (the state of not enough blood flow to the tissues of the body as a result of problems with the circulatory system)".

On 02/20/19 at 08:00 am, in an interview with LVN 6, stated "if any lab results are not followed up and reported to the physician, especially on a diabetic resident, it could potentially harm the resident. LVN 6 stated any resident can go into diabetic coma, hyperglycemia, confusion, altered mentation and if the blood sugar was too low, a resident can be severely hypoglycemic, can have seizure or can lose their consciousness".

A review of an undated facility's policy and procedure titled "Laboratory Testing", indicated that "It is the policy of this facility to obtain laboratory and radiology services when ordered by a physician, physician assistant, nurse practitioner or clinical nurse specialist and to promptly notify the ordering entity of test results."

A review of an undated facility's policy and procedure titled "Lab Test Results", indicated that "the resident's attending physician will be notified of the results of diagnostic tests".

A review of the Licensed Vocational Nurse's job description indicated "The primary purpose of the job position is to provide primary care to specific residents under the supervision of the physician

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 _____	02/26/2019

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

(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 773	Continued From page 38 or medical director with emphasis on assessment, illness prevention and health care management." Duties and responsibilities included an administrative functions and indicated to "Implement and maintain established policies, procedures, objectives, quality assurance, safety and environment and infection control. Interpret these to the physician, resident, family members and public, as appropriate."	F 773		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure residents were not exposed to food contamination, by including dented cans in the foods used everyday.	F 812	***F 812*** ***Immediate Corrective action(s) for resident(s) found to have been affected by the deficient practice:*** Dietary Supervisor immediately removed the dented cans on 2/19/19 and was returned to the vendor. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken;*** All the cans in the storage room was immediately checked on 2/19/19 by the Dietary Supervisor, and no other dented cans noted. In-service was provided by Dietary Supervisor on 2/19/19 to the dietary department with regards to facility policy on dented cans – which includes checking the delivery for any dented cans prior accepting.	3/22/19

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 _____	02/26/2019

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

(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 812	Continued From page 39 This deficient practice had the potential to cause foodborne illness, infections and widespread botulism (an infection that can spread through consuming damaged canned foods) in the residents of the facility to the susceptible residents. Findings: During a concurrent observation and interview on 2/19/19 at 7:24 a.m., a total of four dented cans containing food were stocked in the facility's dry goods storage room. The Dietary Supervisor (DS) stated these dented cans are "ok" to use to prepare food for the residents. DS stated they had used the contents of dented cans to prepare resident's meals in the past, and would use them in the future. During an interview on 2/19/19 at 10:42 a.m. DS stated "if a can does not have any swelling or leaking it can be used for resident's meals, we do not need to remove it". During an interview on 2/22/19 at 11:44 a.m. the Registered Dietician (RD) stated that unless the cans have a bulge or significant deep dent, a hole, or are leaking, the facility kept the cans for consumption. RD stated staff eyeball the cans for deep dents, but some dents were acceptable. A review of a correspondence dated 2/20/19 at 11:56 a.m. addressed to the facility DS, from their canned goods supplier indicated "The standard of practice of dented cans with our company is to return them to the supplier, cans that are believed to be unsafe are thrown away. This encompasses	F 812	***What measures and/or systemic changes will be made to ensure that the deficient practice does not recur; process to prevent recurrence:*** Dietary Supervisor/Designee will be checking twice a week during delivery days for all the cans delivered and anything noted dented will be separated and sent back. Registered Dietician will be doing visual checks of the food storage during her monthly kitchen rounds to ensure no dented cans are being stocked. ***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:*** The Dietary Supervisor/Designee will report any findings to QA&A Committee monthly to ensure that the protocols set forth within these corrective measures are followed.	

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

PRINTED: 03/12/2019
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
	055744	A. BUILDING _____ B. WING _____	02/26/2019

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

(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 812	Continued From page 40 all canned items." According to the Food and Drug Administration, ([FDA] a government agency protecting the public health and safety of the nations' food supply) Food Code 2017 indicated, a primary line of defense in ensuring that food meets the requirement of safe, unadulterated and honestly presented (3-101.11) is to obtain food from approved sources. In addition food products should be monitored to ensure that they do not fall victim to conditions that endanger or compromise their honest presentation. FDA Food Code 2017 indicated food in hermetically sealed containers that are swelled or leaking to be adulterated and actionable under the Federal Food, drug and cosmetic ACT. It also indicated that rusted and pitted or dented cans may also present a serious potential hazard.https://www.fda.gov/downloads/Food/GuidanceRegulation/RetailFoodProtection/FoodCode/UCM595140.pdf	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880	***F 880*** ***Immediate Corrective action(s) for resident(s) found to have been affected by the deficient practice:*** Resident 58 and 46's medical records was reviewed, and no recent infection was noted as a result of non-compliant practice. CNA 3 was immediately in-serviced by the DSD regarding principle of hand washing, infection control and use of gloves – dated 2/19/19. Resident 67's medical records was reviewed, and no skin or urinary infection was noted as a result of this non-compliant practice.	3/22/19

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

PRINTED: 03/12/2019
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
	055744	A. BUILDING _____ B. WING _____	02/26/2019

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

(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 880	Continued From page 41 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880	Housekeeping immediately cleaned and sanitized Resident 67's bathroom and the shower chair that was used for Resident 69. Housekeeping department and IDT performed a sweep of facility equipment and bathrooms on 2/19/19 – and no other issues was identified. Housekeeping department immediately replaced the privacy curtains for Resident 6, 35, 58 and 69. Guardian Angels performed a sweep on their assigned rooms and check for any curtains that needs to be replaced – no other issues was identified. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken;*** All the residents in-house have the potential to be affected by this deficient practice. Maintenance Supervisor re-evaluated the deep cleaning schedule for resident's room, bathroom and equipment – updated 2/27/19.	

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

PRINTED: 03/12/2019
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
	055744	A. BUILDING _____ B. WING _____	02/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLANTIC MEMORIAL HEALTHCARE CENTER	2760 ATLANTIC AVENUE LONG BEACH, CA 90806

(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 880	Continued From page 42 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: b. A review of the admission record indicates Resident 58 was admitted to the facility on 4/17/19 with diagnoses not limited to aphasia (inability to speak). A review of the history and physical (H&P) dated 4/30/17 indicates Resident 58 is able to make needs known but can not make medical decisions. During an observation on 2/19/19 at 9:33 a.m., certified nurse assistant (CNA 3) was observed wear clean gloves remove dirty bed linen from Resident 46's bed. CNA 3 was then observed remove the gloves and wheel and park a container for soiled diapers and dirty linen outside Resident 46's room. CNA 3 was further observed wear clean gloves without performing hand hygiene, close Resident 58's privacy curtains, touch herself, touch bed remote control and assist transfer Resident 58 from bed onto a shower chair without changing gloves and or perform hand hygiene. c. A review of the admission record indicates	F 880	Maintenance Supervisor/Designee in-serviced the housekeeping staff regarding deep cleaning policies and procedures, schedule and infection control, dated 2/27/19. The DSD/Designee in-serviced clinical staff regarding infection control policies – which includes disinfecting equipment prior use, hand washing and use of gloves, dated 2/27/19 and 3/1/19. ***What measures and/or systemic changes will be made to ensure that the deficient practice does not recur; process to prevent recurrence:*** RN Supervisor/Designee in the morning will perform daily rounds to ensure cleanliness in the facility is maintained and that any issues will be addressed accordingly. Guardian Angels will also do their rounds weekly – which includes evaluating the cleanliness of the resident rooms, bathrooms and privacy curtains. DSD/Designee will perform hand washing skills checklist with CNAs weekly to ensure compliance.	

PRINTED: 03/12/2018
FORM APPROVED
OMB NO. 0938-0391

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 _____	02/26/2019

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

(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 880	Continued From page 43 Resident 67 was readmitted to the facility on 8/4/2017 with diagnoses not limited to depressive (low mood) disorder. A review of the MDS dated 2/12/18, Indicates Resident 286 has no cognitive (ability to make decisions, remember and learn) and impairment. During an interview on 2/19/19 at 8:25 a.m., Resident 67 stated "I just came back from the hospital last night and they took me to a men's room to use the toilet and the raised toilet seat had dry poop." Resident 67 further stated "I placed toilet paper on top of the seat and then used it. They don't have toilet seat covers. Another time the toilet seat had urine." Resident 67 stated it is degrading and the facility just did not care. Resident 67 continued to state "It made me upset and feel like no one cares." During an interview on 2/19/19 at 3:39 p.m., Resident 67 told the surveyor "look inside the restroom." On a concurrent observation by two surveyors, licensed vocational nurse (LVN 2) and maintenance supervisor (MS) observed, dirty diaper in the trash can, dry black/green smear on the faucet, toilet bowl and commode seat. On a concurrent interview LVN 2 stated "that looks like stool" and that LVN 2 has never seen toilet seat covers for the residents. LVN 2 further stated "we have them (toilet seat covers in the staff and visitors restrooms." MS stated "we have toilet seat covers but give to the residents who ask for them." LVN 2 further stated it was Resident 67 who soiled the restroom. d. A review of the admission record indicates Resident 69 was readmitted to the facility on 1/3/19 with diagnoses not limited to cognitive	F 880	***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:*** The DSD/Designee and the Maintenance Supervisor will report any findings to QA&A Committee monthly to ensure that the protocols set forth within these corrective measures are followed.	

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

PRINTED: 03/12/2019
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
	055744	A. BUILDING _____ B. WING _____	02/26/2019

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

(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 880	Continued From page 44 communication deficit for cerebrovascular accident (CVA, stroke), aphasia (inability to speak) and gait and mobility abnormality. A review of the MDS dated 1/30/19 indicates Resident 69 has severe cognitive impairment and is dependent on staff for ADLs and is not able to walk or transfer between surfaces. During an observation on 2/19/19 at 8:47 a.m., a shower chair smeared with dry brown/black material was observed at Resident 35's bedside. Certified nurse assistants (CNAs 1 and 3) were observed attempt to wake up Resident 35 to shower. Resident 35 declined to shower. Both CNAs 1 and 3 were further observed wheel the same shower chair to Resident 69's bedside. CNA 3 was further observed look at the shower chair seat several times. CNA 3 was observed wear clean gloves, touch bedside curtains, touch her self, turn on main light, elevate the head bed and touch the Resident 69 without changing gloves. Both CNAs 1 and 3 were then observed transfer Resident 69 onto the same shower chair without prior sanitization. Bedside curtains for Residents 35 and 69 observed with white, reddish and brown stains. During an interview on 2/19/19 at 10:45 a.m., CNA 3 stated "I noticed a stain like poop on the shower chair seat. It's from another resident. I was supposed to clean and correct CNA 1. I wont allow anyone to sit me or my loved one on dry poop. That disrespect to the resident and infection control issue." During an interview on 2/20/19 at 7:22 a.m., CNA 1 stated there was a yellow stain on the shower chair which looked like urine. CNA 1 continued to	F 880		

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

PRINTED: 03/12/2019
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
	055744	A. BUILDING _____ B. WING _____	02/26/2019

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

(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 880	Continued From page 45 state "I transferred the resident (Resident 69) onto the shower chair without first disinfecting it." CNA 1 further stated any resident shared equipment must be sanitized before and after use to prevent spread of infection. During an interview on 2/22/19 at 9:05 a.m., the director of staff development (DSD) stated shared equipments equipment must be disinfected prior to, after, and if visibly dirty (anything that is obvious to eyes use to prevent spread of infection from person to person. e. A review of the admission record indicates Resident 135 was admitted to the facility on 2/1/19 with diagnoses not limited to generalized muscle weakness. A review of the MDS dated 2/8/19 indicates Resident 135 has moderate cognitive impairment. During an observation on 2/22/19 at 7:40 a.m., both CNAs 2 and 4 were observed wear gloves, change Resident 135's diaper and close privacy curtains with same gloves. Both CNAS 2 and 4 failed to remove contaminated gloves and or sanitize their hands. During an interview on 2/22/19 at 8:21 a.m., CNA 2 verified and stated she changed Resident 135's wet diaper, closed the privacy curtains with contaminated gloves. CNA 2 stated "this is infection control concern." f. During an observation on 2/19/18 at 9:58 a.m., privacy curtains for Residents 35, 58 and 69 were observed with white, reddish and brown stains. A review of the facility's policy titled Cleaning and	F 880		

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

PRINTED: 03/12/2019
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
	055744	A. BUILDING _____ B. WING _____	02/26/2019

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

(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 880	Continued From page 46 Disinfection of Wheelchairs, walkers, Shower Chairs, and Stretchers revised 3/2009 indicates it is the facility's policy to clean and disinfect wheelchairs, walkers, shower chairs and stretchers when dirty and in between resident use. A review of the facility's undated policy titled Infection Prevention and Control Program Hand Hygiene indicates: 1. The facility considers hand hygiene the primary means to prevent the spread of infections. 2. To perform hand hygiene using alcohol based hand rub or soap and water before and after direct residents contact and before and after removing gloves. 3. Hand hygiene is the final step after removing and disposing personal protective equipment. 4. After contact with objects in the immediate vicinity of the resident.	F 880		

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

PRINTED: 03/12/2019
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
	056744	A. BUILDING _____ B. WING _____	02/26/2019

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

(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 880	Continued From page 47	F 880		

b. Based on observation and interview the facility failed to observe infection control measures by failing to ensure one of 19 sampled residents' (Resident 21) naked feet were not dragging on the floor during transpiration before and after shower. This deficient practice placed Resident 21 at risk for infection.

Findings:

A review of the admission record indicated Resident 21 was admitted on 04/20/17 and re-admitted on 03/15/18 with diagnoses that included lack of coordination, muscle weakness, cerebral infarction (stroke), and attention and concentration deficit.

A review of the minimum data set (MDS - a comprehensive assessment and care planning tool) dated 12/9/18 indicated Resident 21 was severely cognitively (ability to make decision of daily living) impaired. MDS indicated Resident 21 required extensive assistance in activities of daily living such as dressing, eating, toilet use and personal hygiene. Further review of the MDS indicated Resident 21 did not exhibited behaviors of rejecting care, such as assistance with activities of daily living.

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

PRINTED: 03/12/2019
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
	055744	A. BUILDING _____ B. WING _____	02/26/2019

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

(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 880	Continued From page 48 During an observation on 2/19/19 at 9:33 a.m. Resident 21 was being transported to the shower with a shower chair. Resident 21's feet did not have socks on, and were noted touching the floor on the way to the shower. During an observation on 2/19/19 at 9:43 a.m. Resident 21 was being transported back to his room, on a shower chair with no socks on, and both feet dragging on the floor. During an interview on 2/20/19 at 9:47 a.m. certified nursing assistant (CNA) 7 stated that Resident 21's feet would get dirty from dragging on the floor, and she should have cleaned them again, or used socks to protect his feet. During an interview on 2/20/19 at 10:07 a.m. licensed vocational nurse (LVN) 7 stated that Residents feet touching the floor to and from the shower could cause skin breakdown, infection or an accident. F880 Based on observation and interview and record review, the facility failed to provide a clean and sanitary environment to two of 19 sampled residents in the facility when: a) The curtain in Resident 6 room is stained yellow.	F 880		

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

PRINTED: 03/12/2019
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
	055744	A. BUILDING _____ B. WING _____	02/26/2019

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

(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 880	Continued From page 49 b) This failure has the potential to cause infections to affected residents and potentially spread microorganisms and infections to other residents in the facility. Findings: On 02/20/19 at 09:18 am during rounds, Resident 6's curtain was observed with unknown yellow stain. Resident 6 is nonverbal, unaware of his surroundings. Licensed Vocational Nurse 1 (LVN) was called to the room and confirmed the yellow stain and is unable to identify the source. LVN 1 stated that "It should not be there for infection control issues and it does not look good." LVN 1 called housekeeping and maintenance to have the curtain changed. In the guidelines for Environmental Infection Control in Health-Care Facilities Center, Centers for Disease Control and Prevention (CDC) website, https://www.cdc.gov/infectioncontrol/pdf/guidelines/environmental-guidelines.pdf, updated on February 15, 2017, indicated that "Careful cleaning of patient rooms and medical equipment contributes substantially to the overall control of Methicillin-resistant Staphylococcus aureus (MRSA- a bacterium that causes infections in different parts of the body, Vancomycin intermediate staphylococcus aureus (VISA- infection is a condition caused by bacteria) (germs) or VRE transmission. The major focus of a control program for either VRE or MRSA should be the prevention of hand transfer of these organism. Routine cleaning and disinfection of	F 880		

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

PRINTED: 03/12/2019
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
	056744	A. BUILDING _____ B. WING _____	02/26/2019

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

(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 880	Continued From page 60 the housekeeping surfaces and patient care surfaces should be adequate for inactivation of these organisms." A review of the facility policy and procedure, revised 03/2009, titled "Cleaning and disinfection ..." outlined a procedure that indicated "Cleaning and decontamination, consisting of the removal of dirt, foreign material to include body fluids and any other substances is the first step." A review of the facility policy/procedure section Resident Rights, subject "Dignity and Respect", dated October 4, 2016, indicated that "Resident has the right to a clean environment."	F 880		