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

poc Accepted on 8/3/1/8 # 36356

PRINTED: 08/23/2018 FORM APPROVED OMB NO. 0938-0391

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OSAGE HE	MANUED OF CHECKED	056143	B. WING	STREET ADDRESS, CITY, STATE, ZIP CO		3/22/2018
F 000 I	NAME OF PROVIDER OR SUPPLIER OSAGE HEALTHCARE & WELLNESS CENTRE			1001 SOUTH OSAGE AVE INGLEWOOD, CA 90301	סטב	
[i (((EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE
((F	INITIAL COMMENTS The following reflects the findings of the Department of Public Health during a Complaint		F (Preparation, submission and, execution of this Plan of Correction does not constitute admission or agreement by t	te he	
Ç	investigation. Complaint number: CA00588373 and CA00588744. Representing the Department of Public Health: Surveyor ID #: 36356, RN, HFEN.			Provider of the truth of the fa alleged or conclusions set for in this statement of deficient The Plan of Correction is prepared, submitted and/or	rth	
-				executed solely because it is required by the provision of federal and state law.		
f F 655 E SS=D (complaint investigated in the complaint investigated in the complaint CA00588 Baseline Care Plan CFR(s): 483.21(a)(iciency issued as a result of 8373 and CA00588744	Fé	F655 CORRECTIVE ACTION(S): Resident #1 was transferred to acute hospital on 5/20/20 The identified CNA #1 were g one on one in-service by the regarding NPO: nothing by mouth on 8/22/2018.	18. given	8/24/20
	§483.21(a) Baselin §483.21(a)(1) The implement a baseli that includes the in effective and perso that meet profession. The baseline care (i) Be developed wadmission. (ii) Include the mininecessary to proper including, but not li	facility must develop and ne care plan for each resident structions needed to provide on-centered care of the resident onal standards of quality care plan mustithin 48 hours of a resident's imum healthcare information erly care for a resident mited to-sed on admission orders.		HOW TO IDENTIFY OTHER RESIDENTS: The RN supervisor and Direct of Nursing completed a comprehensive review from 8/27/2018 to 8/29/2018 to a patients with GTUBE, no oth care planning issues noted.	all	g/201/2
ABORATDRY I	DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SO	ATURE	TITLE		(X6) DATE
						(1.0) 01116

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 formula program participal of the provided in the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participal of the provided in the facility.

FORM CMS-2567(02 Par Previous Xersion 02018

Event ID YTIE1:

Facility ID CA910000004

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	(X3) DATE SURV COMPLETED	/EY	
		056143	B. WING		08/22/201	18
NAME OF PROVIDER OR SUPPLIER OSAGE HEALTHCARE & WELLNESS CENTRE			1	STREET ADDRESS, CITY, STATE, ZIP CODE 1001 SOUTH OSAGE AVE NGLEWOOD, CA 90301		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	STEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPL	(5) LETION ATE
F 655	Continued From pa (D) Therapy service (E) Social services (F) PASARR recom	es.	F 655	DON and DSD in-serviced licensed staff and Certified Nursing Assistants (CNAs) on 8/23/2018-8/28/2018 regarding.		

§483.21(a)(2) The facility may develop a

comprehensive care plan in place of the baseline care plan if the comprehensive care plan-

- (i) Is developed within 48 hours of the resident's admission.
- (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).

§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:

- (i) The initial goals of the resident.
- (ii) A summary of the resident's medications and dietary instructions.
- (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.
- (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by:

Based on interview and record review, the facility failed to develop a plan of care for the risk of aspiration for the resident who had a gastrostomy tube [(GT)- a tube surgically inserted directly into the stomach to administer nutrition and hydration? and was at risk for aspiration for one of three sampled resident (1).

This deficient practices placed the resident at risk for aspiration and related complication including aspiration pneumonia.

Baseline Care Plan, Choking/ Aspiration and Nothing by mouth.

1

SYSTEMIC CHANGES: The Director of Nursing and RN supervisors will check the charts of newly admitted patients within 24 hours upon admission and review/update residents care plans after completion of comprehensive assessment, quarterly and as needed. All patients on Gtube will be reflected on Special Needs List: updated daily by the Medical

MONITORING PROCESS:

Records Designee

The Director of Nursing will track any trends or concerns related to baseline care plans; this will be communicated to the QA Committee for further evaluation and recommendations monthly. If it is determined that we have accomplished the objective in the POC above and the results are successful, then the facility will consider the matter resolved. The QA committee will continue to review until

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DEPARTMENT OF HEALTH AND HUMAN SERVICES							FORM APPROVED		
CENTER	S FOR MEDICARE	& MEDICAID SERVICES					0.0938-0391		
		(X1) PROVIDER/SUPPLIER/CL'A IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		056143	B. WING			0	C 8/22/2018		
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE				
OSAGE H	IEALTHCARE & WEL	LNESS CENTRE			of South OSAGE AVE GLEWOOD, CA 90301				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFIC:ENCY)	JLD BE	(X5) COMPLETION DATE		
F 655	Continued From pa	age 2	F	6 5 5	such time that the deficiency has	been			
	Findings:				proven to be resolved for 2 consemonths and/or advised by the QA	cutive			
	An unannounced visit was made to the facility on 5/30/18, to investigate a complaint allegation regarding Resident 1's quality of care and treatment.				Committee.		İ		
	resident admitted treadmitted on 5/18 included sepsis (a an infection), cereb death of brain cells hemiparesis (partial	lent 1's admission record the to the facility on 5/07/18 and 5/2018, with diagnoses that life-threatening complication of oral vascular accident (suddens due to lack of oxygen), all paralysis affecting one side ralized muscle weakness, and ty swallowing).		:					
	(MDS), a standard screening tool, dat resident had sever (ability to think, masolving) and requirectivities of daily limited.	dent 1's Minimum Data Set lized assessment and care ted 5/10/18, indicated the re impairment in cognitive skills ake decisions, and problem red extensive assistance for ving [(ADL)- mobility, dressing, cording to the MDS the resident	t						
		ent 1's Physician Admitting 18, indicated the resident was							

placed on nothing per oral [(NPO), nothing by mouth], and had an order for GT feeding with Jevity 1.5 to administer at 55 milliliters per hour (ml/hr) via GT pump for 20 hrs to provide 1100 ml a day.

A review of Resident 1's clinical record indicated there was a plan of care for Tube feeding, dated 5/7/18, indicated the resident was on G-Tube feeding related to dysphagia. According to the

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PRINTED: 08/23/2018 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING _ C 056143 B. WING 08/22/2018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1001 SOUTH OSAGE AVE OSAGE HEALTHCARE & WELLNESS CENTRE INGLEWOOD, CA 90301 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 655 Continued From page 3 F 655 listed interventions there was no documented evidence the risk for aspiration was identified with related interventions in place. During an interview on 5/30/18 at 11:28 a.m., with Resident 1's responsible party (RP) stated that on 5/10/18, at 12:25 p.m., RP visited Resident 1 and observed dry vomit on the resident's gown. RP stated, when RP asked the resident what happened, the resident stated to RP "drink." The RP stated a certified nurse assistant 2 (CNA 2), stated to RP, that she used a straw to give the resident water and the resident vomited. RP stated CNA2 did not know if the speech therapist had cleared the resident to have liquids by mouth. During an interview on 5/30/18 at 12:43 p.m., the charge nurse (CN), stated Resident 1 was transferred to GACH because the resident had fever and low oxygen saturation at 90 percent. CN stated, the resident was administered Tylenol (medication for pain and fever) and a breathing treatment. CN stated CNA 2 had stated the resident asked for water, and CNA 2 gave the resident water by mouth. CN stated during morning report, CNA 2 was informed the resident had a GT and was NPO. During an interview 5/30/18 at 1:10 p.m., CNA 2

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stated, "I gave Resident 1 a little bit of water using a straw. It was about 5.0 ml (less than one teaspoon) of water, and he started to cough. He did not swallow the water. I did not ask the charge

According to the licensed nurses progress notes,

Resident 1's had oxygen saturation at 94 percent

nurse before giving the water."

(reference range 95 to 100 percent)

dated 5/10/18, at 12 p.m.,

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(HB) DAILO	OCINEDITOR					0.0	C	
056143 NAME OF PROVIDER OR SUPPLIER OSAGE HEALTHCARE & WELLNESS CENTRE			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 SOUTH OSAGE AVE INGLEWOOD, CA 90301					
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F 655	Fahrenheit (F) [nor to 98.6 F]. Nurses administered Tyler and chest X-ray waindicated the resid (SOB) or pain, and Blood pressure was According to the life 5/10/18 at 1 p.m., 100.3 F, and oxyg. The resident was a oxygen via non-resident was a oxygen via non-resident was a oxygen via non-resident (GACH) esaturation level of temperature. According to the life 5/10/18 at 3 p.m., GACH in stable coand not in acute defined and not in acute defined and review of GACH 5/10/18, indicated emergency room on the complaint of the stable complaint of the complaint of the same stable complaint of the same same same same same same same sam	y temperature was 101.9 mal body temperature is close documented the resident was lol for the elevated temperature as ordered. The progress notes ent had no shortness of breath was not in acute distress. Is 138/64. Censed nurses noted dated the resident's temperature was en saturation was 90 percent. Indiministered six liters (6.0 L) of coreather mask. Indiana, there was a physician's to cent to a general acute care mergency room for oxygen 88 percent and elevated Censed nurses notes dated Resident 1 was transferred to condition with no SOB, no pain		655				
	According to Resirecord, dated 5/10 diagnosed with as	ature was 98.4 F, respirations nute, blood pressure of 105/81, ation 99 percent. Ident 1's GACH admission 1/18, the resident was piration pneumonia (infection in bod or liquids being breathed into						

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		056143	B. WING	;		1	C 22/2018	
NAME OF PROVIDER OR SUPPLIER OSAGE HEALTHCARE & WELLNESS CENTRE				100	REET ADDRESS, CITY, STATE, ZIP CODE 01 SOUTH OSAGE AVE GLEWOOD, CA 90301			
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F 655	Resident 1 was d	oage 5 of being swallowed). ischarged from the GACH on dmitted to the facility same day.	F	655				
	Choking and Asp individuals who h	cility's policy titled "About iration" dated 2014, indicated ave feeding tubes and receive (NPO) have a risk of aspiration		A COMPANY OF A PROPERTY OF A P				
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