7/9/2021 POC approved @ 12:30pm
36526

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

PRINTED: 06/28/2021
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
	555128	A. BUILDING _____ B. WING _____	C 06/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOWNEY COMMUNITY HEALTH CENTER	8425 IOWA STREET DOWNEY, CA 90241

(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 The following reflects the findings of the Department of Public Health during the investigation of a Facility Reported incident (FRI). Facility Reported incident (FRI) CA00722963 Representing the Department of Public Health: 37393 RN, HFEN The inspection was limited to the specific FRI investigated and does not represent the findings of a full inspection of the facility. One deficiency was issued for FRI CA00722963	F 000		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure one of three residents were protected and free from abuse	F 600	Corrective Actions: Resident 2 was transferred out to acute hospital for further evaluation of aggressive behavior. Resident 1 was monitored for safety. How to Identify other residents: DON/Designee reviewed all residents' records regarding monitoring of aggressive behavior, residents refusing psych meds. There were no other issues identified.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 7.7.21

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555128	A. BUILDING _____ B. WING _____	C 06/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOWNEY COMMUNITY HEALTH CENTER	8425 IOWA STREET DOWNEY, CA 90241

(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 600	Continued From page 1 (Resident 1). Resident 1 was struck in the face with a water-filled pitcher by Resident 2. Resident 2, who had a history of throwing items with physical aggression, was refusing medications to control her psychotic (mental disorder characterized by a disconnection from reality) behavior and was not being closely monitored by the staff. This deficient practice resulted in Resident 1 being physically assaulted by Resident 2 and sustaining a laceration (deep cut) to the left cheek, requiring wound treatment for wound closure. Findings: a.During a review of Resident 1's Admission Face Sheet, the Face Sheet indicated the resident was admitted to the facility on 8/8/2018 and last readmitted on 9/15/2020. Resident 1's diagnoses included Alzheimer's disease (an irreversible, progressive brain disorder that slowly destroys memory, thinking skills, and the ability to care for oneself), dementia (impairment of brain function such as memory loss and judgment) and anemia (low iron in the blood). During a review of Resident 1's Minimum Data Set (MDS), a resident assessment and care screening tool, dated 10/30/2020, the MDS indicated Resident 1 had no cognitive impairment (thought process) problems. The MDS indicated Resident 1 was assessed requiring a two-person physical assist for bed mobility and transferring, a one-person assist with locomotion on and off the unit, personal hygiene, toileting, and dressing. According to the MDS, Resident 1 was totally dependent with walking in room and corridor.	F 600	Systematic Changes: The facility has revised the policy on handling refused medications, emphasizing on reporting refused meds after each occurrence to MD, with exception of supplements and vitamins, initiating an SBAR, notifying responsible party. The facility also revised the policy on handling aggressive behaviors , to include SBAR completion, MD and responsible party notification, 1:1 staff supervision as needed, and timely transfer to acute hospital for evaluation and better medication management. DON/Designee provided an in-service to staff (PAs, PSs, Licensed Nurses) on 02/01/21-02/07/21 and a follow up in-service to staff (Pas, PSs, and licensed nurses) on 05/24/21-05/30/21 regarding the revised policies. The DON or designee will review EMARS at least 2-3 x a week for any refused medication, to ensure the policy on reporting and further assessment is being followed by the licensed nurses consistently.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555128	A. BUILDING _____ B. WING _____	C 06/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOWNEY COMMUNITY-HEALTH CENTER	8425 IOWA STREET DOWNEY, CA 90241

(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 600	Continued From page 2 During a review of the facility's Situation, Background, Assessment and Recommendation ([SBAR] an internal communication form), dated 1/23/2021 and timed at 11:45 a.m., the SBAR indicated the staff called for help due to Resident 2 verbalizing she was "tired" of Resident 1 talking about her. The SBAR indicated Resident 2 was very upset and suddenly became angry with Resident 1 (Residents 1 and 2 were roommates). Resident 2 assaulted Resident 1 by throwing a filled water pitcher at Resident 1. Resident 1 sustained a 3 x 1.5 centimeter ([cm] unit of measurement) laceration to the left cheek, which was witnessed by the facility's staff during a FaceTime video (allows users to engage in visual video chatting over the internet) call with a family member. According to the SBAR, Resident 2 was redirected and was moved to a single room and placed on one to one staff monitoring. During a review of Resident 1's Nurses Progress Note (NPN), dated 1/23/2021 and timed at 2:53 p.m., the NPN indicated the hospice (end of life care) nurse came to the facility at 2:13 p.m. to see Resident 1 with new physician orders received. The NPN indicated wound treatment was done to Resident 1's left cheek laceration. The wound care treatment included to cleanse the wound with normal saline (solution of salt water), pat dry, apply antibiotic (used for treatment of infection) ointment and apply steri-strips (wound closure tape put across an incision or minor cut to assist in wound healing) as needed. b. During a review of Resident 2's Admission Face Sheet, the Face Sheet indicated Resident 2 was admitted to the facility on 9/8/2003 and last	F 600	Monitoring process: DON/Designee will track any trends or concerns related to residents' refusal of medication and monitoring of residents' aggressive behavior through residents' EMAR, interview, documentation, data collection. Findings will be reviewed and discussed at the facility's monthly QAPI meeting X3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555128	A. BUILDING _____ B. WING _____	C 06/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOWNEY COMMUNITY HEALTH CENTER	8425 IOWA STREET DOWNEY, CA 90241

(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 600	Continued From page 3 readmitted on 2/4/2021. Resident 2's diagnoses included paranoid schizophrenia (a mental disorder that can result in hallucinations sensing things that are not real with delusions [a fixed belief or impression that is not reality] and disordered thinking and behavior), schizoaffective disorder (a combination of schizophrenia and mood disorder, such as depression including symptoms of delusions, hallucinations, depressed episodes, and manic periods of high energy) and chronic obstructive pulmonary disease ([COPD] a chronic inflammatory lung disease that causes obstructed airflow from the lungs). During a review of Resident 2's MDS, dated 10/30/2020, the MDS indicated Resident 2 had mild impaired cognitive skills (ability to reason and think) for daily decision-making and usually understood others. The MDS indicated Resident 2 required an extensive assistance of a one-person physical assist for transferring, dressing, and bed mobility. During a review of Resident 2's SBAR, dated 1/23/2021 and timed at 12:21 p.m., the SBAR indicated Resident 2 had physical aggression towards another resident (Resident 1). The SBAR indicated Resident 2 was upset and angry because she believed Resident 1 was talking "about" her. The SBAR indicated Resident 1 was on a FaceTime video call with a family member and a staff member observed Resident 2 throwing a filled water pitcher striking Resident 1 on the face. The SBAR indicated Resident 2 was transferred to a psychiatric (conditions that affect mood, thinking, and behavior) hospital for a behavioral evaluation. During a review of Resident 2's care plan,	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555128	A. BUILDING _____ B. WING _____	C 06/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOWNEY COMMUNITY HEALTH CENTER	8425 IOWA STREET DOWNEY, CA 90241

(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 600	Continued From page 4 initiated on 6/15/2018 and last revised on 8/25/2019, identified Resident 2 receiving psychotropic medication (drugs that affects behavior, mood, thoughts, or perception) for schizoaffective disorder manifested by intense paranoia (involves intense anxious or fearful feelings and thoughts often related to persecution, threat, or conspiracy) with auditory hallucinations, as she states, "I hear staff and others talking about me." The goal indicated the resident would have decrease adverse reaction to the medication through the next target date of 4/18/2021. The staff interventions included to monitor and record episodes of behavior, redirect resident's attention as appropriate, and provide reality orientation as needed. During a review of Resident 2's care plan, initiated on 12/8/2020, the care plan identified behavior problem due to increased agitation as evidenced by throwing objects at staff and others, refusing care, and refusing medications. The goal indicated Resident 2 would be able to demonstrate effective coping skills; the resident would have fewer episodes of behavior problems, such as agitation as evidenced by throwing objects, refusing care, and refusing medications by a target date of 4/18/2021. The staff's interventions included to modify the environment, monitor / document any signs or symptoms of Resident 2 posing danger to self or others, and psychiatric consult as indicated. During a review of Resident 2's NPN, dated 12/8/2020 and timed at 7:55 p.m., the NPN indicated Resident 2 was noted with increased agitation as evidenced of throwing objects to staff and other residents, refusing care, and refusing medications. Redirections and counseling	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555128	A. BUILDING _____ B. WING _____	C 06/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOWNEY COMMUNITY HEALTH CENTER	8425 IOWA STREET DOWNEY, CA 90241

(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 600	Continued From page 5 rendered but ineffective. During a review of Resident 2's NPNs, dated 12/9/2020, 12/10/2020, 12/11/2020, 12/26/2020, 12/27/2020, 12/28/2020, the NPNs indicated Resident 2 was on close monitoring by staff for episodes of yelling out, verbal aggression, throwing items at others, and refusing care. During an interview, on 2/9/2021 at 12:10 p.m., Resident 1's family member (FM 1) stated on 1/23/2021 while having a FaceTime conversation with her family member (Resident 1), her roommate (Resident 2), was heard cursing, opening the privacy curtain between the residents and threw a filled water pitcher at Resident 1. FM 1 stated Resident 1 was all wet, crying and yelled for assistance from one of the nurses. Resident 1 told FM 1 her roommate (Resident 2) continuously cursed, yelled, and threatened her (Resident 1). FM 1 stated Resident 1 had a cut to the face that may have been prevented, because Resident 1 had complained about Resident 2 before the abuse incident occurred. During an interview, on 2/9/2021 at 2:15 p.m., Licensed Vocational Nurse 1 (LVN 1) stated while sitting at the nursing station a staff member could be heard yelling for help in a resident's room. LVN 1 stated the Activities Assistant (AA) told her Resident 2 suddenly threw a filled water pitcher at Resident 1's face during a FaceTime video call. LVN 1 stated Resident 2 had a history of being verbally aggressive towards others. LVN 1 stated Resident 1 sustained a laceration to the face and was observed bleeding and crying. During an interview, on 2/9/2021 at 2:26 p.m., LVN 2 stated she was called to clean Resident 1's	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555128	A. BUILDING _____ B. WING _____	C 06/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOWNEY COMMUNITY HEALTH CENTER	8425 IOWA STREET DOWNEY, CA 90241

(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 600	Continued From page 6	F 600		

face laceration wound with slight bleeding close to the resident's left eye. LVN 2 stated steri-strips were applied and an ice pack to Resident 1's face. LVN 2 stated LVN 1 reported the incident to the assigned physician.

During an interview, on 2/9/2021 at 3 p.m., the AA stated she overheard Resident 1 call out for help and she responded. The AA stated Resident 2 was "acting up" and she went to call for help. The AA stated Resident 2 had a history of being verbally abusive towards staff.

During a concurrent observation and interview on 2/9/2021 at 3:11 p.m., Resident 1 was seen with a dark purple discoloration to the left cheek and a laceration from the left eyebrow to the left cheekbone with yellow color drainage. Resident 1 was tearful and stated Resident 2 hit her in the face and she was afraid of Resident 2. Resident 1 denied "talking" about Resident 2. Resident 1 stated there was water and blood all over her face after being hit with the water pitcher. Resident 1 stated she told her family member (FM 1) what occurred.

During an interview, on 2/9/2021 at 3:20 p.m., the Social Services Director (SSD) stated Resident 2 was verbally aggressive towards others, but not physically aggressive.

During an interview, on 2/9/2021 at 3:45 p.m., the Activities Director (AD) stated she was assisting Resident 1 to talk with FM 1 through FaceTime. The AD stated Resident 2 was initially quiet in bed during Resident 1's FaceTime call with family. The AD stated while standing next to Resident 1 and she noticed Resident 2 moving in bed and suddenly opened the room dividing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555128	A. BUILDING _____ B. WING _____	C 06/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOWNEY COMMUNITY HEALTH CENTER	8425 IOWA STREET DOWNEY, CA 90241

(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 600	Continued From page 7 curtain while throwing the water pitcher at Resident 1. The AD stated Resident 2 was very aggressive and should not have been in the same room with Resident 1. The AD stated Resident 2 has behaviors of paranoia and aggressiveness. During an interview, on 2/9/2021 at 4 p.m., the Director of Nursing (DON) stated Resident 2 was placed in the skilled nursing unit due to a decline in caring for herself, and required staff assisted care. During an interview, on 2/25/2021 at 7:51 a.m., LVN 1 stated Resident 2's behavior was usually delusional, aggressive and would often refuse medications for control of the behaviors. LVN 1 stated Resident 2 believed staff was poisoning her with the prescribed medications. During a review of the facility's policy and procedure (P/P), dated 1/14/2013 and titled, "Resident-to-Resident," indicated the facility's staff will monitor residents for aggressive / inappropriate behavior towards other residents, family members, visitors, and or to the staff. Should a resident be observed /accused of abusing another resident, the facility will implement the following actions: remove the aggressor from the situation if the aggressor is still in the area in which the incident occurred. Counsel the resident to determine the cause of the behavior. Evaluate the circumstances/events leading up to the incident; develop a care plan that includes interventions to prevent the recurrence of such incident. Document in the resident's clinical record all interventions and their effectiveness, consult psychiatric services for assistance in assessing the resident and developing a care plan or intervention and	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555128	A. BUILDING _____ B. WING _____	C 06/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOWNEY COMMUNITY HEALTH CENTER	8425 IOWA STREET DOWNEY, CA 90241

(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 600	Continued From page 8 management as necessary or as may be recommended by the attending physician or interdisciplinary care planning team.	F 600		