



CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY  
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>056166</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/09/2014</b>
NAME OF PROVIDER OR SUPPLIER <b>PARAMOUNT MEADOWS NURSING CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>7039 Alondra Blvd, Paramount, CA 90723-3925 LOS ANGELES COUNTY</b>		
(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) COMPLETE DATE
	<p>The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>§483.65 (a) Infection Control Program The facility must establish an Infection Control Program under which it-</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>On [REDACTED] [REDACTED] 2014 at 9:54 a.m., the Department received a complaint allegation about patient care provided to a resident (Resident 1). The complaint alleged that the facility's staff ignored repeated complaints by Resident 1 that the indwelling catheter that was inserted into her urethra (a tube that connects the urinary bladder to the genitals for the removal of fluids from the body) was hurting her badly, and she was having bad back and side pain and diarrhea. The complaint also alleged the staff was rude and ignored her. The complaint indicated on [REDACTED] 2014, the resident was sent to the hospital for having low blood pressure and was found to have a bad bladder infection. The resident died on [REDACTED] 2014 because of this infection.</p> <p>On [REDACTED] [REDACTED] 2014 at 10:30 a.m., during a telephone interview with a family member (FM 1), she stated Resident 1 suffered from "frequent back, side, and the indwelling urinary catheter site pain</p>		<p><b>System for Compliance:</b></p> <ol style="list-style-type: none"> <li>1. Beginning [REDACTED]/14 and completed on [REDACTED]/14 staff received education from DSD on reporting changes in condition of urine in residents with foley catheter, as well as monitoring quality and character of urine.</li> <li>2. Beginning [REDACTED]/14 and completed [REDACTED]/14, staff received re-education by DSD in securing foley catheter tubing with use of bed-sheet clamp, as well as indication to irrigate foley catheter and to report to MD.</li> <li>3. Beginning [REDACTED]/14 and completed on [REDACTED]/14 staff received education from DSD to use stabilizing tape for foley catheter if clamp not functioning properly or absent.</li> <li>4. The Licensed Nurses (LN) shall conduct rounds every shift to ensure that each resident's foley catheter and drainage is secure.</li> <li>5. Each shift LNs and CNAs shall continue to monitor foley catheter for any change in quality or character in urine.</li> </ol>	

Event ID:2XYV11

12/17/2014

4:01:55PM

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY  
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>056166</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/09/2014</b>
NAME OF PROVIDER OR SUPPLIER <b>PARAMOUNT MEADOWS NURSING CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>7039 Alondra Blvd, Paramount, CA 90723-3925 LOS ANGELES COUNTY</b>		
(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) COMPLETE DATE	
	<p>and would become worst when the catheter was pulled or tugged." FM 1 reported she observed no device in place to secure the catheter tubing. Resident 1 reported to FM 1 the pain medication she was receiving had minimal pain relief. FM 1 stated she reported the resident's complaints repeatedly to the primary physician and staff, but she stated, "They made it seemed like there was nothing to worry about."</p> <p>On [REDACTED] [REDACTED] 2014 at 8:30 a.m., an unannounced complaint investigation was conducted. During the tour of the facility, several residents were observed with indwelling urinary catheters with cloudy urine and sediment (solid matter in the urine), which can be indicative of UTI.</p> <p>Based on observation, interview and record review, the facility failed to ensure Resident 1, who had an indwelling urinary catheter (tube inserted into the bladder to drain urine) received appropriate care and services to prevent urinary tract infections (UTI) including:</p> <ol style="list-style-type: none"> <li>1. Failing to assess the urine color and character, and report abnormalities to the physician, as indicated in the resident's plan of care and the facility's policy.</li> <li>2. Failing to maintain a closed drainage system (use of a water- or air-tight system to drain a body cavity) as indicated in the resident's plan of care and the facility's policy.</li> <li>3. Failing to use clamps (a urinary catheter</li> </ol>		<p>6. Beginning [REDACTED]/14 and completed [REDACTED]/14 LN and CNA received education from DSD on foley catheter care to prevent infection of the resident's urinary tract which included hand washing, glove usage, maintaining unobstructed urine flow, when to change catheter and drainage bags and procedure for obtaining urine specimen from an indwelling catheter, while maintaining a closed system, to prevent infection of the resident's urinary tract.</p> <p><b><u>Performance and Compliance Monitoring and POC Evaluation:</u></b></p> <ol style="list-style-type: none"> <li>1. The Director of Nursing and QA nurses will monitor for compliance weekly, and any deficiencies will be reported to the administrator and reviewed at the monthly QA meeting.</li> </ol> <p><b><u>Completion date: 05/30/14</u></b></p>		

Event ID: 2XYV11

12/17/2014

4:01:55PM

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY  
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>056166</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/09/2014</b>
NAME OF PROVIDER OR SUPPLIER <b>PARAMOUNT MEADOWS NURSING CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>7039 Alondra Blvd, Paramount, CA 90723-3925 LOS ANGELES COUNTY</b>		
(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) COMPLETE DATE	
	<p>securement device that keeps a catheter securely in place) to anchor the catheters to prevent urethral pain, discomfort and tissue damage, as indicated in the facility's policy.</p> <p>4. Failing to assess the effectiveness of the chosen interventions to treat Resident 1's UTIs, and failing to consult with the resident's physician and care planning team to consider an alternative intervention to treat UTIs or obtaining urine for urinalysis (UA) and culture and sensitivity (C/S).</p> <p>5. Failing to implement the facility's indwelling catheter or UTI risk care plan and policy and procedures.</p> <p>These and other deficient practices described in the findings resulted in Resident 1 complaining of back, side, vaginal pain in the indwelling catheter site, becoming unresponsive, and being transferred to a general acute care hospital (GACH). Immediately upon arrival to the GACH the resident became unstable requiring telemetry (heart monitoring) and transferred to the intensive care unit (ICU) with a diagnosis of urosepsis (a life threatening bacterial infection in the urinary tract). While in the ICU, the resident required mechanical ventilation (machine to assist with breathing), cardiopulmonary resuscitation (CPR) twice, intravenous (into the vein) medications such as Levophed (to help increase the blood pressure), had two episodes of cardiac arrest (the heart develops an abnormal rhythm and stops beating) and expired on [REDACTED] 2014, less than 24 hours after admission to the</p>				

Event ID:2XYV11

12/17/2014

4:01:55PM

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY  
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>056166</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/09/2014</b>	
NAME OF PROVIDER OR SUPPLIER  <b>PARAMOUNT MEADOWS NURSING CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>7039 Alondra Blvd, Paramount, CA 90723-3925 LOS ANGELES COUNTY</b>		
(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) COMPLETE DATE
	<p>GACH.</p> <p>A closed record review of Resident 1's Admission Face Sheet indicated the resident was a 66 year-old female who was admitted to the facility on [REDACTED] 2014 from a GACH. The resident's diagnoses included morbid obesity (excess body fat), muscle weakness, cellulitis (infection of the skin and deep underlying tissue) of both legs and sacral (triangular-shaped bone at the bottom of the spine) pressure sore (skin damage caused by pressure).</p> <p>A review of a Minimum Data Set (MDS), a standardized assessment and care screening tool, dated [REDACTED] 2014, indicated the resident was independent in cognitive skills without memory problems, had the ability to make needs known and understand others. According to the MDS, Resident 1 was totally dependent upon staff and required two or more persons assist in bed mobility, transferring and toilet use, and was frequently incontinent of bowel (involuntary loss control of bowel).</p> <p>According to the National Institute of Health, the signs and symptoms of UTI included, but not limited to fever, pain with urination, pressure pain or spasm in the back or lower part the belly and cloudy, milky or sediment in the urine. Milky or sediment in the urine can be caused by bacteria or mucus in the urine and can produce the foul odor urine. In the elderly, altered mental status or confusion may be the only sign of UTI <a href="http://www.nlm.nih.gov/medlineplus">http://www.nlm.nih.gov/medlineplus</a>.</p>			

Event ID:2XYV11

12/17/2014

4:01:55PM

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY  
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>056166</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/09/2014</b>	
NAME OF PROVIDER OR SUPPLIER <b>PARAMOUNT MEADOWS NURSING CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>7039 Alondra Blvd, Paramount, CA 90723-3925 LOS ANGELES COUNTY</b>		
(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) COMPLETE DATE
	<p>A plan of care, titled, "Requires Use of Indwelling Urinary Catheter," dated [REDACTED] 2014, indicated the resident was at risk for UTI. The staff's plan of approach included, but not limited to: monitoring and observing for change of condition such as; urine output, color, clarity, (clear or cloudiness of the urine), amount, and presence of sediment; report to physician as needed; obtain lab if ordered and report result to physician.</p> <p>A review of the laboratory report, dated [REDACTED] 2014, and timed at 7:52 p.m., indicated the UA results; yellow cloudy urine; positive nitrite (indicative of presence of bacteria) and moderate amount of bacteria. The urine (C/S) results indicated Proteus Mirabilis (a rod-shaped bacteria found in putrid meat, abscesses, and fecal material responsible for complicated UTIs that sometimes causes bacteremia ?bacteria in the blood? ) was isolated which was resistant (without response to treatment) to Ciprofloxacin (an antibiotic). At the bottom of the C/S report, next to the column that indicated Ciprofloxacin resistant, the nurse wrote, "Cipro 500 mg BID (twice a day) x 10 days Dr. .... (Physician [MD] 3's name)."</p> <p>A review of a nurse's note, dated [REDACTED] 2014, and timed at 10:45 p.m., indicated the physician was called regarding the abnormal UA and C/S results awaiting a call back. Another nurse's note dated [REDACTED] 2014, and timed at 5:10 a.m., indicated the physician was made aware of UA and C/S results with new orders given and carried out.</p> <p>A review of MD 3's telephone order, dated [REDACTED]</p>			

Event ID:2XYV11

12/17/2014

4:01:55PM

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY  
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>056166</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/09/2014</b>	
NAME OF PROVIDER OR SUPPLIER <b>PARAMOUNT MEADOWS NURSING CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>7039 Alondra Blvd, Paramount, CA 90723-3925 LOS ANGELES COUNTY</b>		
(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) COMPLETE DATE
	<p>█ 2014, and timed at 5:10 a.m., indicated an order for Ciprofloxacin 500 milligrams (mg) twice daily for 10 days. A review of the Medication Record Administration (MAR) indicated Resident 1 received Ciprofloxacin 500 mg two times daily from █ █ 2014, which the Proteus organism was resistant to. There was no documented evidence during this period that the facility questioned or assessed the effectiveness of the chosen intervention, Ciprofloxacin, to treat Resident 1's UTI, or consulted with the resident's care planning team to consider an alternative intervention to treat the UTI.</p> <p>A review of a hospice care note, dated █ █, 2014, and timed at 5:30 p.m., indicated Resident 1 began hospice care on █ █ 2014 and hospice care discontinued on █ █ 2014 per FM 1's request. The hospice nurse documented on █ █ 2014, Resident 1 was morbidly obese, with an indwelling urinary catheter draining yellow urine with mild sediment and cloudiness. According to the same note, a licensed vocational nurse (LVN 5) reported the resident had been having increased episodes of confusion and foul odorous urine with a possible urinary tract infection.</p> <p>However, a review of the nurse's notes, dated from █ █ 2014 █ █ 2014, indicated Resident 1 had clear urine, without any documentation of the presence of sediment or foul smelling cloudy urine. There was also no documentation of the resident being confused.</p> <p>A review of MD 4's telephone order, dated █ █</p>			

Event ID:2XYV11

12/17/2014

4:01:55PM

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY  
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>056166</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/09/2014</b>	
NAME OF PROVIDER OR SUPPLIER <b>PARAMOUNT MEADOWS NURSING CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>7039 Alondra Blvd, Paramount, CA 90723-3925 LOS ANGELES COUNTY</b>		
(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) COMPLETE DATE
	<p>2014, and timed at 6 p.m., indicated an order for Nitrofurantoin (an antibiotic to treat infection) 100 milligrams (mg) by mouth two times a day for seven days, which Resident 1 received. However, a review of the C/S, dated [REDACTED] 2014, indicated that the pathogenic organism found in the urine was resistant to Nitrofurantoin. There was no documented evidence that the facility assessed the effectiveness of the chosen intervention, Nitrofurantoin, to treat Resident 1's UTI, or consulted with the resident's care planning team to consider alternative interventions to treat UTIs. There was no documentation that the facility consulted with the resident's physician and care planning team to consider obtaining urine for urinalysis (UA) and C/S, after the hospice nurse documented the urine was cloudy with sediment and LVN 5 indicated the resident's urine had a foul smell and her confusion had increased.</p> <p>A review of a physician's order, dated [REDACTED] 2014, indicated orders that included: indwelling urinary catheter for bladder retention (inability of the bladder to empty urine); change catheter every month on the sixth of the month and PRN (as needed), dislodgement, malfunction or blockage; catheter care daily; change the catheter drainage bag twice monthly on the sixth and 21st and PRN when soiled/ leaking, and irrigate with 40 milliliters (ml) normal saline daily/PRN if sediment are present.</p> <p>A review of the physician's notes, nurse's notes and the laboratory reports, indicated there was no documented evidence a urine sample was sent to the laboratory for U/A or C/S testing before or after</p>			

Event ID:2XYV11

12/17/2014

4:01:55PM

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY  
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>056166</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/09/2014</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER <b>PARAMOUNT MEADOWS NURSING CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>7039 Alondra Blvd, Paramount, CA 90723-3925 LOS ANGELES COUNTY</b>
---	--

(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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

	<p>the antibiotic was prescribed on [REDACTED] 2014, to determine the presence of a pathogenic organism and/or what medications would best to treat the infection. According to an article by the National Kidney Foundation, at <a href="http://www.kidney.org">www.kidney.org</a>, titled, "Urinary Tract Infection," the physician will test a sample of the urine for bacteria and blood cells, which is called a urinalysis (U/A). It further indicated a culture of the urine will tell the physician which bacteria are present and different antibiotics may be tested to see which works best against the bacteria.</p> <p>On [REDACTED] 2014, at 1:10 p.m., during a telephone interview, the assistant administrator was asked for Resident 1's urine lab reports in [REDACTED] 2014 and [REDACTED] 2014, the assistant administrator stated, "We did not send the urine for testing."</p> <p>A physician's order, dated [REDACTED] [REDACTED] 2014, and timed at 12:15 p.m., indicated to transfer Resident 1 to a GACH for further evaluation of hypotension (low blood pressure), tachycardia (rapid heart rate &gt;101), and congestion (accumulation of excess fluid and mucus in the lungs). The nurse's note, dated and timed the same time, indicated the resident had altered mental status and the blood pressure was low at 85/57, heart rate was high at 105 beats per minute, and the respiratory rate was also high at 25 breaths per minute.</p> <p>A review of the GACH's Emergency Room (ER) notes indicated the resident was admitted on [REDACTED] [REDACTED] 2014, at 1:31 p.m., with a presenting complaint of chest congestion, hypotension, and tachycardia and altered mental status (confused).</p>			
--	---	--	--	--

Event ID: 2XYV11

12/17/2014

4:01:55PM

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY  
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>056166</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/09/2014</b>	
NAME OF PROVIDER OR SUPPLIER <b>PARAMOUNT MEADOWS NURSING CENTER</b>		STREET ADDRESS, CITY STATE ZIP CODE <b>7039 Alondra Blvd, Paramount, CA 90723-3925 LOS ANGELES COUNTY</b>		
(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) COMPLETE DATE
	<p>According to the ER notes, Resident 1 arrived with an indwelling urinary catheter and the following laboratory specimens were sent: urinalysis UA; chemistry (a test to determine levels of electrolytes (sodium, potassium, chloride, and bicarbonate in the blood) and enzymes (to determine heart function, as well as any damage to the heart); and urine and blood C/S.</p> <p>On [REDACTED] [REDACTED] 2014 at 5:46 p.m., approximately four hours after admission to the GACH, the resident was diagnosed with UTI and sepsis (life threatening infection of the blood) with the probable source to be UTI.</p> <p>A review of the lab reports from the GACH, dated [REDACTED] [REDACTED] 2014, indicated the WBC (white blood cells) were elevated at 29.7 (reference range 3.8-10.8); neutrophils (type of white cells) were elevated at 89% (reference range 50-80%, if elevated can be indicative of an infection); neutrophil Abs (absolute level) elevated at 26.4 (reference range 2.2-4.8, an elevated result is indicative of infection, damage, or inflammation of tissue).</p> <p>A review of Resident 1's UA lab results, dated [REDACTED] 2014, and timed at 2 p.m., indicated the urine was yellow and cloudy, and positive for protein (can be a sign of kidney damage or UTI). The lab indicated the WBCs and blood in the urine were too many to count. According to WebMD, blood in the urine can be an indicative of trauma to the urinary tract and/or infection. The blood</p>			

Event ID:2XYV11

12/17/2014

4:01:55PM

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY  
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  056166	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  05/09/2014	
NAME OF PROVIDER OR SUPPLIER  PARAMOUNT MEADOWS NURSING CENTER		STREET ADDRESS, CITY, STATE, Z.P. CODE 7039 Alondra Blvd, Paramount, CA 90723-3925 LOS ANGELES COUNTY		
(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) COMPLETE DATE
	<p>chemistry, dated [REDACTED] 2014, indicated an elevated level of Lactic acid 2.60 (reference range 1.80). WebMD indicated an elevated Lactic acid level in the blood is an indication of severe sepsis/septic shock (life threatening due to the presence of bacteria in the blood).</p> <p>A review of the C/S results, dated [REDACTED] 2014, and timed at 6:38 a.m., indicated Resident 1's urine tested positive for Proteus Mirabilis (&gt;100,000 cfu), (the same organism that was identified on the C/S [REDACTED] 2014); Escherichia coli ([E. coli] commonly found in the lower intestine), and Extended Spectrum Beta Lactamase &gt;100,000 ([ESBL] bacteria that frequently cause diarrhea. According to the MAR, Resident 1 had several episodes of diarrhea in [REDACTED] and [REDACTED] 2014, requiring twelve administrations of Imodium (used to treat diarrhea) to control the resident's diarrhea. The GACH's sensitivity report results indicated Proteus Mirabilis was resistant to Nitrofurantoin, as was indicated on the C/S on [REDACTED] 2014.</p> <p>A review of the MAR for the month of [REDACTED] 2014 indicated Resident 1 received Nitrofurantoin by mouth for a UTI from [REDACTED] 2014.</p> <p>During a telephone interview on [REDACTED] 2014, at 10:30 a.m., FM 1 stated that on [REDACTED] 2014, she assisted a licensed vocational nurse (LVN 1) by holding the resident's legs during the removal and insertion of the indwelling urinary catheter. She</p>			

Event ID: 2XYV11

12/17/2014

4:01:55PM

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY  
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>056166</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/09/2014</b>
NAME OF PROVIDER OR SUPPLIER <b>PARAMOUNT MEADOWS NURSING CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>7039 Alondra Blvd, Paramount, CA 90723-3925 LOS ANGELES COUNTY</b>		
(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) COMPLETE DATE	
	<p>stated she observed Resident 1's urine to be "brown, dirty, and had a foul smell." A review of the licensed nursing note, dated [REDACTED] 2014, indicated Resident 1 had no complaint of pain and discomfort and the urine was described as clear and there was no documentation of the brown, foul smelling urine, or if the physician was notified as stipulated should be done in the resident's plan of care and the facility's policy and procedure.</p> <p>On [REDACTED] 2014, at 10:20 a.m., LVN 1, the treatment nurse, stated he was responsible for all assessments regarding indwelling catheters, insertion, replacement, and urine collection for cultures or other urine specimen for studies. LVN 1 stated the urine in the catheter is monitored for sedimentation, leakage, clogged or kinked tubing and blood, potential sign of UTI. When LVN 1 was asked to demonstrate the procedure to flush an indwelling catheter or to collect a urine specimen, LVN 1 failed to demonstrate correct standard of practice according to the facility's policy and procedure in flushing, irrigating, and collecting urine from indwelling urinary catheter. LVN 1 stated he disconnects the indwelling catheter from the catheter bag to collect urine specimen and to inject normal saline into the catheter, thereby breaking the closed system. LVN 1 was shown the sampling port (used for UA collection) on the catheter and stated he was not aware the catheter had a sampling port for collecting urine specimen or irrigating the indwelling catheter to maintain aseptic technique and a closed system.</p> <p>According to an undated facility's policy and</p>				

Event ID:2XYV11

12/17/2014

4:01:55PM

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY  
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>056166</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/09/2014</b>
NAME OF PROVIDER OR SUPPLIER <b>PARAMOUNT MEADOWS NURSING CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>7039 Alondra Blvd, Paramount, CA 90723-3925 LOS ANGELES COUNTY</b>		
(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) COMPLETE DATE
	<p>procedure titled, "Prevention of Urinary Tract Infection-Indwelling Urinary Catheters," a closed system will be maintained whenever possible. If it is necessary to disconnect the catheter from the drainage system, both the catheter and the drainage tubing will be clamped as close to the connection site as possible and the sterile technique used to protect open ends. If urine is needed for a specimen, the distal end of the catheter, or the sampling port, will be cleaned with a disinfectant and the urine aspirated (removal by suction of a fluid from a body cavity using a needle) with the sterile needle and/or syringe by a licensed nurse.</p> <p>On [REDACTED] 2014, at 11 a.m., during an interview, the director of staff development (DSD) who is also the infection control nurse, stated she conducted "some training" about UTI to the licensed staff and certified nursing assistants (CNAs). She also stated the licensed staff had been trained in the use of the sampling port in the indwelling urinary catheter for urine specimen collection.</p> <p>An interview with the registered nurse supervisor (RN1) on [REDACTED] 2014, at 1:50 p.m., she stated residents admitted from outside hospitals with an indwelling urinary catheter were not checked for the catheter insertion date once admitted.</p> <p>On [REDACTED] 2014, at 2 p.m., during an interview, certified nursing assistant (CNA1) stated the resident frequently refused treatments because of pain in the back and legs when repositioned in bed and cleaned due to multiple episodes of diarrhea (loose stool). CNA 1 stated, sometime in [REDACTED]</p>			

Event ID:2XYV11

12/17/2014

4:01:55PM

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY  
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>056166</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/09/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>PARAMOUNT MEADOWS NURSING CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>7039 Alondra Blvd, Paramount, CA 90723-3925 LOS ANGELES COUNTY</b>		
(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) COMPLETE DATE	
	<p>or [REDACTED] 2014 (she was unable to remember the exact date), she observed the resident with "dark brown urine that looked as if the diarrhea (liquid brown stool) was going into the urine bag," which she reported to LVN 2 immediately.</p> <p>On [REDACTED] [REDACTED] 2014 at 12 p.m., during an interview, LVN 1 stated he did not require assistance in changing Resident 1's indwelling urinary catheter. He stated "No, I did not have anyone help me. She allowed me to do it by myself." LVN 1 stated he does not recall the resident having brown, cloudy or foul smelling urine. LVN 1 stated during the interview he had not reviewed the facility's undated policy and procedure titled, "Prevention of Urinary Tract Infection-Indwelling Urinary Catheters."</p> <p>On [REDACTED] [REDACTED] 2014 at 12:05 p.m., during an interview, LVN 3, another treatment nurse, stated Resident 1 was "not easy to turn because she was overweight" and required two people to help with her treatments.</p> <p>On [REDACTED] 2014, at 3:55 p.m., during an interview, CNA 2 stated around mid-[REDACTED] 2014 through [REDACTED] 2014, Resident 1 was complaining of pain in the private area where the catheter was inserted and she reported it to LVN 4. CNA 2 recalled LVN 4 coming in the resident's room and telling the resident she was having pain because of the UTI. CNA 2 stated the resident required two or more person assist because she was obese.</p> <p>A review of Resident 1's MARs for [REDACTED] [REDACTED] 2014, indicated the resident</p>				

Event ID:2XYV11

12/17/2014

4:01:55PM

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY  
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>056166</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/09/2014</b>	
NAME OF PROVIDER OR SUPPLIER <b>PARAMOUNT MEADOWS NURSING CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>7039 Alondra Blvd, Paramount, CA 90723-3925 LOS ANGELES COUNTY</b>		
(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) COMPLETE DATE
	<p>received three doses of Hydrocodone 5/325 mg, one dose of morphine sulfate 5 mg elixir and 27 doses of Norco 10/325 mg for pain. The MAR for [REDACTED] 2014, indicated the resident received 28 doses of hydrocodone 10/325 mg. and 23 doses of Norco 10/325 mg. for pain, which are all strong narcotic pain medications.</p> <p>On [REDACTED] [REDACTED], 2014, at 10:30 a.m., RN 1 stated it was the facility's nurses responsibility to call the physician and report abnormal lab results with the findings. A review of the facility's undated policy, titled, "Lab Result Reporting" indicated the purpose was to assure the abnormal results are reported promptly by the nurse calling and informing the physician.</p> <p>A review of a declaration, dated [REDACTED] [REDACTED], 2014, written by FM1, indicated Resident 1 complained constantly of pain at the catheter site in which FM1 reported to four RNs, five LVNs, and one physician that was listed by name on the declaration, but nothing was ever done.</p> <p>The facility's undated policy and procedure titled, "Prevention of Urinary Tract Infection for residents with indwelling urinary catheter" indicated an indwelling catheter will be secured to the resident's legs and/or body (unless contraindicated) after insertion to prevent movement and urethral traction.</p> <p>The facility's undated policy and procedure titled, "Change of Condition," indicated to assure that appropriate care and documentation occurs when residents experience a change in condition, the procedure included, but not limited to: notifying the</p>			

Event ID: 2XYV11

12/17/2014

4:01:55PM

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY  
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>056166</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/09/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>PARAMOUNT MEADOWS NURSING CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>7039 Alondra Blvd, Paramount, CA 90723-3925 LOS ANGELES COUNTY</b>		
(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) COMPLETE DATE	
	<p>physician promptly, document assessment, and follow-up nursing assessment with monitoring until the condition standardized for at least 24 hours.</p> <p>A review of Resident 1's Certificate of Death, in which the coroner signed on [REDACTED] 2014, indicated the resident expired on [REDACTED] 2014 at 2:27 a.m., less than 24 hours after admission to the GACH. The recorded cause of death included: cardiorespiratory failure (failure of the heart and lung to function to support the body's need), urosepsis (a life threatening bacterial infection in the urinary tract), and septic shock (complication of an infection where the toxins damaged the tissues and caused low blood pressure and poor organ function).</p> <p>The facility failed to ensure its residents received appropriate care and services to prevent urinary tract infections (UTI) including:</p> <ol style="list-style-type: none"> <li>1. Failing to assess the urine color and character, and report abnormalities to the physician, as indicated in the resident's plan of care and the facility's policy.</li> <li>2. Failing to maintain a closed drainage system (use of a water- or air-tight system to drain a body cavity) as indicated in the resident's plan of care and the facility's policy.</li> <li>3. Failing to use clamps (a urinary catheter securement device that keeps a catheter securely in place) to anchor the catheters to prevent urethral pain, discomfort and tissue damage, as indicated in the facility's policy.</li> </ol>				

Event ID: 2XYV11

12/17/2014

4:01:55PM

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY  
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>056166</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/09/2014</b>
NAME OF PROVIDER OR SUPPLIER <b>PARAMOUNT MEADOWS NURSING CENTER</b>			STREET ADDRESS CITY, STATE, ZIP CODE <b>7039 Alondra Blvd, Paramount, CA 90723-3925 LOS ANGELES COUNTY</b>		
(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) COMPLETE DATE	
	<p>4. Failing to assess the effectiveness of the chosen interventions to treat Resident 1's UTIs, and failing to consult with the resident's physician and care planning team to consider an alternative intervention to treat UTIs or obtaining urine for urinalysis (UA) and culture and sensitivity (C/S).</p> <p>5. Failing to implement the facility's indwelling catheter or UTI risk care plan and policy and procedures.</p> <p>The above violations, jointly, separately or in any combination, presented either imminent danger that death or serious harm would result or a substantial probability that death or serious physical harm would result and was the direct proximate cause of death for Resident 1.</p>				

Event ID:2XYV11

12/17/2014

4:01:55PM