STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555854	A. BUILDING _____ B. WING _____	**05/07/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MESA GLEN CARE CENTER	**638 E COLORADO AVENUE GLENDORA, CA 91740**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to thoroughly investigate one of 3 sampled residents (Resident 3) for unknown injury source related to the dislocation of the prosthetic right hip. Resident 3 was observed during the physical therapy exercise with the right leg shorter than the left, an X-ray result indicated Resident 3 had dislocated prosthetic hip (an artificial joint designed to perform the same functions as the natural one and which is surgically implanted). Findings: A review of an admission record indicated Resident 3 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the Minimum Data Set (MDS) a resident assessment and care-screening tool, dated 10/8/19, indicated Resident 3 had no memory of cognitive impairment (ability to think and reason) that required extensive (resident involved in activity, staff provide weigh bearing support) assistance in bed mobility and transfers. On 3/11/20 at 12:10 p.m., during an investigation of the ERI, it was indicated on 10/7/19, Resident 3 was observed by the Physical Therapy Assistant (PTA) with complaint of hip pain, right hip swelling, and the right leg was shorter than the left leg. In a concurrent interview the Director of Nursing (DON) stated, when interviewed Resident 3 denied falling or having trauma. On 3/13/20 at 9:30 a.m., a record review conducted with the DON indicated, an X-ray result, dated 10/8/19, indicated Resident 3 had complete dislocation of the prosthetic right hip with the prosthetic femoral head lying along the super acetabular (cup-shaped socket of the hip) region. On 3/13/20 at 9:45 a.m., in an interview the DON stated, she had not done a thorough investigation with the staffs and possible witnesses, which she should have done it because it was an unusual incident. On [DATE] at 2:19 p.m., the DON explained she did not document and did not thoroughly investigate Resident 3's injury on October 7, 2019. The DON stated, she did not interview the staffs or any person who could have a knowledge of the incident that resulted in the resident's injury. The DON stated there was no documented evidence that other licensed staff documented in the clinical record on 10/5/19-10/8/19, indicating other staffs, visitors, and family were interviewed about Resident 3's injury. According to the facility's policy and procedure, titled Investing Unexplained Injuries indicated an investigation of all unexplained injuries will be conducted by the DON and other individuals appointed to ensure safety of the residents had not been jeopardized. The documentation shall include information relevant to risk factors and conditions that could cause or predispose someone with similar signs and symptoms. Any description in the medical record shall be objective and sufficiently detailed and should not speculate causes. With the help of the staff and management, the investigator will compile a list of all personnel, including consultants, employees, visitors and family members who have had contact with the resident during the past 48 hours.
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to revise the plan of care to indicate non-compliance with care and identify alternative measures to prevent fall and injury to one of the 3 sampled residents (Resident 3). This deficient practice has the potential to cause pain and discomfort to the resident due to fall injuries. Findings: A review of an admission record indicated Resident 3 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the Minimum Data Set (MDS) a resident assessment and care-screening tool, dated 10/8/19, indicated Resident 3 had cognitive impairment (ability to think and reason) that required extensive (resident involved in activity, staff provide weigh bearing support) assistance in bed mobility and transfers. A review of the plan of care, dated 9/2[DATE]9, indicated Resident 3 was at high risk for injury. To reduce the risk of fall and injury, the facility will maintain a safe environment for the resident and assist the resident with activities of daily living. The plan of care did not indicate interventions or alternative measures for resident who was not compliant with instructions to ask for help during transfers. On 3/20/10 at 2:19 p.m., during a telephone interview the Director of Nursing (DON) stated, she was told Resident 3 was sometimes confused and non-compliant with treatments, however, there was no documented evidence the IDT and the licensed staff revised the plan of care.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 3) was monitored and supervised to prevent a repeated fall and accident. This deficient practice had caused the resident to sustained injury that resulted in complete dislocation of the prosthetic femoral head (an artificial joint designed to perform the same functions as the natural one and which is surgically implanted) of unknown cause. Findings: A review of an admission record indicated Resident 3 admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the Minimum Data Set (MDS) a resident assessment and care-screening tool, dated 10/8/19, indicated Resident 3 had cognitive impairment (ability to think and reason) that required extensive assistance (resident involved in activity, staff provide weigh bearing support) in bed mobility and transfers. On 3/11/20 at 12:10 p.m., during an investigation of the ERI, indicated on 10/7/19, Resident 3 was observed by the Physical Therapy Assistant (PTA) with complained of hip pain and right hip swelling and the right leg was shorter than the left leg. In a concurrent interview the Director of Nursing (DON) stated, when interviewed Resident 3 denied falling or having trauma. On 3/13/20 at 9:30 a.m., a record review conducted with the DON indicated, an X-ray result, dated 10/8/19, indicated Resident 3 had complete dislocation of the prosthetic right hip with the prosthetic femoral head lying along the super acetabular (cup-shaped socket of the hip) region. On [DATE] at 1:49 p.m. during a telephone interview Certified Nursing Assistant 2(CNA 2) stated Resident 3 was mobilize with the wheelchair in and out of the facility including smoking outside but does not usually ask for assistance on transfers to bed/chair or toilet. CNA 2 stated, Resident 3 required assistance with ADL but often does not ask for help and likes to do things on her own. On [DATE] at 2:19 p.m., during telephone interview the DON stated, Resident 3 was at high risk for injury and fall due to recent fall with injury of the right hip that required surgery. The DON also stated Resident 3 was at high risk for fall due to weakness that required assistance with transfer and non-compliance with instruction to call for assistance when transferring in which the resident could had been monitored and supervised closely. A review of the plan of care, dated 9/2[DATE]9, indicated Resident 3 was at high risk for injury. To reduce the risk of fall and injury, the facility will

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

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F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) maintain a safe environment for the resident and assist the resident with activities of daily living. According to the facility's policy and procedure, titled Fall Risk Assessment the facility staffs will identify and document risk factors for falls. The staff and the attending physician will collaborate to identify and address modifiable fall risk factors and interventions to try to minimize the consequence of risk factors that are not modifiable.
F 0697 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide safe, appropriate pain management for a resident who requires such services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility must ensure that pain management was provided to one of three sampled residents (Resident 3) in accordance with professional standards of practice by failing to assess, evaluate, document, and determine the possible cause of pain. Resident 3 complained of pain on 10/6/19 to 10/7/19 range from 3/10 to 10/10 on the scale (0- no pain and 10 severe pain) and received pain medications. There was no documented evidence of the location of pain and what relieved or made the pain worst. The pain was not evaluated after the pain medication was given. On 10/7/19 Resident 3 was observed with pain and the right leg was shorter than the other during physical therapy. This deficient practice had caused in the delayed treatment and pain relief. Findings: A review of an admission record indicated Resident 3 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the Minimum Data Set (MDS) a resident assessment and care-screening tool, dated 10/8/19, indicated Resident 3 had cognitive impairment (ability to think and reason) that required extensive assistance (resident involved in activity, staff provide weigh bearing support) in bed mobility and transfers. On 3/11/20 at 12:10 p.m., during an investigation of the ERI, indicated on 10/7/19, Resident 3 was observed by the Physical Therapy Assistant (PTA) with complained of hip pain and right hip swelling and the right leg was shorter than the left leg. In a concurrent interview the Director of Nursing (DON) stated, when interviewed Resident 3 denied falling or having trauma. On 3/13/20 at 9:30 a.m., a record review conducted with the DON indicated, an X-ray result, dated 10/8/19, indicated Resident 3 had complete dislocation of the prosthetic femoral head of lying along the super acetabular region. On 3//13/20 at 9:45 a.m., a review of the Nursing Progress Notes/Medication Administration Record [REDACTED]. In a concurrent interview the DON stated, there was no documented evidence the location of pain and if the pain medication was effective or evaluated for pain relief. On 3//13/20 at 9:50 a.m., in a concurrent interview with the DON according to Resident 3's clinical records, on 10/6/19 at 4 p.m., Resident 3 received [MED] with [MEDICATION NAME] two tablets for right hip pain rated as 10/10 on the scale and there was no documented evidence the pain medication was evaluated to relieve the severe pain on right hip or identified the cause of the pain. The DON stated, the staff should have assessed and documented for the pain level, location and evaluated for pain, and the physician was informed if the medication was not effective, and ensure x-ray was done to determine the cause of the pain. On [DATE] at 3:20 p.m., in during a telephone interview, the Licensed Vocational Nurse (LVN 1) stated, Resident 3 complained random types of pain, but she was okay until towards the time end before she was discharged and hospitalized , I give her pain medication , which she said it helped. LVN 2 explained, I am not sure if I documented the pain assessment and pain evaluation. According to the facility's policy and procedure, titled Pain Management the facility will comprehensively assess the characteristic of pain such as the intensity of pain, description of pain, pattern of pain, location, [MEDICAL CONDITION] of pain, frequency, duration, factors that precipitate, exacerbate and strategies that reduce pain, symptoms that accompany and how pain impact on quality of pain. The policy also indicated to identify the cause of pain by reviewing the resident's documents for indication of the onset and worsening of pain symptoms.