STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555099	A. BUILDING _____ B. WING _____	05/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LAKEWOOD HEALTHCARE CENTER	12023 LAKEWOOD BLVD. DOWNEY, CA 90242

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 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review Physical Therapist Assistant (PTA) and Occupational Therapist (OT) failed to verbally redirect one of one sampled resident (Resident 51) when the resident attempted to exit Special Care Unit (SCU). This deficient practice had the potential for socially isolation, lowered self esteem and negatively affecting the psychosocial well-being. Findings: A review of the facility's Resident Rights policy, revised on 1/1/12, indicated, Employees are to treat all residents with kindness, respect, and dignity and honor the exercise of the resident's rights. A review of the Face Sheet indicated the facility admitted Resident 51 on 7/17/19 with [DIAGNOSES REDACTED]. A review of the Minimum Data Set (MDS, a standardized assessment and care-screening tool) dated 10/23/19 indicated Resident 51 had severe cognitive (ability to understand and make decisions of daily living) impairment and depended on staff for mobility, eating, dressing, toilet use and personal hygiene. During an observation in SCU on 11/6/19 at 12:00 p.m. Resident 51's left side of the body was half way between. The resident's left shoulder was in contact with the glass door and locked black barrier doors leading to the smoking patio and Acute Care Unit (AC unit). The PTA and Occupational therapist (OT) both opened the glass door. Resident 51 stated Ouch when PTA pushed the glass door shut to prevent the resident from exiting SCU. During an interview on 11/6/19 at 12:02 p.m. PTA and OT stated Resident 51 had a behavior of standing and waiting at the door. PTA stated Resident 51 had a tendency to attempt exit SCU without staff, or when visitors entered or exited the unit. PTA stated Resident 51's body encountered the glass door and that he should have verbally and not physically redirected the resident. During an interview on 11/6/19 at 12:15 p.m., CNA 4 stated PTA and OT forced the door closed. CNA 4 stated it was easy to redirect Resident 51 and that the resident could not go past the black barrier doors. During an interview on 11/6/19 at 12:37 p.m. the Director of Nurses (DON) stated Resident 51 had a behavior of standing by the door waiting for smoke break and that staff were aware of the behavior. The DON stated PTA and OT needed to redirect Resident 51, and the area between SCU glass door and the locked black barrier doors was secure. A record review of the facility's in-service titled Safety/ Elopement dated 11/6/19, indicated to re-direct residents that are close to exit doors or trying to get out. Utilize another exit if resident cannot be re-directed back inside to prevent injuries. During an interview on 11/7/19 at 11:23 a.m. the Director of Rehabilitation (DR) PTA and OT were familiar with Resident 51's behaviors of waiting at the glass door and should have verbally redirected the resident. DR stated the PTA and OT's action could have resulted in the resident's injury.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview and record review, the facility failed to implement physician's oxygen order for one sampled resident's (Resident 42). This deficient practice had the potential to increased difficulty in breathing and altered mental status related to inadequate oxygen supply. Findings: A review of the facility's policy titled Physician order [REDACTED]. A review of Resident 42's Initial History and Physical dated 6/30/19 indicated that the resident did not have the capacity to understand and make decisions. A review of Resident 42's Face sheet indicated an initial admission to the facility on [DATE] with [DIAGNOSES REDACTED]. (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movement, chiefly affecting middle-aged and elderly people). A review of Resident 42's physician's orders [REDACTED]. May titrate (regulate) to keep oxygen (O2) saturation (sat, amount of O2 in blood) greater than 92%. physician's orders [REDACTED]. During an observation with RN 4 on 11/7/19 at 9:00 a.m. Resident 42 was in bed leaning towards the right side of his bed, moving bilateral arms and not on oxygen. Oxygen (O2)observed flowing at 2.5 liters per minute (lpm). The resident's bed was in high position and no floor mats on the floor. RN 4 stated she was not sure if Resident 42 required continuous oxygen administration. RN 4 checked and recorded Resident 42's O2 saturation (amount of oxygen in the blood) was 92 percent (%) reference range (RR, 94% to 100%) after administering O2 to Resident 42. During an interview on 11/7/19 at 9:06 a.m. Licensed Vocational Nurse 5 (LVN 5) stated the red star posted out Resident 42's door indicated the resident was a high risk for and prone to fall. LVN 5 stated Resident 42 was placed on a concave (curve inward) mattress to prevent falls. Registered Nurse 4 (RN 4) and LVN 5 both stated Resident 42's bed should always be at the lowest position and landing pads placed on either side of the floor to prevent injuries when the resident falls.
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 observation interview and record review the facility failed to monitor, supervise and assist with ambulation, and wore peek a boo mittens (gloves) and helmet (head protection device) for one sampled resident (Resident 37). This deficient practice resulted in Resident 37 traumatically (injury) self amputating (the removal of a limb by trauma, medical illness, or surgery) the tip of his right middle finger, falling and sustaining a bump on the forehead. Findings: A review of Resident 37's Face Sheet indicated the facility admitted the resident on 4/18/17 and readmitted on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 37's Fall care plan dated 1/7/19 indicated the resident had poor balance, lack of awareness, cognitive (ability to understand and make decisions) and communication deficit, and provide a safe environment that minimizes complications associated with falls A review of the History and Physical dated 1/15/19 indicated Resident 37 did not have the capacity to understand and make decisions. A review of Resident 37's Pain Re-assessment dated [DATE] indicated the resident had a bump on the right (R) side of forehead that measured 3 centimeters (cm) by 3 cm. A review of Resident 37's Physical Restraint on peek a boo hand mittens dated 10/22/19 indicated provide direct supervision and the resident will show no signs or symptoms of skin breakdown. A review of Resident 37's Pain Re-assessment dated [DATE], indicated the resident had tip of middle finger amputation (partial or complete removal of a limb by trauma, medical illness, or surgery) measuring 1.5 cm by 1.5 cm. A review of Resident 37's Interdisciplinary Team Conference Record (IDT, a group of health care professionals from diverse fields who work in a coordinated fashion toward a common goal for the patient) plan of care dated 10/22/19 indicated to provide 1:1 monitoring related to biting self and apply peek boo mittens for Resident 37. A review of Resident 37's X-ray completed 10/23/19 timed 6:18 a.m. indicated the resident sustained [REDACTED]. A review of Resident 37's Physician order [REDACTED]. A review of Resident 37's Fall Risk assessment dated

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

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.

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F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) [DATE], 8/2/19 and 10/27/19 indicated the resident scored 21 which indicated the resident was a high fall risk. A review of Resident 37's Physical Therapy PT Evaluation and Plan of Treatment dated 10/29/19 indicated the resident was not safe ambulating by himself. A review of Resident 37's Minimum data Set (MDS- a standardized assessment and care-screening tool) dated 8/2/19 indicated the resident required supervision for bed mobility and one-person physical assist for transfers, walk in room and eating. The MDS indicated Resident 37 required extensive one-person physical assist with dressing, toilet use and personal hygiene. The MDS indicated Resident 37 was not stable and only stabilize with staff assistance when moving from seated to standing position, walking, turning around, moving on and off toilet and surface to surface transfer. A review of Resident 37's S/P Fracture dated 10/23/19 indicated to apply peek a boo mittens to bilateral hand to prevent further injury due to episodes of biting self and 1:1 monitoring. A review of Resident 37's SBAR indicated on: 1/22/19 the resident missing right (R) hand upper digit S/P self inflicted amputation and resident seen self amputating right (R) middle finger on the top 10/24/19 the resident slightly bumped head on the wall next to bed. 10/27/19 the resident fell . A review of Resident 37's Pain Re-assessment dated [DATE] indicated the resident had almost constantly had pain to the right hand. A review of Resident 37's Short Term Care Plan indicated on: 10/25/19 resident removing helmet and the approach was to apply helmet while awake. 10/27/19 resident had a fall and to continue with falling star program and find the root cause of the fall. A review of Resident 37's Wound Assessment and Plan dated 10/25/19 indicated The patient traumatically bit off the distal tip of the right 2nd finger measuring 2 cm by 2.5 cm by 0.2 cm. A review of Resident 37's Short Term fall Risk Care Plan, dated 10/27/19 indicated to continue with falling star program. A review of Resident 37's Licensed Personnel Progress Notes dated 10/27/19 from 6:00 a.m. to 7:00 p.m. indicated the resident fell , continue 1:1 supervision at all times for poor safety awareness and on observation status [REDACTED]. During an observation of the East Wing on 11/5/19 at 11:25 a.m. Resident 37 was ambulating unaccompanied in front of the unit's entrance/exit door. Resident 37 observed with a white dressing on the right hand middle finger and had not mittens (gloves) to both hands. Resident 37 was wearing a helmet. During an observation on 11/5/19 at 11:35 a.m. fifteen residents were observed in the hallway unsupervised in Special Care Unit (SCU). During an interview on 11/6/19 at 10:17 a.m. Restorative Nursing Assistant (RNA) stated staff are assigned zones to monitor the hallways to ensure residents do not slip, fall or engage in altercations and attend to the residents' needs to ensure the residents' safety. During an interview on 11/6/19 at 11:03 a.m. Certified Nurse Assistant 4 (CNA 4) stated zoning was to ensure residents did not fight or enter other residents rooms. During an interview on 11/6/19 at 11:40 a.m. CNA 5 stated staff sometimes did not communicate with each the residents needs. CNA 5 stated it was communication was important to ensure residents safety. During an interview on 11/7/19 at 8:20 a.m. Certified Nurse Assistant 7 (CNA 7) stated Resident 37 did not require assistance with ambulation but required supervision because the resident looks like he is falling. During an interview on 11/7/19 at 9:45 a.m. Licensed Vocational Nurse 6 (LVN 6) stated that Resident 37 ambulates independently, was unsteady and was a fall risk. During an interview on 11/7/19 at 1:32 p.m. Registered Nurse 1 (RN 1) stated Resident 37 was able to ambulate independently but was very unsteady and had a fall in the facility. RN 1 stated due to spasms (sudden involuntary contraction of a muscle) Resident 37 was a high risk for falls. RN 1 stated that Resident 37 had a fall while in the facility a while back. RN 1 stated Resident 37 was not a 1:1 monitoring. A review of the facility's Fall Management Program policy revised on 11/7/16 indicated: 1. A resident considered a high risk to fall may require more frequent observation of activities and whereabouts, and interventions documented on the resident's plan of care and clinical record. 2. A resident who sustains multiple falls more than one fall in a day, week or month will be considered as a high risk for fall and interventions A review of the facility's policy titled Safety of Residents revised 1/1/12 indicated to maintain one on one supervision of the resident until the behavior has subsided.
F 0760 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to follow a physician's order to administer Tetanus [MEDICATION NAME] shot (a substance used to stimulate the production of antibodies and provide immunity against one or several diseases) for one sampled resident (Resident 37). This deficient practice resulted in Resident 37 missing the tetanus [MEDICATION NAME] for 28 days. Findings: A review of the facility's policy titled Physician Orders revised 1/1/12 indicated: 1. Physician orders will include name of the prescriber, name of resident, the date and time the order was received and the signature of the licensed nurse receiving and documenting the order. 2. Medication orders will include name of medication, dosage, frequency, duration of the order, the route and condition/[DIAGNOSES REDACTED]. 3. The licensed nurse receiving the order will be responsible for documenting and implementing the order. During an observation on 11/5/19 at 11:25 a.m. Resident 37 had a white gauze (dressing) on the right hand middle finger. A review of Resident 37's Face Sheet indicated the facility readmitted Resident 37 on 1/7/19 with [DIAGNOSES REDACTED]. Order dated 10/22/19 indicated, May administer Tetanus (a serious bacterial infection that causes painful muscle spasms and can lead to death) [MEDICATION NAME] vaccine x 1. A review of Resident 37's Interdisciplinary Team Conference Record (IDT, a group of health care professionals from diverse fields who work together toward a common goal for the patient) dated 10/23/19 indicated the plan of care to include 1:1 monitoring, Tetanus [MEDICATION NAME] shot to be given x 1 and for the peek a boo mittens to be applied. During a concurrent interview and Resident 37's record review with Registered Nurse 1 (RN 1) on 11/8/19 at 9:01 a.m. indicated the Medication Record dated 10/19 and undated Immunization Record had no initials or signature to indicate the resident received Tetanus [MEDICATION NAME] shot. RN 1 stated Resident 37 did not have a physician's order to discontinue peek a boo mittens. RN 1 stated licensed nurses were aware to document after medication and or vaccine (a substance used to stimulate the production of antibodies and provide immunity against one or several diseases) is administration. A review of Medication Refill Binder dated from 10/22/19 to 10/24/19 indicated the facility did not receive Tetanus [MEDICATION NAME] shot from the pharmacy. During an phone interview on 11/18/19 at 10:40 a.m. the Pharmacist Technician stated the facility had just faxed in Resident 37's Tetanus [MEDICATION NAME] shot physician's order. During an interview on 11/8/19 at 11:05 a.m. the Pharmacist stated the pharmacy did not dispense Tetanus [MEDICATION NAME] Vaccine for Resident 37. A review of the facility's policy titled Physician Orders revised 1/1/12 indicated: 1. Physician orders will include name of the prescriber, name of resident, the date and time the order was received and the signature of the licensed nurse receiving and documenting the order. 2. Medication orders will include name of medication, dosage, frequency, duration of the order, the route and condition/[DIAGNOSES REDACTED]. 3. The licensed nurse receiving the order will be responsible for documenting and implementing the order.