STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555039	A. BUILDING _____ B. WING _____	**08/24/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FIRESIDE HEALTH CARE CENTER	**947 3RD STREET SANTA MONICA, CA 90403**

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 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to accurately reflect the functional status at the time of the Minimum Data Set (MDS, a standardized resident assessment and care-screening tool) assessment for one of one sampled resident (Resident 1). This deficient practice had the potential to not meet or maintain Resident 1's highest practicable level of physical, mental, and psychosocial well-being. Cross Reference F842 Findings: On 6/26/20, at 12:05 p.m., an unannounced visit was made to the facility to investigate a complaint regarding admission, transfer and discharge rights. Resident 1 was no longer at the facility. A review of Resident 1's Admission Record indicated, Resident 1 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of the facility's discharge list, dated 6/2020, indicated Resident 1 was discharged from the facility on 6/25/20. A review of the physician's discharge order, dated 6/23/20, at 9:25 a.m., indicated Resident 1 may discharge home on 6/25/20 with home health services. A review of the physical therapy (PT) discharge summary form, dated 6/25/20, at 4:22 p.m., indicated Resident 1 required supervision for bed mobility, transfers, and walking on distance level surfaces at time of discharge from the facility. A review of section G (functional status) of the MDS form, dated 6/25/20, indicated Resident 1 required extensive assistance with bed mobility, locomotion off unit, dressing, and personal hygiene, limited assistance with transfers, and total dependence with bathing. A review of the occupational therapy (OT) discharge summary form, dated 6/28/20, at 10:10 a.m., indicated Resident 1 achieved the highest practical level of functioning, and was independent with personal hygiene, supervised for lower body bathing, minimal independence for upper body bathing, independent for upper body dressing, minimal independence with lower body dressing. A telephone interview and a concurrent record review of Resident 1's MDS assessment form, and PT and OT discharge summaries, dated, 6/25/20, was conducted with Licensed Vocational Nurse 1 (LVN 1), on 8/13/20, at 9:38 a.m. LVN 1 acknowledged the finding and stated MDS assessment form should have accurately reflect Resident 1's functional status at time of discharge from the facility to ensure consistency in Resident 1's care and wellbeing. A telephone interview and a concurrent record review of Resident 1's MDS assessment form, and PT and OT discharge summaries, dated, 6/25/20, was conducted with Director of Nursing (DON), on 8/13/20, at 10:10 a.m. The DON stated and confirmed that the MDS assessment should have accurately reflected Resident 1's functional status at time of discharge to meet Resident 1's needs and care. The facility's policy and procedure titled Resident Assessment Instrument, with revised date 9/2010 indicated, The purpose of the assessment is to describe the resident's capability to perform daily life functions. Information derived from the comprehensive assessment helps the staff to plan care that allows the resident to reach his/her highest practicable level of functioning.
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to accurately complete the Notice of Transfer or Discharge at the time of discharge for one of one sampled resident (Resident 1). This deficient practice had the potential for inaccurate and incomplete records and impeding continuity of care for Resident 1. Findings: On 6/26/20, at 12:05 p.m., an unannounced visit was made to the facility to investigate a complaint regarding admission, transfer and discharge rights. Resident 1 was no longer at the facility. A review of the admission record indicated Resident 1 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of the physician's discharge order, dated 6/23/20, at 9:25 a.m., indicated Resident 1 may discharge home on 6/25/20 with home health services. A review of the facility's discharge list, dated 6/2020, indicated Resident 1 was discharged from the facility on 6/25/20. A review of Resident 1's Notice of Transfer or Discharge, form dated 6/25/20, indicated the signature and date portions of the form for the facility's administrative officer and for Resident 1 (indicating facility staff provided the notice to Resident 1 and Resident 1 received the notice) were blank. An interview and a concurrent record review of Resident 1's Notice of Transfer or Discharge form, dated, 6/25/20 was conducted with the Director of Nursing (DON) and Administrator, on 06/26/20, at 1:55 p.m. The DON and the Administrator confirmed the findings. The DON stated the charge nurse discharged Resident 1. The DON further stated the charge nurse should have signed and dated the notice to ensure accurate records, provision, and receipt of the notice for Resident 1's discharge on 6/25/20. The facility's policy and procedure titled Charting and Documentation, revised 7/2017 indicated, All services provided to the resident shall be documented in the resident's medical record; Documentation of procedures will include: a. the date and time the procedures was provided; b. the name and title of the individual who provided the care; g. the signature and title of the individual documenting.

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