STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055870	A. BUILDING _____ B. WING _____	**03/20/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SUNRAY HEALTHCARE CENTER	**3210 W PICO BLVD LOS ANGELES, CA 90019**

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 0552 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that residents are fully informed and understand their health status, care and treatments.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to inform one of three sampled residents (Resident 1) about the treatment and procedure that Resident 1 would be receiving. The facility failed to inform Resident 1 that a urine sample would be collected using a catheter (allows urine to be drain from the bladder for collection). This deficient practice resulted in Resident 1 stating that she felt violated. Findings: A review of the Admission Record, dated [DATE], indicated Resident 1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the Minimum Data Set (MDS - resident assessment and care screening tool), dated 12/26/19, indicated Resident 1 was oriented to year, month and day. Resident 1 needed one to two physical assistance with activities of daily living (ADLs). A review of the After Hours Initial Consent to Treatment, which was signed by Resident 1 and Facility Representative on 12/19/19, indicated the facility will keep (the resident) informed about the routine nursing and emergency care we provide to you, and we will answer your questions about the care and services we provide you. A review of the Situation Background Appearance Review (SBAR) Communication Form, dated 12/24/19, indicated Resident 1 had increased confusion or disorientation. Resident 1's primary physician was notified and gave an order for [REDACTED]. Over 100.4 degrees F means fever caused by an infection or illness). The notes indicated Resident 1 was arousable but confused and intermittently follows commands. The notes indicated that . upon trying to get urine sample via catheter (a hollow tube inserted into the bladder to drain or collect urine) she (Resident 1) was yelling 'stop moving my legs.' During an interview on 2/4/20 at 8:13 a.m., Resident 1 stated that on 12/24/19 she was asleep and when she woke up there was a physician and staff members by her bedside. Resident 1 stated that without explanation someone shoved a catheter in her genital area and Resident 1 told them to stop because it hurts. Resident 1 stated that if the nurse asked for a specimen she could have used the bedpan or gone to the bathroom and given the urine specimen. Resident 1 stated I felt violated. During an interview on 2/5/20 at 2:21 p.m., and concurrent record review, the registered nurse supervisor (RNS) stated there was no documentation in the nursing progress notes regarding the urine specimen collection. The RNS stated there was no documented evidence that an explanation was given to Resident 1 prior to collecting urine sample. During an interview on 2/11/20 at 2:44 p.m., and concurrent record review, the director of nursing (DON) confirmed that the urine specimen was collected using a catheter. The DON stated there was no documented evidence that there was an explanation provided to Resident 1 prior to urine specimen collection. The DON stated there was no documented evidence regarding Resident 1's response to the urine specimen collection. A review of the facility's policy and procedure titled, Residents Guidelines for All Nursing Procedures, revised on October 2010, indicated To provide general guidelines for resident rights while caring for the resident Explain the procedure to the resident. Answer any questions he/she may have. Ask permission to implement the procedure. If the resident refuses, notify your supervisor. If permission is obtained, proceed with the procedure. A review of the facility's policy and procedure titled, Catheterization, Intermittent, Female Resident, revised on October 2010, indicated The following information should be recorded in the resident's medical record: 1. The date and time the procedure was performed. 2. The name and title of the individual(s) who performed the procedure. 3. The amount of urine drained. 4. The character, clarity, and color of urine. 5. Any observation of obstruction, evidence of blood, pus, etc. 6. Any change in resident condition (e.g. swelling, discomfort, etc.). 7. Any problems or complaints made by the resident related to the procedure. 8. The resident's response to the treatment. 9. All assessment data obtained during the procedure. 10. If the resident refused the procedure, the reason(s) why and the intervention taken. 11. The signature and title of the person recording the data.
F 0559 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide a written notice and reason for the change of room to one of three sampled residents (Resident 1). This deficient practice resulted in Resident 1 being moved to a room where she did not feel safe. Findings: A review of the Admission Record, dated [DATE], indicated Resident 1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the Minimum Data Set (MDS - resident assessment and care screening tool), dated 12/26/19, indicated Resident 1 was oriented to year, month and day. Resident 1 needed one to two physical assistance with activities of daily living (ADLs). A review of the Room Change Report, dated 1/2/20 at 2:30 p.m., indicated Resident 1 was moved to a different room. During an interview on 2/4/20 at 8:13 a.m., Resident 1 stated she was moved to a room that was near the exit door. Resident 1 stated she was scared because the room was far from the nurses' station and someone could enter the facility using the exit door. During an interview on 2/5/20 at 3:33 p.m., and concurrent record review, the social services designee (SSD) stated that on 1/2/20 the facility needed a room closer to the nurses' station to accommodate another resident who had a high risk for falls and Resident 1's room was close to the nurses' station. SSD stated there was no documented evidence that Resident 1 agreed to the room change. SSD stated she did not ask Resident 1 to sign the Notification of Room Change Form and no copy of the Form was given to Resident 1. During a review of the facility's policy and procedure titled, Room Change/Roommate Assignment, revised on May 2017, indicated Prior to changing a room or roommate assignment all parties involved in the change/assignment (e.g., residents and their representatives (sponsors) will be given one hour advance notice of such a change Unless medically necessary or for the safety and well-being of the resident(s), a resident will be provided with an advance notice of the room change. Such notice will include the reason(s) why the move is recommended Documentation of a room change is recorded in the resident's medical record.
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report an allegation of verbal abuse (includes the use of oral, written, or gestured communication, or sounds, to residents within hearing distance, regardless of age, ability to comprehend, or disability) for one of three sampled residents (Resident 1) to the State Survey Agency. The allegation was that the Certified Nursing Assistant (CNA) 1 called Resident 1 a racial slur word. This deficient practice resulted in a delay of an onsite inspection by the Department of Public Health potentially placing Resident 1 at risk for further verbal

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

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F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) abuse. Cross referenced to F610. Findings: A review of the Admission Record, dated [DATE], indicated Resident 1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the Minimum Data Set (MDS - resident assessment and care screening tool) dated 12/26/19, indicated Resident 1 was oriented to year, month and day. Resident 1 needed one to two physical assistance with activities of daily living (ADLs). A review of the Quality Assurance - Grievance Report, dated 1/8/20, indicated Resident 1 complained of staff (CNA 1) used inappropriate language outside (Resident 1's) room. The Report indicated CNA 1 had been removed from the entire assignment on 1/8/20 and was moved from station B to station A. The Report indicated the facility removed CNA 1 from the entire assignment until further notice and assured Resident 1 that CNA 1 would not be assigned to Resident 1 again. During an interview on 1/23/20 at 11:22 a.m.,the social services director (SSD) stated Resident 1 allegedly overheard CNA 1 called Resident 1 a racial slur word while CNA 1 was in the hallway near Resident 1's room. SSD stated CNA 1 was removed from the assignment and was asked not to come to work for one week. SSD stated Resident 1's allegation that CNA 1 had called Resident 1 a racial slur word was not a form of abuse and was not reported to other officials in accordance with the State law. During an interview on 1/31/20 at 1:31 p.m., the licensed vocational nurse (LVN 1) stated he received a telephone call from Resident 1's next of kin (NOK) who stated that Resident 1 overheard CNA 1 call Resident 1 a racial slur word. LVN 1 stated he filled out the grievance form and reported the allegation to the SSD. During an interview on 2/4/20, at 8:13 a.m., Resident 1 stated she overheard CNA 1, who was in the hallway near her room, calling her a racial slur word for everyone to hear. Resident 1 stated she felt embarrassed and felt threatened by CNA 1. Resident 1 stated she spoke with the DSD and SSD. Resident 1 stated CNA 1 did not come to work for one week and when she was told that CNA 1 would be returning to work, Resident 1 asked her primary physician to be discharged to home. During an interview on 2/5/20 at 2:56 p.m., the director of staff developer (DSD) stated the racial slur word was derogatory and she would feel insulted if someone called her that word. The DSD stated the allegation was not identified as a form of abuse. DSD stated that if the allegation of abuse had been identified, it would have been reported and investigated. During an interview on 2/11/20 at 1:49 p.m., and concurrent record review, the director of nursing (DON) stated there was a Grievance that LVN filled out for Resident 1 on 1/8/20. The DON stated that Resident 1's allegation that CNA 1 called Resident 1 a racial slur word was not a form of abuse. The DON stated that if an abuse happens the facility would go to the process of investigation and reporting because the facility is mandated to report the abuse. During an interview on 3/20/20 at 9:51 a.m., the Regional Director for Operations (RDO), also the Acting Abuse Coordinator, stated that this was an allegation of abuse and should have been reported to the State Agency and investigated immediately. The RDO stated that moving forward facility will immediately report to the State Agency and investigate allegations of abuse. A review of the facility's policy and procedure titled, Abuse Investigation and Reporting, revised on July 2017, indicated All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported An alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but not later than: Two (2) hours if the alleged violation involves abuse
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to identify and thoroughly investigate an allegation of verbal abuse (includes the use of oral, written, or gestured communication, or sounds, to residents within hearing distance, regardless of age, ability to comprehend, or disability) for one of three sampled residents (Resident 1). The allegation was that the Certified Nursing Assistant (CNA) 1 called Resident 1 a racial slur word. This deficient practice resulted in Resident 1 feeling embarrassed and felt threatened by CNA 1. Cross referenced to F609. Findings: A review of the Admission Record, dated [DATE], indicated Resident 1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the Minimum Data Set (MDS - resident assessment and care screening tool) dated 12/26/19, indicated Resident 1 was oriented to year, month and day. Resident 1 needed one to two physical assistance with activities of daily living (ADLs). A review of the Quality Assurance - Grievance Report, dated 1/8/20, indicated Resident 1 complained of staff (CNA 1) used inappropriate language outside (Resident 1's) room. The Report indicated CNA 1 had been removed from the entire assignment on 1/8/20 and was moved from station B to station A. The Report indicated the facility removed CNA 1 from the entire assignment until further notice and assured Resident 1 that CNA 1 would not be assigned to Resident 1 again. During an interview on 1/23/20 at 11:22 a.m.,the social services director (SSD) stated Resident 1 allegedly overheard CNA 1 called Resident 1 a racial slur word while CNA 1 was in the hallway near Resident 1's room. SSD stated CNA 1 was removed from the assignment and was asked not to come to work for one week. SSD stated Resident 1's allegation that CNA 1 had called Resident 1 a racial slur word was not a form of abuse and was not reported to other officials in accordance with the State law. During an interview on 1/31/20 at 1:31 p.m., the licensed vocational nurse (LVN 1) stated he received a telephone call from Resident 1's next of kin (NOK) who stated that Resident 1 overheard CNA 1 call Resident 1 a racial slur word. LVN 1 stated he filled out the grievance form and reported the allegation to the SSD. LVN 1 stated there was no nursing documentation and no care plan about the allegation. During an interview on 2/4/20, at 8:13 a.m., Resident 1 stated she overheard CNA 1, who was in the hallway near her room, calling her a racial slur word for everyone to hear. Resident 1 stated she felt embarrassed and felt threatened by CNA 1. Resident 1 stated she spoke with the DSD and SSD. Resident 1 stated CNA 1 did not come to work for one week and when she was told that CNA 1 would be returning to work, Resident 1 asked her primary physician to be discharged to home. During an interview on 2/5/20 at 2:56 p.m., the director of staff developer (DSD) stated the racial slur word was derogatory and she would feel insulted if someone called her with that word. The DSD stated the allegation was not identified as a form of abuse. The DSD stated, looking back, the facility should have done interviews and investigated when the allegation first happened. The DSD stated the facility investigated the incident on 1/23/20 and 1/24/20 (after the investigation was started by the State Agency). DSD stated the investigation was too late. DSD stated that if the allegation of abuse had been identified, it would have been reported and investigated. During an interview on 2/11/20 at 1:49 p.m., and concurrent record review, the director of nursing (DON) stated there was no documentation and no care plan about Resident 1's allegation. The DON stated the only documentation was the Grievance that LVN 1 filled out for Resident 1 on 1/8/20. The DON stated that Resident 1's allegation that CNA 1 called Resident 1 a racial slur word was not a form of abuse. The DON stated that if an abuse happens the facility would go to the process of investigation and reporting because the facility is mandated to report the abuse. During an interview on 3/20/20 at 9:51 a.m., the Regional Director for Operations (RDO), also the Acting Abuse Coordinator, stated that this was an allegation of abuse and should have been reported to the State Agency and investigated immediately. The RDO stated that moving forward facility will immediately report to the State Agency and investigate allegations of abuse. A review of the facility's policy and procedure titled, Abuse Prevention Program, revised on December 2016, indicated Our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse and physical or chemical restraint not required to treat the resident's symptoms. As part of the resident abuse prevention, the administration will: Protect our residents from abuse by anyone including, but not necessarily limited to: facility staff, other residents, consultants, volunteers, staff from other agencies, family members, legal representatives, friends, visitors, or any other individual Identify and assess all possible incidents of abuse. Investigate and report any allegations of abuse within timeframes as required by federal requirements A review of the facility's policy and procedure titled, Abuse Investigation and Reporting, revised on July 2017, indicated All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported.