STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555690	A. BUILDING _____ B. WING _____	**04/01/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ALAMEDA CARE CENTER	**925 W. ALAMEDA AVE. BURBANK, CA 91506**

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 0604 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement the facility's policy by applying a gait belt (a device used to help someone move) for one of three sampled residents (Resident 1) without a physician's order and without the consent of Resident 1's representative. This deficient practice resulted to limiting Resident 1's freedom of movement and had the potential to result in an impairment in an individual's ability to function. Findings: A review of Resident 1's Admission Record (face sheet) indicated Resident 1 was re-admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 1's Minimum Data Set (MDS - a standardized assessment and screening tool) dated 2/17/2020, indicated Resident 1's cognition (ability to think, understand and reason) was severely impaired. The MDS indicated Resident 1 requires extensive assistance from staff with bed mobility, transfers, walking, moving between locations, dressing, eating, toilet use and personal hygiene. A review of the Order Summary Report for Resident 1 dated 10/19/19, indicated to provide Resident 1 with new customized wheelchair with lap tray for safety. However, there was no physician's order found indicating to apply a gait belt. During an observation, on 3/2/20, at 1:51 p.m., Resident 1 was observed sitting in a wheelchair in the hallway with a lap tray placed in front of the resident and a gait belt placed around the resident's waist and buckled on the back of wheelchair. During a follow-up observation, on 3/2/20, at 2:20 p.m., Resident 1 was observed sitting at the dining room and the gait belt was not placed around the waist. On 3/2/20, at 2:50 p.m., during an interview with Certified Nursing Assistant 1 (CNA 1), she stated the gait belt is a restraint (any manual method, physical or mechanical device, equipment or material, near or on the body which restricts movement) and should have not been placed around Resident 1's waist. CNA 1 verified she placed the gait belt to prevent Resident 1 from slipping down even though there was no physician's order to apply the gait belt. On 3/2/20 at 3:07 p.m., during an interview with Licensed Vocational Nursing 1 (LVN 1), she verified Resident 1 had no physician's order to apply a gait belt. LVN 1 further stated the gait belt should have not been applied unless there was a physician's order and consent from Resident 1's representative. On 3/2/20 at 03:10 p.m., during an interview with Registered Nurse 1 (RN 1) she stated the gait belt should have not been placed around Resident's waist and buckled on the back of wheelchair because it limits Resident 1 movement and ability to perform her physical activities. A review of the facility's policy and procedure titled, Physical Restraint, undated, indicated that physical restraint assessment and use shall be managed accordingly. The licensed nurse shall be responsible for obtaining an order from the attending physician which is to include the specific type of restraint, purpose of the restraint, time and place of application, approaches to prevent decreased functioning when applicable and informed consent obtained from resident or resident's representative.

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