STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555893	A. BUILDING _____ B. WING _____	**09/17/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LEGACY HEALTHCARE CENTER	**1570 NORTH FAIR OAKS AVE PASADENA, CA 91103**

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 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 observation, interview, and record review the facility failed to maintain accurate records of inventory log for one of one sampled resident (Resident 1). Resident 1 received a package containing a cell phone and earphones, which the facility staff opened and did not update the resident's inventory log. This deficient practice had the potential for the resident to not receive a refund or replacement of items lost or stolen. Findings: A review of Resident 1's Face Sheet (a record of admission), dated 8/06/20, indicated the resident admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 1's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 9/03/20, indicated Resident 1 had intact cognition (mental process of acquiring knowledge and understanding). During a telephone interview, on 8/2/20 at 9:25 a.m., Resident 1 stated she received her stimulus check, purchased a phone and told the facility she was expecting a package. Resident 1 stated the facility opened the box because they could not find a name or an address. Resident 1 stated the name on the label was slightly covered by a sticker and instead of pulling the sticker back to expose the name, they opened the box. Resident 1 stated they handed her the box and left the room, when she removed the cell phone box it was empty and only the earbuds were inside. Resident 1 stated the facility denied taking the phone and had to purchase a new phone. A review of Resident 1's untitled document of a list of inventory items on admission, dated 8/18/17, indicated multiple items that included five suitcases, 10 boxes, and other clothing and personal items listed. A review of Resident 1's untitled document of a list of inventory items, dated 4/22/20, indicated Resident 1 refused. A review of Resident 1's handwritten note, dated 4/22/20, indicated that the resident did not want people knowing what was in the resident's luggage because of items stolen in the past. A review of Resident 1's medical records did not indicate any other documentation of the resident's inventory of belongings since 8/18/17. A review of Resident 1's Progress Notes, dated 5/22/20 at 4:29 p.m., indicated Resident 1 screamed and a Registered Nurse 1 (RN 1) entered the resident's room. Resident 1 told RN 1 that the phone was not in the box. RN 1 documented that she informed the administrator and Social Services Director (SSD) about the missing phone. A review of Resident 1's Progress Notes, dated 5/22/20 at 5:56 p.m., indicated the charge nurse was present when the package was delivered to Resident 1 and the box was sealed. The SSD documented that she will notify the administrator and continue with the investigation of the incident. A review of an order invoice, dated 5/20/20, indicated a Samsung Galaxy S10 Lite phone and Samsung Galaxy lite Buds were purchased in the amount of $692.35. The invoice indicated the items were shipped on 5/21/20. A review of another order invoice, dated 5/24/20, indicated a Samsung Galaxy S10 Lite phone was purchased in the amount of $551.24. The invoice indicated the item was shipped on 5/25/20. During an interview, on 8/06/20 at 12:22 p.m., the SSD stated the facility's process when a package is delivered is to deliver the package with a witness to the resident. SSD stated she was newly employed and not familiar with investigation. During an interview, on 8/06/20 at 12:37 p.m., the Director of Nursing (DON) stated Resident 1 orders a lot of items online and a package arrived, which the staff opened and delivered it to the resident. The DON stated the three staff members that delivered the package did not stay in the room to see Resident 1 open the package. During an interview on 8/26/20 at 10:20 a.m., the Administrator stated that staff opened Resident 1's package because it did not indicate who it was for on the label and after the staff took the package to Resident 1. The Administrator stated three staff members took the phone to the resident and the resident took receipt of the package with no complaints. The Administrator stated the three staff did not witness the resident open the cell phone box to confirm contents. The Administrator stated 30 minutes later the resident claimed the phone was not in the box. The Administrator stated the facility did not update the receipt of the cell phone or earphones on Resident 1's inventory log to ensure accuracy of belongings. During a telephone interview, on 9/02/20 at 8 a.m., SSD stated even though Resident 1 refuses to have belongings inventoried, staff should document refusal and when the items were received, it should be documented in the resident's medical record. A review of the facility's policy and procedure title, Personal Belongings Policy & Procedure, dated 4/09/20, indicated staff inventory and update items retained quarterly and as needed when there are new items during the resident's stay. The policy also indicated that staff report all alleged violations involving misappropriation of resident property immediately to the Social Services Department.

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.