STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055192	A. BUILDING _____ B. WING _____	**09/08/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PROVIDENCE ST ELIZABETH CARE CENTER	**10425 MAGNOLIA BLVD NORTH HOLLYWOOD, CA 91601**

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 0697 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe, appropriate pain management for a resident who requires such services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to monitor pain and ensure pain was effectively managed for one of two sampled residents (Resident 1). Resident 1's pain level was not assessed after administration of pain medication as per facility's Pain Assessment and Management policy. This deficient practice had the potential for Resident 1 to experience unnecessary pain. Findings: A review of Resident 1's Admission Record (Face Sheet) indicated the facility readmitted the resident on 10/16/2018, with the [DIAGNOSES REDACTED]. A review of Resident's 1 Minimum Data Set (MDS - standardized assessment and care-screening tool) dated 1/18/2019, indicated Resident 1 had moderately impaired thought process and needed supervision with transfer from bed to chair, standing, and dressing. On 8/10/2020 at 11:30 a.m., during a concurrent interview and record review with Licensed Vocational Nurse 1 (LVN 1), indicated on 4/05/201 Resident 1 fell on [DATE], at 6 p.m. LVN 1 confirmed Resident 1 had pain 10/10 (pain rating scale from zero to 10, zero indicating no pain and 10 the worst possible pain). LVN 1 stated she administered [MEDICATION NAME] (a medication used to treat minor pain) for pain at 6:10 p.m. At 7:45 p.m. indicated Resident 1 was transferred to General Acute Care Hospital 1 (GACH 1) with severe coccyx (tailbone) pain. LVN 1 did not administer Resident 1 additional pain medication. LVN 1 confirmed she did not reevaluated Resident 1's pain level after giving [MEDICATION NAME]. On 8/10/2020 at 11 a.m., during a concurrent interview and record review, the Director of Nursing (DON) confirmed there was no documentation on Resident 1's Pain Assessment Flow sheet. A review of the facility's policy on Pain Assessment and Management, revised on 10/2008, indicated to ensure the resident's pain is properly assessed, controlled and adequate pain management is provided. The pain management process is to document on the Pain Assessment Flow Sheet to reflect every medication given, response to medication and non-pharmacological interventions.
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 ensure the Medication Administration Record [REDACTED]. This deficient practice placed the resident at risk of a medication error and resulted on an incomplete clinical record. Findings: A review of Resident 1's Admission Record (Face Sheet) indicated the facility readmitted Resident 1 on 10/16/2018, with the [DIAGNOSES REDACTED]. A review of Resident's 1 Minimum Data Set (MDS - standardized assessment and care-screening tool) dated 1/18/2019 indicated Resident 1 had moderately impaired thought process and required supervision with transfer from bed to chair, standing, and dressing. On 8/10/2020 at 11:30 a.m., during a concurrent interview and a review of Resident 1's nursing note indicated she administered Resident 1 [MEDICATION NAME] after a fall on 4/5/2019, at 6:10 p.m., however, the MAR indicated [REDACTED]. LVN 1 stated that she should have documented giving the medication and could not explain the lack of documentation. A review of the facility's policy on Medication Administration - General Guidelines, dated 04/2008, indicated the individual who administers the medication dose records the administration on the resident's MAR indicated [REDACTED]. In no case should the individual who administered the medication report off-duty without first recording the administration of any medications.

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.