STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056188	A. BUILDING _____ B. WING _____	**03/19/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LONG BEACH CARE CENTER, INC	**2615 GRAND AVENUE LONG BEACH, CA 90815**

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 0684 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident received the necessary care and services and follow the physician's orders, which included STAT (immediate) laboratory test orders, (which included a STAT (immediately) complete blood count ((CBC) a blood test to detect disorders such as, [MEDICAL CONDITION] (low blood) infection) and resident's plan of care for one of two sampled residents (Resident 1). Resident 1, who had a change of condition, which included poor appetite, fever (elevated body temperature) and a decreased oxygen saturation (low oxygen level in the blood). This deficient practice resulted in a 48-hour delay in [DIAGNOSES REDACTED]. Resident 1 was diagnosed with [REDACTED].). Resident 1 was hospitalized for [REDACTED]. Findings: A review of Resident 1's Admission Record (face sheet), indicated Resident 1 was admitted to the facility on [DATE] and last re-admitted on [DATE]. Resident 1's [DIAGNOSES REDACTED]. A review of Resident 1's Advance Directives (a written statement of a person's wishes regarding medical treatment), dated and signed by Resident 1's family member (FM 1) on [DATE] indicated for the resident not to receive resuscitation (lifesaving measures), but may be hospitalized . A review of Resident 1's Physician Orders for Life-Sustaining Treatment ((POLST) a physician order that outlines a plan of care reflecting a resident's wishes concerning care at end of life), dated and signed by Resident 1's physician on [DATE]. The POLST indicated for Resident 1 not to receive cardiopulmonary resuscitation ((CPR) prolonging life by all medically effective means) but to receive comfort measures, such as pain medications and a transfer to a GACH. A review of Resident 1's revised care plan, dated [DATE] and titled, Resident is a Do Not Resuscitate ((DNR) do not provide treatment for [REDACTED]. A review of Resident 1's revised care plan, dated [DATE] and titled, Resident is at risk for compromised health condition associated by [MEDICAL CONDITION] following [MEDICAL CONDITION] of the left non-dominant side, indicated for the staff to obtain Resident 1's vital signs (measurements which includes body temperature, blood pressure, pulse (heart rate), and respiratory rate), observe changes in condition and notify the physician accordingly. A review of Resident 1's revised care plan, dated [DATE] and titled, Resident has potential for shortness of breath (SOB), chest pains, irregular heart rate, and elevated blood pressure related to compromised (weaken) cardiac (heart) function associated with heart failure, indicated for the staff to observe Resident 1 for episodes of SOB, chest pains, monitor the resident's heart rate and blood pressure and notify Resident 1's physician accordingly. A review of Resident 1's Interdisciplinary Team ((IDT) a group of professionals working toward a resident's goals) note, dated [DATE] indicated Resident 1 was alert and oriented to name, but with confusion and forgetfulness. The IDT note indicated Resident 1 required an extensive to total assistance with activities of daily living ((ADL) routine activities that are done every day such as: eating, bathing, dressing, toileting, transferring and walking). A review of Resident 1's physician monthly physical examination, dated [DATE] indicated Resident 1 spoke clearly, was confused with spurts of yelling out and agitation (feeling or appearing troubled or nervous) as reported by the staff. A review of a Situation, Background, Assessment and Recommendation ((SBAR) an internal communication tool) form, dated [DATE] indicated Resident 1 had a poor oral intake and generalized weakness. The SBAR indicated Resident 1's physician was notified at 12:35 p.m. and orders were obtained for Resident 1 to have a CBC, comprehensive metabolic panel ((CMP) a blood test to determine body's fluid balance and check kidneys and liver function) and a urinalysis ((UA) a urine test to assess all range of disorders including infection). A review of Resident 1's nurses' note, dated [DATE] and timed at 2 p.m. indicated Resident 1 had verbalized weakness, with a poor oral intake, tolerating 50 percent (%) of lunch and Resident 1's blood pressure was ,[DATE] millimeters of mercury (mmHg), (Normal Reference Rate (NRR) ,[DATE]- ,[DATE] mm/hg) and the physician was notified. A review of Resident 1's Medication Administration Record [REDACTED]. A review of Resident 1's nurses' notes, dated [DATE] and timed at 6:30 p.m. indicated Resident 1 was assessed as being warm to touch, responsive to verbal and tactile stimuli (the ability to sense touch). A review of Resident 1's physician's orders, dated [DATE] and timed at 7:30 p.m., indicated an order for [REDACTED]. [DATE] and timed at 7:30 p.m., indicated Resident 1 received cooling measures that were effective with a body temperature decreased to 99.0 degrees Fahrenheit ((F) a temperature scale) (NRR= 97XXX,[DATE].0 F), the staff placed a call to the contracting laboratory regarding Resident 1's STAT labs and a message was left on the laboratory's afterhours line. A review of Resident 1's nurses' note, dated [DATE] and timed at 10:25 p.m., indicated the staff received an order from a Physician's Assistant ((PA) a health care practitioner who practices medicine under the supervision of a physician) to transfer Resident 1 to an urgent care center (treats injuries or illnesses requiring immediate care but not serious enough for an emergency department (ED) visit) (located 29 miles from the facility). The nurses' note indicated the staff was waiting a bed availability from the urgent care center for Resident 1. A review of Resident 1's nurses' note, dated [DATE] and timed at 11:45 p.m. indicated Resident 1's body temp was 98.9 F, received cooling measures and was easily arousable to verbal stimuli. The nurses' note indicated there was no available beds for Resident 1 at the urgent care center located 29 miles from the facility. A review of Resident 1's nurses' note, dated [DATE] and timed at 3 a.m. indicated no bed availability for Resident 1 at the urgent care center located 29 miles from the facility. A review Resident 1's nurses' note, dated [DATE] and timed at 6:30 a.m. indicated Resident 1's oxygen saturation ((O2) amount of oxygen in the blood) was 90%, (NRR ,[DATE]%) and was receiving two (2) liters of oxygen by nasal cannula (tube though the nose) and was easily arousable to verbal stimuli. A review of an online article by the American Red Cross indicated an oxygen saturation rate of ,[DATE] % is indicative of mild [MEDICAL CONDITION] (not enough oxygen supply). https://www.redcross.org/content/dam/redcross/atg/PDF_s/AdministeringEmergencyOxygenFactandSkill.pdf A review of Resident 1's nurses' note, dated [DATE] and timed at 8 a.m. indicated Resident 1 was observed with a blank stare (without expression) and was not responsive to verbal and tactile stimuli. The nurses' note indicated Resident 1 had labored breathing (abnormal and increased effort to breathe), a heart rate of 130 bpm (NRR= ,[DATE] bpm), received an increased amount of oxygen at four (4) liters of oxygen via nasal cannula. The nurses note indicated Resident 1 was transported by the paramedics to the GACH on [DATE] at 8:20 a.m. (sic) A review of Resident 1's transfer record, dated [DATE] indicated Resident 1 was transferred from the facility to the GACH at 8:20 a.m. (sic). The transfer record indicated Resident 1's baseline mental status was oriented x1, verbally aggressive and a handwritten notation as lethargic, but a line was drawn through the word lethargic. A review of Resident 1's paramedic run sheet, dated [DATE] indicated the paramedics arrived to the facility on [DATE] at 8:33 a.m., and Resident 1's heart rate was elevated at 130 bpm, was in respiratory distress and received two (2) doses of [MEDICATION NAME] (medication that relaxes muscles in the airways and increases air flow to the lungs) 5 mg inhaler (medical device used for delivering medication into the lungs) for rales (rattling sound heard in the lungs) and rhonchi (continuous low pitched, rattling lung sounds that resemble snoring). The paramedic run sheet indicated Resident 1 had a Glasgow Coma Scale ((GCS) an assessment used to determine level of consciousness (alertness/function)) of 10. According to the GCS, a score of 15 is normal and a score between ,[DATE] is indicative of moderate brain damage. A

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.

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F 0684 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) review Resident 1's GACH Emergency department (ED) H/P, dated [DATE] indicated Resident 1 had altered mental status and was lethargic (state of tiredness, weariness, fatigue, or lack of energy) and weak. The H/P indicated Resident 1 had pyuria (pus in the urine) with slightly cloudy urine and an elevated WBC of 24.5 per microliter (uL) (NRR =levels 4.50 -10.00). The ED 's H/P, Resident 1 was given an antibiotic via intravenous (into the veins). On [DATE] at 1:30 p.m., Resident 1's family member 1 (FM 1) stated Resident 1 was verbal until she became ill on [DATE] on the 3 p.m. to 11 p.m. shift. FM 1 was crying and stated on [DATE], she received a call from the staff indicating they were going to transfer Resident 1 to a GACH in another city on a non-emergency basis. FM 1 stated Resident 1 was not eating well, the facility failed to properly assess Resident 1 after emergency labs were drawn and were abnormal. FM 1 stated Resident 1 was transferred to the GACH on [DATE] at 8 a.m. and upon her arrival to the GACH, the physician indicated Resident 1 was bad, had a stroke, MI, was dehydrated (excessive loss of body water), blind (loss of sight) in one eye and could not talk anymore. FM 1 stated Resident 1 expired (died) 17 days later. On [DATE] at 9:18 a.m., during an interview, Registered Nurse Supervisor 1 (RNS 1) stated Resident 1 was usually alert to her name, able to identify her family and had behaviors of yelling and screaming. RNS 1 stated on [DATE] she received a report from the previous shift (RNS 1) of Resident 1 was reported as being okay. RNS 1 stated on [DATE] she observed Resident 1 slightly slumped over with her eyes opened and was not verbally responsive and had a fixed upward stare. RNS 1 stated on the same day, [DATE] approximately 7:30 a.m., Resident 1 had a change of condition (COC) and the paramedics were called. RNS 1 stated an endorsement from the previous shift indicated Resident 1 had a poor appetite, had some changes, and an elevated body temperature. RNS 1 stated according to the previous nurse's endorsement Resident 1's physician was notified and Resident 1's condition was stable. RNS 1 asked the previous shift RNS (RNS 2) why the paramedics was not called for Resident 1. RNS 1 stated RNS 2 told her she wanted to wait and endorse calling an ambulance for Resident 1, to the oncoming shift because Resident 1 was not in any distress (sic). On [DATE] at 1:20 p.m., during a concurrent interview and nurses' notes from ,[DATE] to ,[DATE], RNS 1 stated Resident 1 had a COC on [DATE] due to having a poor intake and was being monitored. RNS 1 stated Resident 1 did not have the STAT labs drawn per the physician's order dated on [DATE]. On [DATE] at 1:49 p.m., during a telephone interview, Certified Nursing Assistant 1 (CNA 1) stated he no longer worked at the facility. CNA 1 stated he was assigned to Resident 1 on [DATE] on the 11 p.m. -7 a.m. shift and stated Resident 1 had lost a lot of weight. CNA 1 stated Resident 1 was alert to her name, but on [DATE], close to the end of the shift (7 a.m. on [DATE]), he informed the charge nurse that something was different with Resident 1 and she had a fever. CNA 1 stated the next day, on [DATE] at 11 p.m. when he returned to work, Resident 1 had been sent out to the hospital. On [DATE] at 2:58 p.m. and [DATE] at 12:41 p.m. several attempts were made to contact the PA for an interview, who gave a verbal order to transfer Resident 1, who had a change of condition, 29 miles away from the facility to an urgent care. On [DATE] at 3:08 p.m., during an interview, RNS 2 stated in the month of ,[DATE], Resident 1 was being monitored for a previous COC and her condition was stable. RNS 2 stated she could not recall if Resident had a fever in the month of ,[DATE]. On [DATE] at 3:48 p.m., during a concurrent interview and record review of Resident 1's nurses' notes, Licensed Vocational Nurse 1 (LVN 1) stated on [DATE] between the hours of 3 p.m. to 11 p.m., she was called into Resident 1's room by a CNA. LVN 1 stated on the same day ([DATE]), Resident 1 was not eating, but was able to take her medications with sips of water. LVN 1 stated Resident 1 was usually alert and would answer to her name, but on [DATE], Resident 1 appeared to be asleep and had a low-grade body temperature. LVN 1 stated on [DATE] at 7:30 p.m., she called Resident 1's physician, obtained orders from the PA for STAT labs. LVN 1 stated she left a message on the laboratory's answering service, but no one returned her call for the STAT lab work ordered for Resident 1. LVN 1 stated the laboratory technician would usually come to the facility and collect the resident's lab work. LVN 1 stated Resident 1's STAT labs for a CBC, CMP and a urinalysis C/S was not collected. LVN 1 stated Resident 1 had a low-grade body temperature of 99.0 F and cooling measures (applying ice packs, a cool blanket or a cool bath) were performed on Resident 1. LVN 1 stated Resident 1 would normally yell and cry, but on [DATE], Resident 1 was quiet. On [DATE] at 10:20 a.m., during an interview, RNS 2 stated she worked in the facility on [DATE] on the 11 p.m. to 7 a.m. shift on [DATE]. RNS 2 stated on [DATE], Resident 1 could not speak, but was in stable condition. RNS 2 stated Resident 1's vital signs were normal and was not in any distress. RNS 2 stated Resident 1 had a poor appetite and was waiting for bed availability at a hospital in another city. RNS 2 stated she could not recall assessing Resident 1's breath/lung sounds at the time of her assessment, but stated Resident 1 was arousable and there was not anything different about Resident 1. RNS 2 stated on the morning of [DATE] between the time of 7 a.m. to 7:30 a.m. she conducted rounds with the oncoming RNS (RNS 1) and she observed Resident 1 not being in any distress. RNS 2 stated a change of condition was completed when a resident had a new issue and the resident would be monitored for 72 hours. RNS 2 stated Resident 1 was being monitored for a poor appetite. A review of the facility's revised policy and procedure dated 2019 and titled, Verbal Orders, indicated the physician orders may be received by telephone by a licensed nurse or other licensed or registered health care specialist in their own area of specialty. The policy indicated for the staff to use clarification questions to avoid misunderstandings and to follow through with orders by making appropriate contact or notification. A review of the facility's revised policy and procedure dated 2019 and titled, Care Plans Comprehensive indicated care plan interventions are designed after careful consideration of the relationship between the resident's problem areas and their causes. When possible, interventions address the underlying source(s) of the problem area(s), rather than addressing only symptoms or triggers. Identifying problem areas and their causes and developing interventions that are targeted and meaningful to the resident are interdisciplinary processes that require careful data gathering, proper sequencing of events and complex clinical decision making. A review of the facility's undated policy and procedure titled, Making an Emergency Transfer or Discharge, indicated the facility shall make an emergency transfer or discharge when it is in the best interest of the resident.