STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055753	A. BUILDING _____ B. WING _____	**09/03/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LONGWOOD MANOR CONV.HOSPITAL	**4853 W. WASHINGTON BL. LOS ANGELES, CA 90016**

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 0689 **Level of harm -** Actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the environment was hazard free and provide supervision to prevent aspiration (breathing in a foreign object (plastic medication cup) into the airway) of a resident who had a history of [REDACTED]. Resident 1, who had intellectual delay disabilities (below-average intelligence or mental ability and a lack of skills necessary for life skills) and severe dysphagia (difficulty in swallowing) due to a history of [MEDICAL CONDITION]'s disease (a genetic disorder that causes progressive breakdown of nerve cells in the brain and deteriorates a person's physical and mental abilities over time and can be fatal) with a habit of putting objects in her mouth was left unsupervised by the facility's staff. This deficient practice resulted in Resident 1 having access to a plastic medication cup and putting it in her mouth and aspirating. Resident 1 had low oxygen levels for an unknown amount of time and required a transfer to a general acute care hospital (GACH) on 5/10/2020. Resident 1 was intubated (a medical procedure in which a tube is placed into the windpipe (trachea) through the mouth in an emergency for ventilation) and placed on mechanical ventilation (a breathing machine) and was admitted to the intensive care unit ((ICU) higher level of care unit) for a total of 9 days. Findings: A review of Resident 1's Admission Face Sheet indicated the resident was admitted to the facility on [DATE] and last readmitted on [DATE]. Resident 1's [DIAGNOSES REDACTED]. A review of Resident 1's Minimum Data Set (MDS), a resident assessment and care-screening tool, dated 3/23/2020 indicated Resident 1 had impaired cognitive skills (ability to reason and think) for daily decision-making and rarely or never understood others. The MDS indicated Resident 1 required supervision and a one-person physical staff assist for eating, transferring, dressing, and bed mobility (how the resident moves). According to the MDS, under Section K 300 (Nutritional approaches) Resident 1 was receiving nutrition through a feeding tube. A review of Resident 1's care plan, initiated on 5/12/12 and last reviewed on 4/6/2020, identified a problem of cognitive and communication deficit due to short and long-term memory problem, problems making self-understood, and understanding others related to intellectual disability. The goal indicated Resident 1 would be able to maximize cognitive skills and decision-making capabilities daily. The staff's interventions included to speak clearly, slowly and maintain eye contact with Resident 1 and notify physician of any significant changes. A review of Resident 1's care plan, initiated on 8/2/15 and last reviewed on 4/6/2020, identified a problem for Resident 1's risk for aspiration related to dysphagia. The goal indicated Resident 1 would have no aspiration daily. The staff's interventions were to provide moderately thick liquids, a pureed diet (food that is soft, moist, and smooth in the texture, as of pudding), speech therapy (specially trained to improve communication techniques and treat swallowing disorders) evaluation and treatment as ordered and to monitor for signs and symptoms of aspiration such as shortness of breath and respiration changes. A review of Resident 1's care plan, initiated on 2/14/2020, identified a problem of Resident 1 being at risk for injuries/complication related to the resident's tendency to grab items/objects. The goal indicated Resident 1 would have no injury and will receive adequate care daily for 90 days. The staff's interventions included daily room visits, resident's room free from clutter, redirect resident as needed, and a psychiatric (a mental health assessment used to diagnose problems with thought processes and behaviors) evaluation. A review of a Situation, Background, Assessment and Recommendation ((SBAR) an internal communication form), dated 5/10/2020 and timed at 1:37 p.m. indicated the following: At 7 a.m., on 5/10/2020 the resident (Resident 1) was sleeping with even breathing (smooth equal breathing). No shortness of breath noted. At 9 a.m., all due medications administered and resident (Resident 1) tolerated well. At 11 a.m., the resident was noted with a low-grade fever (abnormal body temperature) and the physician made aware with new orders. Resident (Resident 1) received an x-ray; awaiting results, will continue to monitor throughout shift. A review of the radiology results report, dated 5/10/2020 and timed at 2:23 p.m., indicated Resident 1 had a chest x-ray due to having a fever. The x-ray results indicated Resident 1 had right lower lobe (RLL) pneumonia (an infection that inflames the air sacs of the lungs). A review of Resident 1's Licensed Nurse Record Change of Condition, dated 5/10/2020 and timed at 7:11 p.m. indicated the following: At 3 p.m., Resident 1 was received with a change of condition from the morning shift with an assessment done and had an elevated body temperature of 101.0 degrees Fahrenheit (F) (Normal Reference Range (NRR) 97.2-98.8) and Tylenol ([MEDICATION NAME]) fever reducing; pain reliever) 325 milligrams ((mg) unit of measurement) was given. Resident 1's vital signs (measurements of the body's essential basic functions) were as follow; blood pressure 128/68 (normal reference range (NRR) is 90/60- 139/89), respirations 18 (NRR 12-20 breaths per minute (bpm)), and heart rate at 82 (NRR 60-100 per minute). At 5 p.m., Resident 1 was administered all prescribed medications and tolerated it well. The chest x-ray showed Resident 1 had pneumonia and had generalized body weakness. Resident 1's physician was called, and an order received to transfer the resident to the hospital. At 6 p.m., Resident 1 was transferred to the hospital. A review of Resident 1's GACH Emergency Department (ED) report, dated 5/10/2020 and timed at 6:46 p.m. indicated Resident 1 arrived to the ED with an elevated heart rate of 145, increased respirations of 28, a low blood pressure of 79/46 and a pulse oximetry (measure the amount of [MEDICATION NAME] blood (Spo2) in the body) measuring a low oxygen saturation of 85 % (NRR 95-100%) while receiving five (5) liters (L) of oxygen with a nasal cannula (a small flexible plastic tube used to deliver oxygen into the nostrils). The ED report indicated Resident 1's physical assessment indicated the resident was awake, moving all extremities, non-verbal with tachypnea (abnormally rapid breathing) with an increased work to breathe, no cough, no audible wheezes (breathing with a [MEDICATION NAME] sound in the chest). The ED note indicated Resident 1 had to be advanced to a nonrebreather mask (a device used to delivery higher concentrations of oxygen) at 15 L with no significant improvement in oxygenation. The ED note indicated due Resident 1's extra work to breathe with persistent [MEDICAL CONDITION] (deprived of adequate oxygen) despite increased oxygen therapy a decision was made to intubate Resident 1 at 8:03 p.m. According to the note, during intubation, under direct visualization there was a plastic foreign body (medication cup) sitting over Resident 1's vocal cords. The medication cup was removed with an alligator clamp (surgical instrument used for grasping small objects or removing items from small cavities in the body). The note indicated Resident 1 was successfully intubated without complication. A review of Resident 1's ED note indicated Resident 1 was admitted to the intensive care unit (ICU) secondary to [DIAGNOSES REDACTED]. According to LVN 1, at times Resident 1 would move her hands about and put her fingers in her mouth often. LVN 1 denies giving Resident 1 anything by mouth. On 7/23/2020 at 9:43 a.m., during a telephone interview, the Director of Nursing (DON) stated she received a call from an unknown GACH Risk management caseworker and was told a pill (sic) was found in Resident 1's throat. The DON stated she did not document the information received from the GACH in Resident 1's records and an investigation was started, but not completed. The DON stated an investigation was not necessary to report to the Department of Public Health because it was not abuse, neglect or mistreatment. The DON stated the nurses that administered Resident 1's medication only gave the medications through the [DEVICE]. On 7/23/2020 at 10:12 a.m., during a telephone interview, LVN 2 stated Resident 1 reaches for items at times, but

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

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F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) during medication administration time the resident does not grab any medication or medication cups. LVN 2 stated Resident 1 had to be monitored due to the habit of putting her fingers in her mouth. LVN 2 stated she would observe Resident 1 putting her fingers in her mouth daily approximately perhaps three to four times during her rounds. LVN 2 stated Resident 1 had no gag reflex (a contraction of the back of the throat, evoked by touching the soft palate; helps prevent aspiration) and was unable to cough. According to LVN 2, Resident 1 was dysphagic and received medications through the [DEVICE]. On 7/23/2020 at 10:28 a.m., during a telephone interview, Certified Nursing Assistant (CNA 1) stated she was regularly assigned to Resident 1 during the day shift. CNA 1 stated Resident 1 does not speak and was unable to move around much, only her arms. CNA 1 stated she have seen Resident 1 put her fingers in her mouth in a child-like manner. CNA 1 stated Resident 1 does not eat food by mouth only through the [DEVICE]. According to CNA 1, she has observed medication cups left at the residents' bedside, including Resident 1's bedside, after the nurses gave the residents their medications. A review of the facility's undated policy and procedure (P/P) titled, Monitoring Residents indicated the purpose was to identify ways in which the facility monitors residents and resident care. The P/P indicated residents with special care needs and potential for neglect shall likewise be monitored in accordance with their plan of care, and at a minimum included in the regular monitoring of charge nurses during endorsements of care to nurse's aides. The facility's monitoring programs included daily rounds, medication pass, nourishment pass, and etc.