STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555441	A. BUILDING _____ B. WING _____	04/10/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MEMORIAL HOSPITAL OF GARDENA D/P SNF	**1145 W. REDONDO BEACH GARDENA, CA 90247**

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 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement an abuse policy which indicated that injuries of unknown origins (a sign of abuse) must be reported to the Department of Public Health within 24 hours. Resident 1 developed an injury to the head during her residence at the facility. This deficient practice resulted in the facility's failure to report an injury of unknown origin and possible delay in investigation. Findings: On [DATE]20, at 10:10 AM, an announced visit was made to the facility to investigate a complaint which alleged that Resident 1 developed a head injury on 9/21/2019 during the night. A review of the undated admission record indicated the facility originally admitted Resident 1 on 4/28/2014 and readmitted on [DATE]. Resident 1's [DIAGNOSES REDACTED]. Resident 1 had a history of [REDACTED]. A review of the Minimum Data Set, (MDS) a standardized resident assessment and care-screening tool, dated 11/9/2019, indicated Resident 1 had difficulty communicating some words or finishing thoughts. Resident 1 misses some parts of the message when understating others. Resident 1 required total dependence with bed mobility, transfer, dressing, eating, toilet use, and personal hygiene. A review of a progress note, dated 9/21/2019 at 4:20 PM, indicated Resident 1 noted today with a bump on the head with maroon/purple skin discoloration, no open area. FM at bedside. Physician made aware with order to do a computer tomography (CT - a x-ray that takes images in several sections to look at the bones and tissues inside the body) scan without contrast and neurological checks. A review of the Photographic Documentation - Nursing, dated 9/21/2019, indicated Resident 1 had a right-sided, occipital (back of the head) area, bump with discoloration, size 7 x 6 centimeters (cm - a unit of measure). A review of the results of a CT scan, dated 9/21/2019, indicated Resident 1 had posterior right parietal scalp (upper back area of the head) swelling. A review a physician's orders [REDACTED]. On [DATE]20, at 11:25 AM, Resident 1 was observed in bed, awake. Resident 1 was non-verbal. A nickel-size bald spot was observed on the right side of the head. Resident 1 had a [MEDICAL CONDITION] and [DEVICE] in place. Resident 1 was unable to reposition self. On [DATE]20, at 11:30 AM, during an interview, a registered nurse (RN 1) stated Resident 1 had a scar to the right side of the head from an injury. RN 1 stated the injury was discovered to the right side of Patient 1's head on 9/21/2019 during bedside care with a family member (FM). The area was covered in dried blood but was not actively bleeding. RN 1 stated she informed the Charge Nurse (CN), the Treatment Nurse, the Director of Nursing (DON), and the physician on 9/21/2019 about the injury. RN 1 stated that the injury to the head was not endorsed by the previous nurse. RN 1 stated she saw Resident 1 on the morning of 9/21/2019 but did not notice the injury. RN 1 stated she had no previous knowledge of the bump or how it occurred. On [DATE]20 at 11:51 AM, during an interview, the CN stated she became aware of the bump to Resident 1's head on 9/21/2019. The CN stated she notified the physician and he ordered a CT of the head. The CN stated she notified the DON. The CN stated she interviewed the treatment nurse RN 1, she assessed Resident 1 that morning, and neither the treatment nurse or RN 1 were aware of the bump or knew how the it originated. On [DATE]20 at 11:59 AM, during an interview, the DON stated that none of the staff knew how Resident 1's injury happened. The DON stated she assisted with the investigation, and the cause of the injury was never determined. The DON stated the injury was not reported to the Department. The DON stated that the facility did not report the injury to the state agency because they felt the injury was not a result of abuse. The DON, however, confirmed that the facility could not rule out abuse. A review of the policy, Abuse/Neglect/Exploitation Reporting (Child, Dependent Adult/Elder and Domestic), effective September 2018, indicated all staff members are responsible for the reporting of any reasonable suspicion or of any witnessed or alleged abuse. Written reports will be completed within 24 hours of the incident and sent via fax. Telephone, and regular mail to the Los Angeles Department of Public Health, Health Facilities Inspection Division at 3400 Aerojet Avenue, Suite #323, El Monte, CA ; phone number (800) [PHONE NUMBER] using form SOC 341. Physical indicators of abuse included but were not limited to, bruises, welts, discoloration, swelling, and absence of hair/bleeding scalp.
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to report a bump (an injury of unknown origin or sign of abuse) to Resident 1's head to the Department of Public Health (Department) within 24 hours of becoming aware of the injury for one of three sampled residents. This deficient practice delayed the Department's investigation with the potential for on-going abuse. Findings: On [DATE]20, at 10:10 AM, an announced visit was made to the facility to investigate a complaint which alleged that Resident 1 developed a head injury on 9/21/2019 during the night. A review of the undated admission record indicated the facility originally admitted Resident 1 on 4/28/2014 and readmitted on [DATE]. Resident 1's [DIAGNOSES REDACTED]. Resident 1 had a history of [REDACTED]. A review of the Minimum Data Set, (MDS) a standardized resident assessment and care-screening tool, dated 11/9/2019, indicated Resident 1 had difficulty communicating some words or finishing thoughts. Resident 1 misses some parts of the message when understating others. Resident 1 required total dependence with bed mobility, transfer, dressing, eating, toilet use, and personal hygiene. A review of a progress note, dated 9/21/2019 at 4:20 PM, indicated Resident 1 noted today with a bump on the head with maroon/purple skin discoloration, no open area. FM at bedside. Physician made aware with order to do a computer tomography (CT - a x-ray that takes images in several sections to look at the bones and tissues inside the body) scan without contrast and neurological checks. A review of the Photographic Documentation - Nursing, dated 9/21/2019, indicated Resident 1 had a right-sided, occipital (back of the head) area, bump with discoloration, size 7 x 6 centimeters (cm - a unit of measure). A review of the results of a CT scan (a x-ray that takes images in several sections to look at the bones and tissues inside the body), dated 9/21/2019, indicated Resident 1 had posterior right parietal scalp (upper back area of the head) swelling. A review a physician's orders [REDACTED]. On [DATE]20, at 11:25 AM, Resident 1 was observed in bed, awake. Resident 1 was non-verbal. A nickel-size bald spot was observed on the right side of the head. Resident 1 had a [MEDICAL CONDITION] and [DEVICE] in place. Resident 1 was unable to reposition self. On [DATE]20, at 11:30 AM, during an interview, a registered nurse (RN 1) stated Resident 1 had a scar to the right side of the head from an injury. RN 1 stated the injury was discovered to the right side of Patient 1's head on 9/21/2019 during bedside care with a family member (FM). The area was covered in dried blood but was not actively bleeding. RN 1 stated she informed the Charge Nurse (CN), the Treatment Nurse, the Director of Nursing (DON), and the physician on 9/21/2019 about the injury. RN 1 stated that the injury to the head was not endorsed by the previous nurse. RN 1 stated she saw Resident 1 on the morning of 9/21/2019 but did not notice the injury. RN 1 stated she had no previous knowledge of the bump or how it occurred. On [DATE]20 at 11:51 AM, during an interview, the CN stated she became aware of the bump to Resident 1's head on 9/21/2019. The CN stated she notified the physician and he ordered a CT scan of the head. The CN stated she notified the DON. The CN stated she interviewed the treatment nurse RN 1, she assessed Resident 1 that morning, and neither the treatment nurse or RN 1 were aware of the bump

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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