STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056166	A. BUILDING _____ B. WING _____	06/29/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AFFINITY HEALTHCARE CENTER	**7039 ALONDRA BLVD PARAMOUNT, CA 90723**

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 0641 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents' Minimum Data Set, an assessment and care screening tool, were accurately documented to reflect the resident's status for two of five sampled residents (Residents A and B). Resident A and B's MDS was inaccurately assessed for cognition (thought process) and bowel and bladder. This deficient practice resulted in the resident's clinical status being incorrectly assessed and documented and had the potential for inaccurate care and services as well as no continuity of care. Findings: a. A review of Resident A's Admission Records indicated Resident A was admitted to the facility on [DATE] and last readmitted on [DATE]. Resident A's [DIAGNOSES REDACTED]. A review of Resident A's Minimum Data Set (MDS), dated [DATE] indicated the resident was unable to complete the brief interview for mental status ((BIMS)), however, the Staff Assessment for Mental Status, Section C0700 indicated Resident A seems or appears to recall after 5 minutes Resident A seems or appears to recall long past and Resident A was normally able to recall location of his own room and staff names and faces. Resident A's cognitive (thought process) skills for daily decision-making was documented as Independent - decisions consistent/reasonable. On 6/26/2020 at 12:17 p.m., during a telephone interview, the MDS nurse (MDS Nurse 1) stated Resident A's MDS was inaccurately documented for cognitive skills for daily decision-making. MDS Nurse 1 stated the MDS should have been coded as severely impaired and a correction would be made. b. A review of Resident B's Admission Records indicated the resident was admitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. According to Resident B's MDS, dated [DATE] under Section H0300 for Urinary Continence Resident B was Always Continent (ability to control) for both bowel and bladder functions. On 6/26/2020 at 1:28 p.m., during a telephone interview, MDS Nurse 1 stated they rely on nursing notes, other assessments and their own observation and assessment before coding the MDS. MDS Nurse 1 stated Resident B was always incontinent (inability to control) of bowel and bladder and the current MDS was incorrect.
F 0686 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to adhere to its policy and procedure to ensure all the necessary care and services were provided to prevent the development of pressure ulcers (injuries to skin and underlying tissue resulting from prolonged pressure on the skin) for four of five sampled residents (Residents B, C, D and E). Residents B, C, D, and E were observed not being turned every two hours as per the facility's policy and the resident's plan of care for prevention of skin breakdown. This deficient practice placed residents at risk for development of skin breakdown and worsening of existing pressure ulcers with delay in healing. Findings: a. A review of Resident B's Admission Records indicated the resident was admitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. A review of Resident B's Minimum Data Set (MDS), an assessment and care screening tool, dated 5/26/2020 indicated Resident B's cognitive skills (thought process) for daily decision-making was severely impaired. The MDS documentation indicated Resident B was totally dependent on staff and required a one-two plus persons physical assist for bed mobility and transfers. Resident B required an extensive one-person physical assist to complete his activities of daily living ((ADL) normal task such as eating, bathing, dressing, grooming and toileting). Resident B was documented as having three Stage III (wound that extends into the tissue beneath the skin) pressure ulcers. A review of Resident B's Braden Scale (tool used for predicting pressure ulcers), dated 3/23/2020, Resident B had a score of 14 indicating a moderate risk of developing pressure ulcers. A review of Resident B's Treatment Administration History, dated 5/23/2020 indicated Resident B had the following pressure injuries: 1. Right buttock MASD 2. Right heel: length 4.0 centimeters ((cm) unit of measurements) x width 3.0 cm 3. Right lateral malleolus (a bone on each side of the ankle define) pressure injury length 1.3 centimeters (cm) x width 0.8 cm 4. Perianal (located around the anus (the opening where feces leaves the body)) moisture associated skin damage ((MASD) inflammation and erosion of the skin caused by prolonged exposure to various sources of moisture including urine, stool, and perspiration). 5. Sacrococcyx (bottom of the spine and tailbone) Stage III pressure ulcer extending to left and right buttock MASD On 6/24/2020, during an observation of Resident B the resident was in his room lying on his back at 10:30 a.m., 11 a.m., 11:45 a.m., 12:15 p.m., 1:35 p.m., and 2:20 p.m., without being repositioned. b. A review of Resident C's Admission Records indicated the resident was admitted to the facility 6/20/2020. Resident C's [DIAGNOSES REDACTED]. A review Resident C's Braden Scale, dated 6/20/2020, Resident C had a score of 9 indicating the resident had a severe risk for developing pressure ulcers. On 6/24/2020, Resident C was observed in his room lying on his back at 10:30 a.m., 11 a.m. 11:45 a.m., 12:15 p.m., 1:35 p.m., and 2:20 p.m., without being repositioned. c. A review of Resident D's Admission Records indicated Resident D was admitted to the facility on [DATE], with a [DIAGNOSES REDACTED]. According to Resident D's Braden Scale for Predicting Pressure Sore Risk, dated 6/17/2020 Resident D had a score of 11, indicating a high risk for developing pressure ulcers. On 6/24/2020, Resident D was observed in his room lying on his back at 10:30 a.m., 11:45 a.m. and 12:35 p.m. At 1:35 p.m. and 2:20 p.m., Resident D was observed with his torso (the body without head, legs or arms) slightly turned to the left, but his buttocks had contact with the mattress. d. A review of Resident E's Admission Records indicated Resident E was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. According to Resident E's Braden Scale for Predicting Pressure Sore Risk, dated 6/18/2020 Resident E scored 10, which indicated a high risk for development of pressure ulcers. On 6/24/2020 at 10:30 a.m., 11 a.m., 11:45 a.m., 12:15 p.m., 1:35 p.m., and 2:20 p.m., Resident E was observed in lying in bed on her back without being repositioned. On 6/24/2020 at 1:25 p.m., during an interview, the Treatment Nurse, a Licensed Vocational Nurse (LVN 1) stated residents should be turned at least every two hours or more often as needed. LVN 1 stated he was not aware residents were not being turned appropriately. On 6/25/2020 at 2:17 p.m., during a telephone interview, the Director of Nursing (DON) was made aware residents were observed not being turned at least every two hours. The DON stated residents should be turned every two hours or more as needed and staff were instructed to do so. A review of the facility's policy and procedure (P/P), dated 5/2013 and titled, Repositioning indicated the purpose was to provide guidelines for the evaluation of resident repositioning needs, to aid in the development of an individualized care plan for repositioning, to promote comfort for all bed or chair bound residents and to prevent skin breakdown, promote circulation and provide pressure relief for residents. The P/P indicated repositioning was a common, effective intervention or preventing skin breakdown, promoting circulation, and providing pressure relief. The P/P indicated the turning and repositioning program included a continuous consistent program for changing the resident's position and realigning the body. Residents who are in bed should be on at least an every two hour repositioning schedule. The P/P also stipulated residents with a Stage I or above pressure ulcers, an every two hour repositioning schedule.
F 0842 **Level of harm -** Potential for minimal harm **Residents Affected -** Some	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.**

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 0842 **Level of harm -** Potential for minimal harm **Residents Affected -** Some	(continued... from page 1) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility's nursing staff failed to ensure the record for one of five sampled residents was documented accurately (Resident A). Resident A's skin rash and moisture associate skin damage ((MASD) inflammation and erosion of the skin caused by prolonged exposure to various sources of moisture including urine, stool and perspiration) was inaccurately documented. This deficient practice resulted in Resident A's clinical records being documented inaccurately and had the potential for lack of continuity of care. A review of Resident A's Admission Records indicated Resident A was admitted to the facility on [DATE] and last readmitted on [DATE]. Resident A's [DIAGNOSES REDACTED]. A review of Resident A's physician's orders [REDACTED]. According to a Discharge/Transfer - Hospital Transfer Observation form, dated 5/13/2020, Resident A's Skin and Body Assessment indicated Resident A had bilateral buttocks MASD (sic) with no mention of the perianal MASD. On 6/26/2020 at 12:43 p.m., during a telephone interview, the Treatment Nurse, a Licensed Vocational Nurse (LVN 1) stated Resident A was being treated daily for a skin rash and perianal MASD. LVN 1 stated when Resident A was transferred to the GACH on 5/13/2020 he still had the rash and perianal MASD but there was never a right and left buttock MASD, he knew this because he turned Resident A daily to apply the treatment to the skin rash on his back and he would have seen it and assessed it. A review of the facility's policy and procedure (p/p), dated 7/2017 indicated all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical physical, functional or psychosocial condition, shall be documented in the resident's medical record. The P/P indicated the medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Documentation in the medical record will be objective (not opinionated or speculative), complete.