STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555716	A. BUILDING _____ B. WING _____	04/20/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PARKWEST HEALTHCARE CENTER	6740 WILBUR AVE RESEDA, CA 91335

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 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the insulin (a hormone that works by lowering levels of glucose (sugar) in the blood) injection sites were rotated as per manufacturer's recommendations for one of three sampled residents (Resident 1). This deficient practice had the potential for injection site adverse reactions such as pain, redness, itching, and swelling. Findings: A review of Resident 1's Admission Record (face sheet) indicated the resident was readmitted on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 1's Minimum Data Set (MDS - a standardized assessment and screening tool) dated 12/7/19 indicated Resident 1's cognition (ability to think, understand and reason) was severely impaired. The MDS indicated Resident 1 needed limited assistance from staff with eating and required extensive assistance from staff with bed mobility, transfer, dressing, and personal hygiene. A review of Resident 1's physician's orders [REDACTED]. A review of Resident 1's Medication Administration Record [REDACTED]. Right upper arm on 1/2/20 11:30 a.m. dose, 4:30 p.m. dose, and 9:00 p.m. dose. 2. Right upper arm on 1/5/20 11:30 a.m. dose and 4:30 p.m. dose. 3. Left lower quadrant (area) of the abdomen on 1/13/20 6:30 a.m. dose and 11:30 a.m. dose. 4. Right lower quadrant of the abdomen on 1/30/20 4:30 p.m. dose and 9:00 p.m. dose. A review of Resident 1's Medication Administration Record [REDACTED].Left upper quadrant of the abdomen on 2/5/20 4:30 p.m. dose and 9:00 p.m. dose. 2. Left lower quadrant of the abdomen on 2/6/20 6:30 a.m. dose and 11:30 a.m. dose. 3. Right upper quadrant of the abdomen on 2/7/20 9:00 p.m. dose and 6:30 a.m. dose. 4. Left lower quadrant of the abdomen on 2/9/20 6:30 a.m. dose and 11:30 a.m. dose. 5. Left lower quadrant of the abdomen on 2/23/20 9:00 p.m. dose and 2/24/20 6:30 a.m. dose. During a phone interview with the Director of Nurse (DON) on [DATE]/20 at 3:55 p.m., she stated insulin injection sites should be rotated so that the insulin will be absorbed properly in the body and to prevent build up of lump under the skin caused by accumulation of extra fat at the site. A review of [MEDICATION NAME] manufacturer's literature, dated 2/2012 indicated injections sites should be rotated within the same region to reduce the risk of [DIAGNOSES REDACTED] (a defect in the breaking down or building up of fat below the surface of the skin, resulting in lumps or small dents in the skin surface which may be caused by repeated injections of insulin in the same spot). A review of the facility's policy and procedure titled Insulin Administration, revised 11/14, indicated injection sites should be rotated.
F 0726 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.** Based on interview and record review the facility failed to ensure licensed vocational nurses (LVN) completed the facility's orientation process prior to caring and providing services for residents for two of three sampled LVN's (LVN 1, LVN 2) reviewed for competency skills checks upon hire. This deficient practice had the potential to place residents at risk of not being provided safe care and services to meet resident's needs safely and in a manner that promotes resident's rights, physical, mental and psychosocial wellbeing. Findings: During a phone interview with LVN 1 on 3/26/20, at 5:00 p.m., LVN 1 confirmed working on 2/15/2020. LVN 1 stated that he provided direct patient care to residents by passing medications on his own on 2/15/20. During an interview with the Director of Staff Development (DSD) on [DATE]/20, at 3:25 p.m., the DSD stated all new hires undergo a 2-day orientation which consists of paper work and training videos. After the 2-day orientation, licensed nurses must complete three days of floor orientation. The newly hired licensed nurse will shadow and observe the process of medication administration being done by the regular licensed nurse. During an interview with the Assistant Director of Staff Development (ADSD) on [DATE]/20, at 3:35 p.m., ADSD stated LVN 1 was scheduled to have floor orientation on 2/15/20, 2/16/20, and on 2/20/20. ADSD continued to state that during floor orientation, new hires shadow and observe licensed nurses and patient care is not provided. LVN 1's orientation release date, to be on his own, was on 2/29/20. ADSD further stated it is required for new hires to obtain the proper orientation before allowing staff to care for residents to ensure residents will be cared in a safe manner. During a concurrent phone interview and record review with the DSD on 4/7/19, at 3:13 p.m., the DSD stated LVN 1 was initially hired on 2/10/20, and the Skills Checklist for Licensed Nurse -Medication Administration is completed during floor orientation and is completed by the person observing the orientee or the Director of Nurses (DON) before the orientee is allowed to pass medications on his/her own. The DSD stated there was no documented evidence Skills Checklist for Licensed Nurse Medication Administration for LVN 1 was found in LVN 1's personnel file. During a concurrent phone interview and record review with DSD on 4/7/19, at 3:15 p.m., the DSD stated LVN 2 was initially hired on 10/25/19. The DSD stated there was no documented evidence Skills Checklist for Licensed Nurse -Medication Administration for LVN 2 was found in LVN 2's personnel file. The DSD further stated the Medication Administration Checklist should be done and is important to ensure licensed nurses administer medications safely. A review of the Job Description: Director of Staff Development (DSD) undated, indicated Duties and Responsibilities: Administrative Functions include but not limited to: Plan, develop, direct, evaluate, and coordinate educational and on-the-job training programs; provide leadership in formulating the goals and objectives of the in-service educational programs if the facility; Develop, evaluate and control the quality of in-service educational programs in accordance with established policies and procedures; Secure, develop and maintain records, reports, instrumental manuals, reference materials, etc., pertinent to in-service educational programs; Perform administrative requirements such as completing necessary forms, reports, class attendance, and subject records, etc., Develop and participate in planning, conducting, and scheduling of orientation programs that orient newly hired personnel to their position, the facility's policies and procedures, resident rights and responsibilities, etc. The facility policy and procedure titled Orientation Program for Newly Hired Employees, Transfers, Volunteers, with a revised date of 1/2008, indicated an orientation program shall be conducted for all newly hired employees, transfers from other department, and volunteers. In addition to our general orientation, each department will orient the newly hired employee to his or her department's policies and procedures, as well as other data that will aid him/her in understanding the team concept, attitudes and approaches to resident car. The orientation program is an in-depth review of our facility's policies and procedures. A checklist is used to record materials reviewed with each employee. A written record will be maintained of each employee's individual orientation program. Orientation records shall include the date reviewed, employee's initials, subject matter reviewed, and other information deemed necessary or appropriate. Records of orientation shall be filed in the employee's personal file upon completion of the orientation program. Completed copies of Employee Orientation Checklists are filed in the employee's personal file.
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.**

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 -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) Based on interview and record review the facility failed to ensure health information and facility information was protected from unauthorized access and use for one of three sampled licensed vocational nurses (LVN 1). This deficient practice resulted to unauthorized access of resident's health information. Findings: During an interview with LVN 1 on 3/26/20, at 4:55 p.m., LVN 1 confirmed working on 2/15/20. LVN 1 stated he did not have log-in access to the facility's computer system at that time because he was still on orientation. LVN 1 stated he was informed he can used LVN 2's computer access and proceed with administration of medications. During an interview with LVN 2 on 3/26/20, at 5:19 p.m., LVN 2 confirmed working on 2/15/20. LVN 2 verified LVN 1 did not have log-in access. In turn, LVN 2 allowed LVN 1 to use her computer access to document medications administered by LVN 1. LVN 2 further stated she should have not shared her log-in accesss information because other people can log into one's account and anything documented will be the responsibility of the person who owns that specific log in access. During a phone interview with the Director of Nursing (DON) on 3/26/20, at 5:38 p.m., the DON stated staff is not supposed to share personal log in access and password with anyone. During a telephone interview with DON on [DATE]/20, at 3:58 p.m., DON stated computer access for new hires should be requested immediately upon hire by the Director of Staff Development (DSD) or the administrator. A review of the Facility IT Network Access Request Form, the form indicates LVN1's computer access was requested on 2/20/20 (10 days after LVN 1 was hired) by the Assistant Administrator. The facility policy and procedure titled Computer Terminals/Workstations, dated April 2014 indicated a user may not share or disclose his/her password or ID code with other staff or allow staff members his or her access privileges while the user is logged onto the facility's information system.