STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055293	A. BUILDING _____ B. WING _____	**05/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SANTA ANITA CONVALESCENT HOSPITAL	**5522 GRACEWOOD AVE. TEMPLE CITY, CA 91780**

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** - Minimal harm or potential for 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 provide adequate supervision and assistance to one of four sampled residents (Resident 1). This deficient practice had the potential to result in bodily injuries due to fall. Findings: A review of Resident 1's Admission Record indicated, Resident 1 was admitted to the facility on [DATE], and readmitted on [DATE], with current [DIAGNOSES REDACTED]. A review of Resident 1's History and Physical form dated 1/7/19, indicated Resident 1 does not have the capacity to understand and make decision. A review of Resident 1's Care Plan for at risk for fall and /or injuries related to history of falls and poor safety awareness/judgement, included the care plan intervention dated 1/7/19, to provide Resident 1 assistance with transferring and locomotion as needed. The intervention revised on 4/29/19, indicated to assess resident for needs and provide assistance as needed; Ensure resident safety at all times. The intervention indicated Resident 1 needed extensive assistance from staff for personal hygiene. Resident 1 required extensive assistance by two staffs for toileting. A review of Resident 1's Minimum Data Set (MDS - standardized assessment and care planning tool) dated 9/[DATE]9, indicated Resident 1 has severe cognitive impairments (has trouble remembering, learning new things, concentrating, or making decisions that affect everyday life). The MDS indicated, Resident 1 required extensive assistance from the staff with bed mobility (how resident moves to and from lying position, turn side to side and position body while in bed), transfer (how resident moves between surfaces including to or from bed, chair, wheelchair, standing position), dressing (how resident puts on fastens and takes off all items of clothing, including putting on and changing pajamas and housedresses). The MDS indicate Resident 1 required extensive assistance from staff with toilet use (how resident uses the toilet room, commode, bedpan, or urinal; transfers on/off toilet, cleanses self after elimination, changes pad, and adjust clothes) and personal hygiene (how resident maintains personal hygiene including combing hair, brushing teeth, washing/drying face and hands). The MDS indicated Resident 1's balance during transitions and walking was not steady, and was only stable to stabilize with staff assistance including; moving from seated to standing position, walking, turning around, and moving on and off toilet, and surface to surface transfer (transfer between bed and chair or wheelchair). A review of Resident 1's Fall Risk (Morse) assessment dated [DATE] indicated Resident 1's assessment score was 55 (Morse Fall scoring indicate high risk for score 45 and higher, moderate risk score as 25 - 44, and low risk score as 0 - 24). The Morse Fall result indicated Resident 1 was high risk for falling. A review of Resident 1's Fall Risk (Morse) assessment dated [DATE] indicated, Resident 1's assessment score was 75. The progress notes dated 11/20/19 indicated Resident 1 transferred to General Acute Care Hospital due to Resident complained of both lower extremities pain during movements. A review of GACH Radiology Report dated 11/20/19 indicated an x ray of bilateral pelvis result; an abnormal offset (means the amount or distance by which something is out of line) at the symphysis pubis (a secondary cartilaginous joint (a joint made of hyaline cartilage and fibrocartilage) located between the left and right pubic bones), which could be acute or chronic. Question acute non-displaced fracture in the left greater trochanter. A review of GACH Radiology Report dated 11/20/19 indicated a Computed Tomography (CT or CAT scan allows doctors to see inside the body. It uses a combination of X-rays and a computer to create pictures of the organs, bones, and other tissues. It shows more detail than a regular X-ray), of Pelvis, findings included: -There was an acute appearing displaced fracture involving the left superior and inferior pubic ramus (is a break of the bony structure of the pelvis). -There was an acute appearing fracture through the acetabular fossa and superior medial acetabulum roof (is a break in the socket portion of the ball-and-socket hip joint that are caused by some type of high-energy event, such as in car collision). -There was a questionable acute, no displaced fracture through the right superior and inferior pubic ramus immediately adjacent to the symphysis pubis. A review of the facility's Summary of the Investigation dated 11/22/19 indicated that during the facility's investigation, the Certified Nursing Assistant 1 (CNA 1) assisted Resident 1 inside the restroom in the hallway and left Resident 1 alone to get clothes and gown at Resident 1's bedroom. A review of the Investigation Interview Record dated 11/22/19 indicated an interview with CNA 1 reported that she wheeled Resident 1 to the restroom and transferred Resident 1 from wheel chair to the toilet. The interview record indicated that while Resident 1 was seated on the toilet, CNA 1 left Resident 1 alone in the restroom to pick up the resident's clothes in the bedroom. The report indicated that when CNA 1 was about to return to the restroom in the hallway from Resident 1's bedroom, Resident 1 was on the hallway lying sideways on the floor in front of the restroom in the hallway. On 12/10/19 at 3:55 PM, during an interview with Licensed Vocational Nurse 1 (LVN 1) stated Resident 1 had always attempted to get up unassisted. LVN 1 stated Resident 1 was high risk for fall. On 3/3/20 at 2 PM, during an interview with LVN 2 stated CNA 1 should had not left Resident 1 alone due to confusion. LVN 2 stated Resident 1 was high risk for fall and always attempted to get up unattended. LVN 2 stated Resident 1 could not stand, walk alone, and could not transfer herself. LVN 2 stated Resident 1 required extensive assistance from staff. On 3/4/20 at 4 PM, during an interview with RN 1 stated Resident 1 was high risk for fall and could not be left alone unattended. A review of the facility's Fall Prevention Program dated 12/2016 indicated; all precautions will be implemented to protect the resident according to the fall prevention and reduction program. The care plan should also include the following interventions but not limited to close observation and increase supervision. Staff assistance to toilet or bedside commode. Assistance to any sensory, knowledge, and perception deficits.
F 0697 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe, appropriate pain management for a resident who requires such services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide care and services for pain management in accordance with standard of practice and resident care plan, to one of four sampled residents (Resident 1). This deficient practice had the potential for lack of effective pain management that could result to more pain and discomfort to the resident. Findings: A review of Resident 1's Admission Record indicated, the facility admitted Resident 1 on 8/28/17, and readmitted on [DATE] with current [DIAGNOSES REDACTED]. A review of Resident 1's Order Summary Report dated 1/3/19 indicated an order for [REDACTED].= moderate pain, 7 - 10 = severe pain, every shift for monitoring level of comfort. A review of Resident 1's History and Physical form dated 1/7/19 indicated, Resident 1 does not have the capacity to understand and make decision. A review of Resident 1's Minimum Data Set (MDS - standardized assessment and care planning tool) dated 9/[DATE]9, indicated Resident 1 has severe cognitive impairments (has trouble remembering, learning new things, concentrating, or making decisions that affect everyday life). The MDS indicated, Resident 1 required extensive assistance from the staff with bed mobility (how resident moves to and from lying position, turn side to side and position body while in bed), transfer (how resident moves between surfaces including to or from bed, chair, wheelchair, standing position), dressing (how resident puts on fastens and takes off all items of clothing, including putting on and changing pajamas and housedresses). The MDS indicated Resident 1 required extensive assistance from staff with toilet use (how resident uses the

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

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F 0697 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) toilet room, commode, bedpan, or urinal; transfers on/off toilet, cleanses self after elimination, changes pad, and adjust clothes), and personal hygiene (how resident maintains personal hygiene including combing hair, brushing teeth, washing/drying face and hands). The MDS indicated Resident 1's balance during transitions and walking was not steady, and was only stable to stabilize with staff assistance including; moving from seated to standing position, walking, turning around, and moving on and off toilet, and surface to surface transfer (transfer between bed and chair or wheelchair). A review of Resident 1's Change in Condition Evaluation form dated 11/15/19 indicated, Resident 1 had a fall incident and complained of left arm pain of 3/10 (mild) pain scale. The form indicated that Resident 1's primary physician was informed of the fall incident but did not clearly indicate the physician was informed about Resident 1's complained of pain. A review of Resident 1's Progress Notes form dated 11/15/19 indicated Resident 1 had a fall incident and complained of pain 3/10 (mild) on the left arm. [MEDICATION NAME] 325 mg two tablet administered to Resident 1. A review of Resident 1's Care Plan dated 11/15/19 indicated an intervention to evaluate the effectiveness of pain interventions. To notify the physician if interventions are unsuccessful. A review of Resident 1's Medication Administration Record [REDACTED]. Resident 1's medical record did not indicate that the primary physician was informed about Resident 1's complaint of moderate pain and was administered [MEDICATION NAME] 650 mg or mild pain administered. Resident 1's MAR indicated [REDACTED]. A review of the facility's Summary of Investigation form indicated that on 11/15/19 Resident 1 complained of pain when the direct care staff provided care. The form indicated that on 11/16/19, during 11 PM - 7 AM shift, Resident 1 complained of pain during change of the resident's disposable brief. On 11/16/19 during 7 AM - 3 PM shift Resident 1 complained of pain when touched on the right leg. A review of Resident 1's Progress Notes dated 11/17/19 indicated Resident 1 complained of mild pain 3/10 on 11/17/19 at 12 midnight, [MEDICATION NAME] 650 mg administered to Resident 1 with no relief. The progress notes indicated that on 11/17/19 at 3:16 AM the primary physician notified of Resident 1 complained of moderate pain 6/10 pain scale of the right knee. A review of the facility's Investigation Interview Record dated 11/26/19 indicated that on 11/15/19 during 11 PM - 7 AM shift, Certified Nursing Assistant 3 (CNA 3) reported that around 12 midnight to 12:30 AM, when providing care and changing disposable brief Resident 1 complained of pain and screamed when turn to side. On 11/16/19 during 11 PM - 7 AM shift, CNA 4 reported Resident 1 complained of pain while changing the resident's disposable brief. CNA 3 and CNA 4 reported to LVN 4 that Resident complained of pain on both occasion. A review of facility's Investigation Interview Record dated 11/27/19 indicated on 11/16/19 CNA 5 reported Resident 1 complained of pain every time CNA 5 touched the right leg. On 3/3/20 at 1:32 PM during an interview and record review with Licensed Vocational Nurse 2 (LVN 2) stated, Resident 1 complained of mild pain during her shift (7 AM - 3 PM). LVN 2 stated she administered [MEDICATION NAME] 325 mg two tablet because it was the standing order. LVN 2 stated on 11/16/19 Resident 1 complained of moderate pain [DATE]0 pain scale. LVN 2 stated she administered [MEDICATION NAME] 325 mg, 2 tablet and did not call the physician because she already have a standing order of [MEDICATION NAME] 325 mg two tablet for pain. LVN 2 stated that she knew that [MEDICATION NAME] 325 mg standing order can be administer for any kind of mild pain. On 3/3/20 at 3:40 PM, during an interview and concurrent record review with LVN 2 stated, on 11/16/19 at 9 AM the pain level/scale was [DATE]0 that indicated moderate pain. LVN 2 stated she administered [MEDICATION NAME] 325 mg two tablet indicated for mild pain to Resident 1 because there was no other pain medication ordered. LVN 2 stated she did not call and inform the primary physician about Resident 1's moderate pain. On 3/4/20 at 3:50 PM, during an interview with LVN 1 stated on 11/15/19 Resident 1 had a fall incident. LVN 1 stated she administered [MEDICATION NAME] 325 mg two tablet as standing order on 1/3/19 to Resident 1 due to complained of mild pain. LVN 1 stated she reported to the primary physician about Resident 1's fall incident but did not asked an order for [REDACTED]. of pain even though there was a standing order for pain medication. RN 1 stated the primary physician should have been notified if there was an increase in pain level/scale. During concurrent interview with RN 1, RN 1 stated the primary physician should have been notified of the increased pain on 11/16/19, when Resident 1 complained of moderate pain of [DATE]0. A review of the facility's policy and procedure titled Pain Management Program dated 1/2019 indicated that the policy of the facility to screen and assess each resident for pain. Pain management is defined as the process of alleviating the resident's pain to a level that is acceptable to the resident and is based on his or her clinical condition and established treatment goal. Monitor appropriately for effectiveness and/or adverse consequences including defining how and when to monitor the resident's symptoms and degree of pain relief.