STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056111	A. BUILDING _____ B. WING _____	**08/28/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GRIFFITH PARK HEALTHCARE CENTER	**201 ALLEN AVE. GLENDALE, CA 91201**

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 0578 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide a Physician order [REDACTED]. This deficient practice affected Residents 1's treatment during the accident. Findings: A review of Resident 1's Admission Records, indicated the facility admitted the resident on [DATE], and readmitted him on [DATE] with [DIAGNOSES REDACTED]. to perform everyday activities). A review of Resident 1's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated [DATE], indicated the resident had severe impairment in cognitive (ability to think and process information) skills and needed limited assistance (resident involved in activity, staff provided weight-bearing support) with one-person assist for locomotion on/off unit, and transferring (how resident moves between surfaces including to or from bed, chair, wheelchair, and standing position). Resident 1 required supervision for eating. A review of Resident 1's Interdiscipilinary Team Conference, dated [DATE], indicated that Resident 1's code status was Full Code (provide life support treatment). A review of a paramedic report, dated [DATE], indicated that Resident 1 was in full arrest upon their (paramedic) arrival at 12:55 PM. The same report indicated the facility staff started cardiopulmonary resuscitation (CPR, method by providing compressions and breaths to bring back to life). When they found out that Resident 1 had a Do Not Resuscitate (DNR) status, the facility staff stopped CPR prior contacting emergency medical service (EMS). The same report indicated DNR status then confirmed and resident was pronounced dead on [DATE] at 1:04 PM. During an interview on [DATE] at 11 AM, a Licensed Vocational Nurse 1 (LVN 1) stated that the facility staff started CPR after [MEDICATION NAME] maneuver (a first aid procedure used to treat upper airway obstructions by foreign objects) was unsuccessful and Resident 1 did not have a pulse. During an interview on [DATE] at 12:15 PM, LVN 2 stated that she helped performed CPR when the incident happened before paramedics came and took over. During an interview on [DATE] at 12:30 PM, Director of Nursing (DON) stated that [MEDICATION NAME] maneuver was performed initially and Resident 1 losses consciousness and pulse. DON stated staff performed CPR and found out Resident 1 status was do not resuscitate. DON stated that time the POLST form wasn't sign by physician. DON stated they need to contact the physician to complete form with the signature. A review of Resident 1's POLST indicated it was prepared on [DATE] for DNR. Resident 1's Responsible Party signed on [DATE] and Resident 1's physician signed on [DATE] (the date Resident 1 was pronouced dead). A review of facility's policy and procedure titled, POLST, dated ,[DATE], indicated that: 1. POLST must be signed by Attending Physician, Nurse Practitioner, or Physician Assistant to be valid. 2. POLST will be honored during the initial comprehensive assessment period even if the Attending Physician has not formally reviewed the form.
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 observation, interview, and record review, the facility failed to ensure a resident was supervised to prevent a choking incident for one of three sampled residents (Resident 1). Resident 1, who needed supervision with eating and was at risk for aspiration (the entry of material such as food or drink form the mouth into the throat or lungs) and choking, was not supervised after Resident 1 took the food from the unlatched food cart, ate, and swallowed the food. This deficient practice resulted in Resident 1 choked on the food that he took from the unlatched food cart. Resident 1 was observed clutching his throat, unable to speak, became unresponsive (no pulse and breathing) on [DATE], at 12:48 p.m. Resident 1 was put in bed, and chest compressions was provided until paramedics (medical emergency services) arrived at 12:55 p.m. The Paramedic suctioned food blockage to be able to provide ventilation by a bivalve valve mask (BVM, a hand-held device to provide ventilation to a resident who is not breathing). The blockage removed from Resident 1 was a bread-like food particle that was a peanut butter substance. Resident 1 was pronounced dead in the facility on [DATE] at 1:02 p.m. Findings: A review of Resident 1's Admission Records indicated the resident was admitted to the facility, on [DATE], and readmitted , on [DATE], with [DIAGNOSES REDACTED]. to perform everyday activities). A review of Resident 1's Minimum Data Set (MDS, a standardized resident assessment and care screening tool), dated [DATE], indicated Resident 1's cognitive skills (ability to think and process information) was severely impaired and needed limited assistance (resident involved in activity, staff provided weight-bearing support) with one-person assist for locomotion on/off unit, and transferring (how resident moves between surfaces including to or from bed, chair, wheelchair, and standing position). The MDS assessment also indicated Resident 1 needed supervision for eating. A review of Resident 1's Progress Notes, dated [DATE], indicated Resident 1 had dementia with behavioral disturbance, and was dependent on a wheelchair. A review of Resident 1's care plan, titled Cognitive Loss/Dementia, initiated on [DATE], indicated resident had a problem due to dementia, decision making skills were severely impaired, and had altered perception/awareness (process of becoming aware of something through the senses). The care plan approaches included for the staff to be aware of triggers creating negative responses such as hunger, thirst, or any action that could negatively affect the resident. A review of Resident 1's Physician order [REDACTED]. A review of Resident's 1's care plan, titled Mechanically Altered Diet, initiated on [DATE], indicated that Resident 1's problem was missing teeth, at risk for choking and aspiration, and required supervision in eating. The interventions included to assist with meals as needed, to monitor the resident's intake, and refer to Speech Therapy as needed. The interventions did not indicate how to supervise and monitor Resident 1, who was at risk for choking and aspiration when eating. A review of Resident 1's care plan, titled Dental Status, initiated on [DATE], indicated Resident 1 had the potential for dental disorder related to no natural teeth and at risk for difficulty chewing and choking. The interventions included provide diet as ordered, monitor tolerance of texture of food, monitor oral intake, and monitor for oral discomfort. A review of Resident 1's Nutritional assessment dated [DATE] completed by a Registered Dietitian indicated Resident 1 had chewing problem, required supervision, oversight, encouragement or cueing when eating, and he required set-up help with the meal tray. A review of facility's Daily Menu Guide, for serving dates [DATE], [DATE], and [DATE] indicated the mechanical soft diet was soft and bite size foods. A review of the facility's investigative summary report, dated [DATE], at 12:48 p.m., indicated Resident 1 was noted at the hallway by Station 3, and Certified Nursing Assistant 1 (CNA 1) saw the resident clutching his throat and unable to speak. The resident was turning blue. A staff member went to attend the resident immediately, charge nurse assessed the resident and announced Code Blue (indicates a medical emergency such as cardiac or respiratory arrest). Registered Nurse Supervisor (RNS) ran over to Station 3, and saw the staff doing

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 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) [MEDICATION NAME] maneuver (a first aid procedure used to treat upper airway obstructions by foreign objects) in his wheelchair several times. A 911 (medical emergency telephone number) was called. Resident 1 was put in bed, and chest compressions was provided until paramedics arrived at 12:55 p.m. The Fire Department had suctioned Resident 1 and obtained soft bread-like food particle. The Charge Nurse (Licensed Vocational Nurse 1, LVN 1) felt the soft bread-like food particle. The next day, on [DATE] at 12:36 p.m., a facility staff spoke with the Paramedic at the Fire Department, who was present at the facility yesterday, when 911 was called for Resident 1. Per the Paramedic, the substance removed from the resident's throat through suction was a food particle that was a peanut butter substance. A review of the paramedic report, dated [DATE], indicated upon arrival at 12:56 p.m., Resident 1 was lying in bed in supine (flat on his back) position. Facility staff state that pt. (patient/resident) had an episode of choking followed by respiratory and [MEDICAL CONDITION]. Pt was seated in a wheelchair according to staff and moved to a bed where Cardiopulmonary Resuscitation (CPR, a medical procedure involving repeated compression of a patient's chest, performed in an attempt to restore the blood circulation and breathing of a person who has suffered [MEDICAL CONDITION]) was initiated by staff. EMS (emergency medical services) visualization of the airway found blockage, and food was removed. The paramedic administered ventilation through a BVM. Resident 1 was assessed with [REDACTED]. Resident 1 was pronounced dead at 13:04 (1:04 p.m.). A review of Resident 1's Certificate of Death, indicated time of death was on [DATE] at 1:02 p.m., the immediate cause of death was cardiopulmonary arrest (respiratory and [MEDICAL CONDITION]). The secondary causes included acute [MEDICAL CONDITION] infarction ([MEDICAL CONDITION]) and hypertension (high blood pressure). During an interview with the LVN 1 on [DATE], at 11 a.m., LVN 1 stated on [DATE], LVN 1 was at the nursing Station 3, when LVN 1 heard CNA 1 yelled for help. LVN 1 stated the time of day was lunch time. LVN 1 stated when she arrived to help, Resident 1 was in his wheelchair sitting in the middle of the hallway at Station 3. LVN 1 stated Resident 1 was blue. LVN 1 stated CPR was provided after [MEDICATION NAME] maneuver was unsuccessful. LVN 1 stated Resident 1 did not have a pulse. During a telephone interview with the CNA 1, on [DATE], at 11:20 a.m., CNA 1 stated, on [DATE] (unable to provide time) CNA 1 saw Resident 1 took some food from the unlatched food cart, and Resident 1 ate the food. CNA 1 then approached Resident 1 and instructed Resident 1 not to take food from the food cart. CNA 1 stated Resident 1 did not respond to him, and he saw Resident 1 wheeled himself towards nursing station. CNA 1 then moved the food cart away and put latch on it. Then, CNA 1 stated that he looked back at Resident 1 and saw him looking pale and was coughing like choking. CNA 1 wheeled Resident 1 to Station 3, and CNA 1 yelled out for help. During an observation of facility's lunch time, on [DATE] at 12:20 p.m., a CNA was noted to take food tray from the food cart in front of room [ROOM NUMBER] and left the food cart open unattended. Residents were observed passing by the unlatched food cart. During a telephone interview on [DATE], at 10:32 a.m., LVN 2 stated the food cart should be closed and latched at all times. During a telephone interview on [DATE], at 2:32 p.m. CNA 1 stated the food cart has latch and it should be latched at all times. CNA 1 stated in the past (unable to provide date), he saw Resident 1 took a sandwich from the nursing station. During an interview with the Director of Nursing 1 (DON 1) on [DATE], at 2:41 p.m., the DON stated that the facility failed to ensure Resident 1 received appropriate interventions for his dementia and choking risk that led him to choke and died . During an interview with DON 2 on [DATE], at 4:18 p.m., DON 2 stated for a resident, who was at risk for choking, the appropriate interventions included to supervise the resident when swallowing any food eaten and offer liquid. During telephone interview on [DATE], at 5:17 p.m., DON 2 stated that she reviewed the care plan for Mechanical Altered Diet and confirmed the interventions did not address how to supervise or monitor the resident who was at risk for choking. DON 2 stated the resident who was at risk for choking should be closely monitored while resident was eating, give time for resident to swallow, and remind the resident to eat slowly. A review of the facility's policy and procedure, titled Safety and Supervision of Resident, revised date on ,[DATE], indicated, Our facility will strive to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. The staff shall use various sources to identify the risk factors for the residents that included medical history and observation of residents, and the MDS. The type and frequency of resident supervision may vary among residents and over time for the same residents. Resident supervision may need to be increased when there are temporary hazards in the environment or if there is a change in the resident's condition.