STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555375	A. BUILDING _____ B. WING _____	05/21/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WINDSOR GARDENS CONVALESCENT CENTER OF LONG BEACH	3232 E. ARTESIA BLVD. LONG BEACH, CA 90805

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 0583 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Keep residents' personal and medical records private and confidential.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the facility's policy and procedure on privacy and confidentiality of records was followed for one of three residents (Resident 1). This deficient practice resulted in Resident 1's confidential health information distributed and accessed by an unauthorized person and had the potential for healthcare fraud and abuse. Findings: During an interview on [DATE] at 4:20 p.m., the facility Receptionist stated an unidentified female (UFEM) called on Friday ([DATE]) at 5 p.m., and stated she was Resident 1's daughter (family member) but did not give her name. The Receptionist stated she informed UFEM that Resident 1 was discharged , when the caller started crying and yelling she needed to know where Resident 1 was. The Receptionist stated she called the business office and was told to transfer the call to the Registered Nurse Supervisor (RN 1) who told the alleged family member the resident had passed away. The Receptionist stated, the following day, Saturday ([DATE]) the UFEM came to pick up Resident 1's belongings and was asked to sign in. The Receptionist stated the UFEM must have faked sign in because later on when the facility discovered the person was not who she claimed to be and checked the sign in sheet, there was no signature written on the sheet. The Receptionist stated she called RN 1 and he came to the receptionist area with a clear plastic bag with the resident's belongings. The Receptionist stated the UFEM stated she was the resident's daughter but did not provide any identification card. The UFEM asked what was the time of resident's death, the Receptionist stated she gave the UFEM a copy of the census and Inquiry Record (a document the facility receives from transferring provider) because she was instructed by RN 1 to give the documents to the UFEM. The Receptionist stated she did not know the Inquiry sheet had the resident's social security number (SSN) information. The Receptionist stated she did not remember what Health Insurance Portability and Accountability Act (HIPAA) meant and was made to watch a video on HIPAA as training. The Receptionist stated if there was a HIPAA breach (the acquisition, access, use, or disclosure of protected health information), someone could commit fraud. During an interview on [DATE] at 4:45 p.m., RN 1 stated he received HIPAA training through a video and remembered keeping confidentiality of resident information and a fine for breach. RN 1 stated he was trained on the facility procedure for releasing resident's belongings to the responsible party as indicated in the resident's chart and to check for identification before releasing belongings. During an interview on [DATE] at 5:05 p.m., the Director of Staff Development (DSD) stated she does training with the staff and tell them not to release information to anyone except the responsible party (RP). The DSD stated if staff did not understand HIPAA, there could be a breach and information given to the wrong person. A review of Resident 1's Inquiry Record dated [DATE] indicated admitted to the facility on [DATE] from a general acute care hospital (GACH). A review of Resident 1's Admission Record (face sheet) indicated the resident was admitted on [DATE] with [DIAGNOSES REDACTED]. The record indicated the resident as responsible party. A review of Resident 1's the Record of Death, indicated date and time of death on [DATE] at 1:40 p.m. The record indicated the resident had no family, no person was notified. A review of a progress note dated [DATE] at 3:23 p.m. by Registered Nurse (RN 3) indicated the police found next of kin, family member (FM 1) who lived out of State. The progress note indicated RN 3 received the name and contacted FM 1, and was told to wait for family member 2 (FM 2) to make a decision regarding Resident 1's body. RN 3 was given FM 2's name and contact information. At 4:40 p.m. RN 3 spoke to FM 2 and gave the phone number for the mortuary where to send the body. At 7:14 p.m., with police present, Resident 1's body was picked up from the facility to the mortuary. During an interview on [DATE] at 10:45 a.m., Registered Nurse (RN 2) stated the family member needs to be verified with identification compared to the resident's face sheet. RN 2 stated the staff followed HIPAA guidelines by not providing resident information unless they are on the face sheet, otherwise it is a violation of a resident's rights. During an interview on [DATE] at 12:45 p.m., the Director of Nursing (DON) stated some of Resident 1's belongings were given to tan alleged family member. The DON stated after a resident dies, the personal property is given to whoever picks up and the inventory sheet is signed. The DON stated the facility safeguards resident information by releasing to the responsible party as indicated on the resident's face sheet. The DON stated the staff are trained by the DSD through in-services. A review of a Corrective Action Memo for violation of policy and procedure dated [DATE] by the DON for RN 1 indicated the RN failed to ensure the resident's personal belongings was given to the responsible party, person authorized by the responsible party and or person identified in the communication documented in the resident's medical record that was contacted by local law enforcement agency. On [DATE] RN 1 provided the resident's belongings to an unconfirmed female to pick up the resident belongings. Also, allowed the Receptionist to provide a copy of the face sheet to the unidentified individual. A review of the facility policy tiled Confidentiality and Non-Solicitation Agreement dated ,[DATE] indicated the employee will not gather, store or use any Resident information in any manner and will not disclose, distribute, sell, share, rent or otherwise transfer any resident information to any third party, except as Employee may be expressly and reasonably directed in advance writing by Company. The document was signed by RN 1 on [DATE]. A review of the facility policy titled Personal Representatives of Residents dated [DATE] indicated before granting access to the resident's personal health information (PHI), facility staff shall verify that the individual claiming to be a resident's personal representative has the authority to do so by reviewing the document authorizing the personal representative.
F 0602 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Protect each resident from the wrongful use of the resident's belongings or money.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure one of three residents' (Resident 1) belongings was not given to an unauthorized person. This deficient practice resulted in Resident 1's loss of the resident's belongings and had the potential for healthcare fraud and abuse. Findings: During an interview on [DATE] at 4:20 p.m., the facility Receptionist stated an unidentified female (UFEM) called on Friday ([DATE]) at 5 p.m., and stated she was Resident 1's daughter (family member) but did not give her name. The Receptionist stated she informed UFEM that Resident 1 was discharged , when the caller started crying and yelling she needed to know where Resident 1 was. The Receptionist stated she called the business office and was told to transfer the call to the Registered Nurse Supervisor (RN 1) who told the alleged family member the resident had passed away. The Receptionist stated, the following day, Saturday ([DATE]) the UFEM came to pick up Resident 1's belongings and was asked to sign in. The Receptionist stated the UFEM must have faked sign in because later on when the facility discovered the person was not who she claimed to be and checked the sign in sheet, there was no signature written on the sheet. The Receptionist stated she called RN 1 and he came to the receptionist area with a clear plastic bag with the resident's belongings. The Receptionist stated the UFEM stated she was the resident's daughter but did not provide any identification card and asked if the resident's cell phone was in the bag. The Receptionist verified the resident's cell phone was in the bag. The Receptionist stated if there was a HIPAA breach (the acquisition, access, use, or disclosure of protected health information), someone could commit fraud. During an interview on [DATE] at 4:45 p.m., RN 1 stated he received HIPAA training through a video and remembered keeping confidentiality of resident information and a fine for breach. RN 1 stated he was trained on the facility procedure for releasing resident's belongings to the responsible party as indicated in the resident's chart and to check for identification before releasing belongings.

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 0602 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) RN 1 stated on [DATE], the Receptionist called him at the nursing station to inform him Resident 1's family member was there to pick up the resident's belongings and found a plastic bag with the resident's name at the nursing station. RN 1 stated he checked the computer records for the name of the responsible party, but there was none indicated but was told that the resident's body was checked by his daughter and this was the same person. RN 1 stated he gave the UFEM a bag of clothing, cellular phone and wallet. RN 1 stated he did not check the wallet contents or pay attention to what kind of cellular phone was in the bag. RN 1 stated he gave instructions to the Receptionist to have the UFEM to sign something that she received Resident 1's belongings. RN 1 stated this was not done in this case and the Resident's medical records (chart) could not be found. RN 1 stated he should have checked for identification and called the Director of Nursing (DON) because there were instructions not to release the belongings unless it was the same person they talked to about the resident's body. A review of Resident 1's Inquiry Record dated [DATE] indicated admitted to the facility on [DATE] from a general acute care hospital (GACH). A review of Resident 1's Admission Record (face sheet) indicated the resident was admitted on [DATE] with [DIAGNOSES REDACTED]. The record indicated the resident as responsible party. A review of Resident 1's the Record of Death, indicated date and time of death on [DATE] at 1:40 p.m. The record indicated the resident had no family, no person was notified. A review of a progress note dated [DATE] at 3:23 p.m. by Registered Nurse (RN 3) indicated the police found next of kin, family member (FM 1) who lived out of State. The progress note indicated RN 3 received the name and contacted FM 1, and was told to wait for family member 2 (FM 2) to make a decision regarding Resident 1's body. RN 3 was given FM 2's name and contact information. At 4:40 p.m. RN 3 spoke to FM 2 and gave the phone number for the mortuary where to send the body. At 7:14 p.m., with police present, Resident 1's body was picked up from the facility to the mortuary. During concurrent record review and interview with RN 2 on [DATE] at 11:05 a.m., Resident 1's Inventory of Personal Effects indicated: one cell phone, one cell phone recharger and one cell phone charger, one brown wallet, one identification card and one social security card, one brown belt, one pair of black shoes, one black shirt and one pair of blue jeans. The inventory was signed on admission on [DATE] with verbal confirmation from the resident and facility representative. The inventory was signed on discharge undated, by a resident representative with undecipherable hand writing and facility representative dated [DATE]. RN 2 stated Resident 1's Inventory of Personal Effects was signed by Licensed Vocational Nurse 1 on discharge. During an interview on [DATE] at 12:45 p.m., the Director of Nursing (DON) stated some of Resident 1's belongings were given to tan alleged family member. The DON stated after a resident dies, the personal property is given to whoever picks up and the inventory sheet is signed. The DON stated the facility safeguards resident information by releasing to the responsible party as indicated on the resident's face sheet. A review of a Corrective Action Memo for violation of policy and procedure dated [DATE] by the DON for RN 1 indicated the RN failed to ensure the resident's personal belongings was given to the responsible party, person authorized by the responsible party and or person identified in the communication documented in the resident's medical record that was contacted by local law enforcement agency. On [DATE] RN 1 provided the resident's belongings to an unconfirmed female to pick up the resident belongings. Also, allowed the Receptionist to provide a copy of the face sheet to the unidentified individual. A review of the facility's policy titled Inventory of Personal Belongings List dated ,[DATE] indicated the facility shall place the resident's belongings in safekeeping after the resident's discharge until the resident representative is able to collect the resident's possessions. A review of the facility policy titled Personal representative of Residents dated [DATE] indicated the facility shall verify and maintain all documentation which authorizes an individual to act as a resident's personal representative.