STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056206	A. BUILDING _____ B. WING _____	**07/31/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
UNIVERSITY PARK HEALTHCARE CENTER	**230 E ADAMS BLVD LOS ANGELES, CA 90011**

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 0580 **Level of harm -** Actual harm **Residents Affected -** Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the physician when one of two sampled residents (Resident 1) developed fever (elevated body temperature), as indicated in the facility's policy and plan of care. On [DATE] at 1:28 p.m., Resident 1 developed a fever of 100.5 degrees Fahrenheit (F - normal range from 97 F to 99 F) and the change of condition was not reported to Resident 1's attending physician for medical interventions, including finding out the source of the fever (possible infection) through laboratory tests, frequent checks of the resident's temperature, pharmaceutical and non-pharmaceutical interventions. As a result, on [DATE], at 9:29 a.m., Resident 1 was transferred to General Acute Care Hospital 1 (GACH 1) where he was found with an elevated body temperature of 106.3 F and hemodynamically unstable (abnormal or unstable blood pressure, which can cause inadequate blood flow to organs). Resident 1 expired on [DATE] at 11:23 p.m. Cross Reference: F755 Findings: A review of Resident 1's Admission Record (Face Sheet) indicated a readmitted d on [DATE] with [DIAGNOSES REDACTED]. vessel) with left [MEDICAL CONDITION] (weakness on one side of the body). A review of Resident 1's physician's orders [REDACTED]. A review of the Care Plan developed on [DATE] indicated Resident 1 had a risk of dehydration (dangerous loss of body fluid caused by illness, sweating, or inadequate intake). The care plan interventions included to observe for contributing factors (such as elevated temperature (fever)) and notify the physician as needed. A review of Resident 1's Minimum Data Set (MDS - standardized assessment and care-screening tool) dated [DATE], indicated Resident 1's cognition (mental processes involved in gaining knowledge and comprehension) was moderately impaired (decision poor, supervision required). Resident 1 needed limited assistance with one-person physical assist with activities of daily living (ADLs - such as transfers, toileting, and personal hygiene). A review of Resident 1's physician's orders [REDACTED].F, and to notify the physician. A review of the facility's contact line listing (surveillance, tracing of an infection) for COVID-19 (Coronavirus disease 2019, a highly contagious [MEDICAL CONDITION] infection that is spread from person-to-person causing respiratory complications requiring in many cases hospitalization and may result in death) dated [DATE], indicated Resident 1 was tested for COVID-19. A review of Resident 1's Change of Condition/SBAR (Situation - Background - Assessment - Recommendation) form dated [DATE] indicated Resident 1's temperature was 98.8 F, the blood pressure at ,[DATE] millimeters of mercury (mmHg - unit of measure , the normal adult blood pressure is below ,[DATE] mmHg), and had pain but was unable to rate the pain. A review of Resident 1's Vital Signs log (measurement of the body's most basic functions such as respiratory and cardiac rate, blood pressure, and body temperature) indicated that on [DATE] at 1:28 p.m., Resident 1's temperature was 100.5 F, on [DATE] at 9 p.m., the temperature was 99.2 F, on [DATE] at 8:22 a.m., the temperature was 104 F. A review of Resident 1's COVID-19 test result dated [DATE] indicated Resident 1 was positive for COVID-19. A review of Resident 1's Medication Administration Record [REDACTED]. A review of Resident 1's medical record indicated no change of condition was conducted on [DATE] after the elevated temperature were identified. There was no documentation the physician was informed. A review of Resident 1's Change of Condition / SBAR form dated [DATE] indicated Resident 1 had a body temperature of 104 F, was shaking and was possibly having [MEDICAL CONDITION]. Resident 1 was transferred to GACH 1 for high body temperature of 104 F. A review of Resident 1's Nursing Notes dated [DATE] indicated Resident 1 was transferred to GACH 1 for high temperature, altered mental status and shortness of breath via paramedics (emergency medical team). A review of the Paramedics' Report dated [DATE], indicated Resident 1 was lying in bed shaking and able to follow commands. Facility staff stated (to paramedics) Resident 1 had a fever and was shaking all morning. The resident was not given any medication for fever. Resident 1 was transported to the GACH 1 at 9:29 a.m. for fever. A review of GACH 1's Emergency Department (ED) Documentation dated [DATE], indicated Resident 1 arrived at the ED from the facility with reports of chills starting Friday ([DATE]), with a high fever of 106.3 F, and was hemodynamically unstable requiring vasopressors (medicines that constrict (narrow) blood vessels, increasing the blood pressure. They are used in the treatment of [REDACTED]. Resident 1 was hypotensive (low blood pressure), hypoxic (deprived of adequate oxygen supply) and was intubated (a tube is inserted into the windpipe (trachea) for ventilation (breathing) and airway protection). Resident 1 had a heart rate of 110 beats per minute, respiration rate of 18 breaths per minute, blood pressure of ,[DATE] mmHg. Resident 1was admitted to the cardiac care unit for further management. A review of GACH 1 Death Summary indicated Resident 1 was febrile (with fever) 101.7 F, maxed (revceived maximum number) on four vasopressors, increasing blood pressure. Resident 1 with no urine elimination (anuria), worsening acidosis (buildup of acid in the bloodstream due to kidneys and lungs failure). Resident 1 was extubated (the tube to the airway was removed) on [DATE] and was placed on comfort care measures. Resident 1 expired on [DATE] at 11:23 p.m. During an interview on [DATE] at 3:45 p.m., the Director of Nursing (DON) stated Resident 1 had a body temperature of 100.5 F on [DATE] and confirmed the physician was not notified and Resident 1 was not given medication for fever and no other interventions such as cooling measures were provided. During an interview on [DATE] at 7:30 a.m., LVN 3 stated she was taking care of Resident 1 on [DATE]. LVN 3 stated she was not informed of Resident 1's temperature of 100.5 F on [DATE]. LVN 3 stated she did not give [MEDICATION NAME] to Resident 1 or notified the physician because she did not know Resident 1's temperature was 100.5 F. On [DATE] at 3:15 p.m., during an interview, Certified Nursing Assistant 1 (CNA 1) stated on [DATE], she took Resident 1's temperature at around 1:30 p.m. and it was 100.5 F. CNA 1 stated she informed Registered Nurse 1 (RN 1) and RN 1 told her he would take care of it. On [DATE] at 2 p.m., during an interview, RN 1 stated he was the RN Supervisor on [DATE] morning shift (7 a.m. to 3 p.m.) and CNA 1 did not inform him of Resident 1's elevated temperature. A review of the facility's policy and procedure titled, Change in a Resident's Condition or Status, revised on [DATE], indicated the nurse will notify the resident's attending physician or physician on call when there has been a significant change in the resident's physical/emotional/mental condition. A significant change of condition is a major decline or improvement in the resident's status that will not normally resolve itself without intervention by staff or by implementing standard disease- related clinical interventions (is not self-limiting), or impacts more than one area of the resident's health status. The nurse will record in the resident's medical record information relative to changes in the resident's medica/mental condition or status.
F 0755 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure medication was administered as prescribed by the physician for one of two sampled residents (Resident 1). Resident 1 had a fever of 100.5 degrees Fahrenheit (F) on [DATE]

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 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) and 104 degrees F on [DATE] and was not administered [MEDICATION NAME] per the physician's orders [REDACTED]. Cross Reference: F 580 Findings: A review of Resident 1's Admission Record (Face Sheet) indicated a readmitted d on [DATE] with [DIAGNOSES REDACTED]. vessel) with left [MEDICAL CONDITION] (weakness on one side of the body). A review of Resident 1's physician's orders [REDACTED]. A review of the Care Plan developed on [DATE] indicated Resident 1's risk of dehydration (dangerous loss of body fluid caused by illness, sweating, or inadequate intake). The care plan interventions included to observe for contributing factors (such as elevated temperature (fever)) and notify the physician as needed. A review of Resident 1's Minimum Data Set (MDS - standardized assessment and care-screening tool) dated [DATE], indicated Resident 1's cognition (mental processes involved in gaining knowledge and comprehension) was moderately impaired (decision poor, supervision required). Resident 1 needed limited assistance with one-person physical assist with activities of daily living (ADLs - such as transfers, toileting, and personal hygiene). A review of Resident 1's physician's orders [REDACTED].F (normal range from 97 F to 99 F), and to notify the physician. A review of the facility's Plan of Correction, dated [DATE], from a previously cited deficiency, indicated the the Pharmacy Nurse Consultant in serviced the licensed staff regarding policy and procedure of following physician's orders [REDACTED]. The Plan of Correction indicated a medication administration audit would be conducted five times per week and non-compliance issues would be brought to the DON for resolution. A review of the facility's contact line listing (surveillance, tracing of an infection) for COVID-19 (Coronavirus disease 2019, a highly contagious [MEDICAL CONDITION] infection that is spread from person-to-person causing respiratory complications requiring in many cases hospitalization and may result in death) dated [DATE], indicated Resident 1 was tested for COVID-19. A review of Resident 1's Change of Condition/SBAR (Situation - Background - Assessment - Recommendation) form dated [DATE] indicated Resident 1's temperature was 98.8 F, the blood pressure at ,[DATE] millimeters of mercury (mmHg - unit of measure , the normal adult blood pressure is below ,[DATE] mmHg), and Resident 1 had pain but was unable to rate the pain. A review of Resident 1's Vital Signs log (measurement of the body's most basic functions such as respiratory and cardiac rate, blood pressure, and body temperature) indicated that on [DATE] at 1:28 p.m., Resident 1's temperature was 100.5 F, on [DATE] at 9 p.m. the temperature was 99.2 F, and on [DATE] at 8:22 a.m., the temperature was 104 F. A review of Resident 1's COVID-19 test result dated [DATE] indicated Resident 1 was positive for COVID-19. A review of Resident 1's Medication Administration Record [REDACTED]. A review of Resident 1's medical record indicated no change of condition was conducted on [DATE] after the elevated temperature were identified. There was no documentation the physician was informed. A review of Resident 1's Change of Condition / SBAR form dated [DATE] indicated Resident 1 had a body temperature of 104 F, was shaking and was possibly having [MEDICAL CONDITION]. Resident 1 was transferred to GACH 1 for high body temperature of 104 F. A review of Resident 1's Nursing Notes dated [DATE], indicated Resident 1 was transferred to GACH 1 for high temperature, altered mental status and shortness of breath via paramedics (emergency medical team). A review of the Paramedics' Report dated [DATE], indicated Resident 1 was lying in bed shaking and able to follow commands. Facility staff stated (to paramedics) Resident 1 had a fever and was shaking all morning. The resident was not given any medication for fever. Resident 1 was transported to the GACH 1 at 9:29 a.m. for fever. A review of GACH 1's Emergency Department (ED) Documentation dated [DATE], indicated Resident 1 arrived at the ED from the facility with reports of chills starting Friday ([DATE]), with a high fever of 106.3 F, and was hemodynamically unstable requiring vasopressors (medicines that constrict (narrow) blood vessels, increasing the blood pressure. They are used in the treatment of [REDACTED]. Resident 1 was hypotensive (low blood pressure), hypoxic (deprived of adequate oxygen supply) and was intubated (a tube is inserted into the windpipe (trachea) for ventilation (breathing) and airway protection). Resident 1 had a heart rate of 110 beats per minute, respiration rate of 18 breaths per minute, blood pressure of ,[DATE] mmHg. Resident 1was admitted to the cardiac care unit for further management. A review of GACH 1 Death Summary indicated Resident 1 was febrile (with fever) 101.7 F, maxed (received the maximum number) on four vasopressors, increasing blood pressure. Resident 1 with no urine elimination (anuria), worsening acidosis (buildup of acid in the bloodstream due to kidneys and lungs failure). Resident 1 was extubated (the tube to the airway was removed) on [DATE] and was placed on comfort care measures. Resident 1 expired on [DATE] at 11:23 p.m. During an interview on [DATE] at 3:45 p.m., the Director of Nursing (DON) stated Resident 1 had a body temperature of 100.5 F on [DATE] and confirmed the physician was not notified, no medication for fever, and no other cooling measures provided to Resident 1. During an interview on [DATE] at 7:30 AM, the Licensed Vocational Nurse 3 (LVN 3) stated she was taking care of Resident 1 on [DATE]. LVN 3 stated she was not informed of Resident 1's temperature of 100.5 F on [DATE]. LVN 3 stated she did not give [MEDICATION NAME] to Resident 1 or notified the physician because she did not know Resident 1's temperature was 100.5 F. On [DATE] at 3:15 p.m., during an interview, Certified Nursing Assistant 1 (CNA 1) stated on [DATE], she took Resident 1's temperature at around 1:30 p.m. and it was 100.5 F. CNA 1 stated she informed Registered Nurse 1 (RN 1) and RN 1 told her he would take care of it. On [DATE] at 2 p.m., during an interview, RN 1 stated he was the RN Supervisor on [DATE] morning shift (7 a.m. to 3 p.m.) and CNA 1 did not inform him of Resident 1's elevated temperature. A review of the facility's policy titled, Medication Administration - General Guidelines, effective date ,[DATE], indicated medications are administered as prescribed.