STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055473	A. BUILDING _____ B. WING _____	**05/08/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NEW VISTA POST- ACUTE CARE CENTER	**1516 SAWTELLE BLVD. LOS ANGELES, CA 90025**

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 ensure the licensed nurses notified the physician of a significant change in condition for one of three sampled residents (Resident 1), who had a clogged indwelling catheter (a soft flexible tube inserted into the bladder to drain urine) with urinary output of 1800 cubic centimeters (cc-a unit of measure), blood-tinged urine, after changing the catheter, and an increased heart rate. The failure of the licensed nurses to recognize Resident 1's change in condition, notified the physician, and transfer the resident to a higher level of care at an acute care hospital resulted in the resident's death. Findings: A review of Resident 1's admission record indicated Resident 1 was re-admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. characterized by irregular and often faster heartbeat). A review of Resident 1's Minimum Data Set (MDS- an assessment and care planning tool) dated 10/2/19, indicated Resident 1 could not speak, required full staff performance with bed mobility, dressing, and toilet use. The MDS also documented the resident had an indwelling catheter. A review of Resident 1's care plan, dated 9/25/18, for being at risk for urinary for infection related to Foley (indwelling) catheter secondary to a [MEDICAL CONDITION] (lack of bladder control due to a brain, spinal cord or nerve problem) bladder indicated interventions that included assess for fever, change of level of consciousness, reviewing lab results and notify physician of abnormal findings. A review of Resident 1's physician order [REDACTED]. Check catheter output every shift, check for cloudiness, blood mucus shreds (thin mucus secretions that may appear in the urine), and sediment (gritty particles, mucus, white or red cells that can be detected in a urine). A review of Resident 1's interdisciplinary progress notes (IDT-professionals from different disciplines (nursing, dietary, therapies, etc.) who worked together to manage the resident's needs), dated 2/10/20 at 1 a.m., indicated Resident 1 had facial grimacing and appeared in pain. The licensed nurse gave the resident [MED] (a medication to treat pain or fever) 325 milligrams (mgs-a unit of measure) two tablets. A review of Resident 1's IDT progress note dated 2/10/20 at 4:30 a.m., indicated Resident 1 was [CONDITION] (sweating), blood sugar was 205 mg/dl (normal 60 - 120), heart rate fluctuating from 69 to 80 beats a minute to 128 to 134 beats a minute, then back to 88 to 90 beats a minute., temperature 99.9) (normal 98.6) , blood pressure 133/79. The licensed nurse notified the physician at 4:35 a.m. but did not document that she informed the physician about the 1800 cc urinary output and blood tinged urine. A review of Resident 1's Situation, Background, Assessment, and Recommendation (SBAR-provides a framework for communication between members of the health care team about a patient's condition) Communication form dated 2/10/20 at 4:53 a.m., indicated Resident 1 heart rate was 104 to 134 (normal 60 - 100), increased respiration (rate not indicated) and facial grimacing. Resident 1's primary physician ordered a complete blood count (CBC - a blood test used to evaluate your overall health and detect a wide range of disorders, including [MEDICAL CONDITION], infection) and a basic metabolic panel (BMP- used to check the status of the kidneys (remove waste products from the blood and produces urine) stat (immediately). A review of Resident 1's IDT Progress Notes dated 2/10/20 during the 11:30 a.m. indicated Resident 1 had an elevated temperature of 102.7 (normal 98.6), low blood pressure of 91/41 (normal 120/80), increased respiration rate of 33 breaths per minute (normal range 12 -16 per minute) and elevated pulse rate of 134 beats per minute (normal 80 - 100). The licensed nurse notified the physician at 11:35 a.m. about the above vital signs (temperature, pulse, and respirations) and received an order to get a stat (immediate) chest X-ray. A review of Resident 1's SBAR dated 2/10/2020 at 11:30 a.m. indicated Resident 1's [MED]gen saturation level (the amount of [MED]gen in the blood-normal reading is between 95 and 100 percent) decreased to 91% and he had a low grade fever of 100.5, a low B/P 90/34, and an elevated pulse rate 101. A review of Resident 1's License Nurses Progress Notes dated 2/10/20 at 12:45 p.m. included an entry timed at 12:32 p.m. indicating desaturation (low [MED]gen levels) of Resident 1's [MED]gen level to 88 %, a decrease in blood pressure to 58/35, a detectable pulse at 98 beats per minute. The licensed nurse called the respiratory therapist who started manual ventilation with an ambu bag (a hand-held device commonly used to provide ventilation to patients who are not breathing or not breathing adequately). Paramedics (911) called and arrived at 12:43 p.m. A review of a paramedic run disposition sheet dated 2/10/202 at 12:53 p.m., indicated, Resident 1 appeared to be dead upon (paramedics) arrival. Resident had lividity, asystole (no heart activity) on monitor, rigor (stiff) and mottling (the skin presents as a red or purple marbled appearance). Resident was blue and mottled from top of head down all limbs. Resident had lividity on back and was cold to touch, feet and jaw stiff. Resident showing asystole on multiple leads, however blood pressure (BP) registered 61/42. Resident unconscious, unresponsive, apneic (without respirations) and pulseless. Facility staff member stated the resident was last well at approximately 7 a.m. (2/10/20). Determination of death at 2/20/20 at 12:53 p.m. Local police department on scene. During an interview on 2/12/20 at 12:45 p.m., Licensed Vocational Nurse (LVN) 1 stated, Stat means immediately. Resident 1 had an unstable heart rate and we should have requested an EKG along with a transfer to the general acute care hospital for evaluation. During a telephone interview on 2/25/20 at 9:30 a.m. the primary care physician stated he wanted the lab results before diagnosing the elevated heart rate and was willing to wait 4 hours for the results. The primary physician further stated he would have ordered an EKG, but it depended on the resident's condition. During an interview on 2/25/2020 at 2:22 p.m., a Sub-Acute Registered Nurse Director (RN) 1 stated she received report on Resident 1's indwelling catheter and [MEDICAL CONDITION] of 1800 cc output, which is a lot. RN 1 stated, There's a problem that may cause [MEDICAL CONDITION] and we may need to clamp catheter off. RN 1 further stated, The nurse should have clamped the catheter and report the output to the physician . During a telephone interview on 4/8/2020 at 11:20 a.m., the primary physician stated he was not aware of the resident's 1800 cc urine output or the low blood pressure, because he would have sent Resident 1 to the acute care hospital. During a telephone interview on [DATE] at 9:41 a.m., the Registered Nurse Supervisor (RN) 2 stated she was the RN supervisor on duty and called the resident's primary physician and made him aware of the elevated heart rate, and clogged indwelling catheter that drained blood-tinged urine on 2/10/20 at 4:35 a.m. RN 2 stated she received orders for a CBC and BMP and made it stat. RN 2 verbalized that she could not recall if she made the physician aware of the 1800 cc urinary output. RN 2 stated she should have clamped the catheter to prevent Resident 1 from going into shock. When asked why the physician was not notified of the clogged catheter when she called at 1:00 a.m. RN 2 stated Resident 1 had a stable heart rate, but when the resident's heart rate elevated she called the physician and made him aware of the elevated heart rate and blood-tinged urine. RN 2 further stated she did not document contacting the physician on the SBAR because Resident 1 had blood tinged urine in the past. The facility policy titled, Change of Condition, dated 11/30/2018 indicated any sudden change in a resident's condition, manifested by a marked change in physical or mental behavior, will be communicated to the physician as soon as identified. Licensed staff will use the Advanced SBAR Change of Condition Documentation /COC (change of condition)/form to evaluate the situation, identify the problem, gather information on applicable systems and report key items to the physician. The facility policy titled, Foley Catheter Care, dated 11/28/2018, indicated to check the resident

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

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F 0580 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) frequently to be sure he or she is not lying on the catheter and to keep the catheter and tubing free of kinks. Unless specifically ordered, do not apply a clamp to the catheter. The urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder. Report any complaints the resident may have of burning, tenderness, or pain in the urethral area. Observe for other signs and symptoms of urinary tract infection or [MEDICAL CONDITION]. Report findings to the physician or supervisor immediately.