STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055918	A. BUILDING _____ B. WING _____	07/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BEL TOOREN VILLA CONVALESCENT	16910 WOODRUFF AVE. BELLFLOWER, CA 90706

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 0626 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow its policy and procedure to ensure two of two sampled residents (Residents 1 and 2) who were placed on a 7-day bedhold (the number of days bed is guaranteed for a resident when transferred out of the facility) were readmitted to the facility after being sent to the hospital for evaluation. Resident 1 was sent to a general acute care hospital (GACH) for an evaluation of a change of condition and returned within two hours and Resident 2 was sent to the GACH for altered mental status (abnormal state of alertness or awareness), and [MEDICAL CONDITION] (low blood pressure). These failures of not readmitting both Residents 1 and 2 within their 7-day bed hold, violated the resident's rights, had the potential to affect the physical and psychosocial well-being of the residents and resulted in the residents being displaced. Resident 1 was held at the GACH for 27 days while waiting for placement. Finding: a. A review of Resident 1's Admission face sheet indicated Resident 1 was admitted to the facility on [DATE]. Resident 1's [DIAGNOSES REDACTED]. A review of Resident 1's Minimum Data Set (MDS), an assessment and care screening tool, dated May 6, 2020, indicated under Section A (identification information for Resident 1) on the Entry/discharged reporting, discharge assessment-return anticipated. Under Section C (thinking and reasoning capacity) Resident 2 was severely impaired. The MDS indicated Resident 1 required a one to two-person physical assist with dressing, toilet use and personal hygiene activities. A review of Resident 1's physician telephone orders, dated May 6, 2020 and timed at 3:45 PM indicated for Resident 1 to have a bed hold for seven (7) days. There was no physician's order for transfer to the hospital. A review of Resident 1's Transfer to Hospital Summary, dated May 6, 2020 at 4:37 PM, indicated Resident 1 was transported to the hospital via ambulance with altered mental status, agitated (feeling or appearing troubled or nervous), and anxious (excessive worry or unease). On May 19, 2020 at 12:58 PM, during an interview, the GACH's Social Worker (SW 1) confirmed that Resident 1 was sent back to the facility a few hours after admission on May 6, 2020, after testing negative for COVID-19 and experiencing a cough. SW 1 stated the GACH deemed Resident 1 did not need hospitalization and Resident 1 was not accepted back to the facility on [DATE]. On May 19, 2020 at 4:04 PM, during an interview, the Administrator stated the reasons for not readmitting Resident 1 on May 6, 2020 was due to the outbreak of COVID-19 (a serious communicable disease caused by a coronavirus) in the facility, and that staff were getting sick from COVID-19. The Administrator stated the current census was 51 residents, and the facility can accommodate 98 residents. The Administrator stated there were 43 residents with COVID-19 and only eight residents who were negative for COVID-19. On June 23, 2020 at 2:31 PM, during an interview, the Director of Nurses (DON) said two days prior to the discharge of Resident 1 on May 6, 2020 to the GACH, the plan was to transfer the resident to another facility for an appropriate placement. The DON stated Resident 1 had become an elopement (leaving the facility without approval) and wandering risk (traveling aimlessly from place to place). The DON stated Resident 1 would wander in and out of other residents' rooms, which put the resident at risk for contracting COVID-19. The DON stated Resident 1 was transferred to the GACH due to change in condition on May 6, 2020. The DON stated Resident 1 was a long-term care resident (a resident who does not have an end of stay date in the facility). The DON stated he found out that nothing had been done regarding Resident 1's move to a more appropriate placement, or even a 30-day notice (letter issued for possible transfer of the resident to another facility) given to Resident 1. The DON stated on May 25, 2020, he made a call to the GACH's case manager, where Resident 1 had been transferred to and made arrangements with the case manager for Resident 1 to be transferred back to the facility. The DON stated the Administrator refused Resident 1's readmission to the facility. The DON also stated he was informed by the Public Health Nurse (PHN) the facility could readmit transferred out residents, but not to admit new residents during the Covid-19 outbreak. On June 26, 2020 at 11:54 AM, during an interview, the facility's Marketer stated Resident 1 was discharged on the afternoon of May 6, 2020 and was expected to return to the facility. The Marketer stated later, the same day Resident 1 was sent to the GACH (May 6, 2020), the hospital discharged Resident 1 back to the facility. The Marketer stated there was no bed available for Resident 1 during that time. On June 29, 2020 at 10:24 AM, during an interview, Registered Nurse Supervisor (RNS 1) stated she was the nurse who discharged Resident 1 to the GACH on May 6, 2020. RNS 1 stated Resident 1 was on 7-day bedhold and was was expected to return to the facility. b. A review of Resident 2's Admission face sheet indicated Resident 2 was admitted to the facility on [DATE]. Resident 2's [DIAGNOSES REDACTED]. A review of Resident 2's MDS (indicated under Section A (identification information for Resident 2) indicated on the Entry/discharged reporting, discharged assessment-return anticipated. A review of Resident 2's physician orders, dated May 17, 2020, indicated May transfer to (name of the hospital) via 911 (emergency services) d/t (due to) altered mental status (abnormal state of alertness) and [MEDICAL CONDITION] (low blood pressure). Bed hold for 7 days on May 17, 2020. On May 19, 2020 at 4:04 PM, during an interview, the Administrator stated the reason Resident 2 was not readmitted on [DATE] was due to the outbreak of COVID-19 in the facility, and staff were getting sick from the COVID-19. On June 23, 2020 at 2:31 PM, during an interview, the DON stated he did not know why Resident 2 was not readmitted to the facility on [DATE]. The DON stated the facility would usually readmit long-term residents like Resident 2. During an observation of the facility's zoning areas, on June 26, 2020 at 3:15 PM, with the DON, rooms 16 to 20 were kept as yellow zone of isolation (rooms for resident without fever, coughing, fatigue or body ache, who were exposed to COVID-19, and for residents who go out of the facility for [MEDICAL TREATMENT]). Rooms 42 to 49 were kept as the red zone (for residents who were tested positive for COVID-19, and are manifesting symptoms). On June 26, 2020 at 10:35 AM, during an interview, Licensed Vocational Nurse 1 (LVN 1) stated she sent Resident 2 out to the GACH on May 17, 2020 at 2 AM via paramedics due to altered mental status, and not responding to verbal cues. According to LVN 1, Resident 2 was a long term care resident, and was expected to return to the facility. Per LVN 1, Resident 2 was on bedhold for 7 days. LVN 1 stated Resident 2 had returned to the facility but could not exactly remember when Resident 2 came back. On June 26, 2020 at 11:54 AM, during an interview, the facility's Marketer stated she spoke with the GACH's Case Manager regarding the return of Resident 2 to the facility on [DATE]. The Marketer stated she had informed the DON, Assistant Director of Nursing (ADON), and the Administrator about the possible return of Resident 2. The Marketer further mentioned that she had instructed the GACH's Case Manager to contact the facility for the return of Resident 2. On June 26, 2020 at 12:34 PM, during an interview, the Infection Preventonist Nurse (IPN) stated she spoke with the Marketer about the possible return of Resident 1. The IPN stated she was informed that there were no beds for Resident 2 in the quarantine (yellow zone) area of the facility. On July 7, 2020 at 3 PM, during an interview with the DON and IPN, the IPN stated the facility was getting verbal guidance from the PHN not to admit or readmit residents. The DON stated, they received a written guidance from the PHN also but failed to read through the entire guidance. The DON also mentioned the first case of outbreak of COVID-19 was on April 13, 2020. The DON also added the facility failed to ask for guidance from the admitting medical doctor for the return of Resident 2 on May 17, 2020 (37 days after the COVID outbreak in the

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 0626 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) facility). A review of the facility's policy and procedure, dated May 18, 2020 and titled, Bedhold/Reservation of Room, indicated a facility must establish and follow written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave.