STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056192	A. BUILDING _____ B. WING _____	04/03/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HARBOR POST ACUTE CARE CENTER	21521 S. VERMONT AVENUE TORRANCE, CA 90502

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 0558 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Reasonably accommodate the needs and preferences of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure Residents' care needs were accommodated when the facility's call light system was inoperable. This deficient practice resulted in the needs of seven out of seven sampled residents (Resident B, C, D, E, F, G and H) needs not being met in a timely manner and had the potential to affect the needs of all other residents who were in the facility and receiving care. Findings: On 2/6/2020, at 7:45 a.m., during an interview, Registered Nurse Supervisor 1 (RN 1) stated call lights in the facility had not been working for approximately two weeks. On 2/6/2020, at 8:05 a.m., during a tour of the facility the following was observed: 1. While standing in the hallway the sounds of several bells were heard ringing, however there was no visual indication of which rooms the sounds were coming from and/or which residents required assistant. Several staff were observed in the hallway trying to determine which room to enter. 2. The bell was rung in the following rooms and no one in the facility responded: Rooms 106, 115, 116, 117, 117, 118, 202, 204, 204, 206, 206, 210, 212, 218, 218, 216, 220, 224 . 3. The call bell was pushed in room [ROOM NUMBER] B, a certified nursing assistant (CNA) came in the room, looked around and left without checking to see which resident needed assistant. On 2/6/2020, at 8:05 a.m., during an interview Resident B stated when Resident C pushed her call bell she (Resident B) has to push her call bell as well to make more sound so the staff could hear the bell. Resident B stated some of the staff were really helpful with checking on them, with others, it was hit or miss and it could take up to an hour at times to get assistance. On 2/6/2020, at 8:08 a.m., during an interview, Resident C stated she has been at the facility for approximately two weeks and the call light has not worked since then. Resident C stated it took up to 1 and a 1/2 hours to get help and sometimes had to use her cell phone to call the front desk then they send someone to help. On 2/6/2020, at 8:28 a.m., during an interview, Resident D stated the staff did not always hear the call bells, and it depended on who was assigned and what they were doing. Resident D stated she was not sure how long it took for staff to respond but it could take a while. On 2/6/2020, at 8:36 a.m., during an interview, Resident E stated the call lights have not been working for about two weeks. Resident E stated she did not use the call bells but usually walked to the doorway until someone saw her. Resident E stated she would prefer to use the call lights. On 2/6/2020, at 8:45 a.m., during an interview, Resident F's Responsible Party (RP 1) stated Resident F was just admitted during the night (2/5/2020). RP 1 stated they were told the call lights did not work and was given a call bell to use, however, when she pressed the call bell no one could hear it over the television and other noises in the facility so no one responded. On 2/6/2020, at 8:47 a.m., the Surveyor was in room [ROOM NUMBER] and pressed the call bell two times. A nurse was observed standing near room [ROOM NUMBER], which was in close proximity to room [ROOM NUMBER], however, no staff responded to the call bell. On 2/6/2020, at 8:55 a.m., during an interview, Certified Nursing Assistant 3 (CNA 3) stated that he was able to hear the call bells while in the hallway but stated it was difficult to determine where the sound of the call bell was coming from. On 2/6/2020, at 9:12 a.m., Resident G was observed lying in bed vomiting (throwing up) fluid and food in a trash can that was next to his bed. Resident G stated he was not doing well, he was nauseated and could not keep his food down. A call bell was observed on the resident's over bed table, however the over bed table was away from the resident, out of his reach. The Surveyor pushed the call bell and CNA 4 came to the room, took the resident's food tray, did not ask him if he needed anything or notice him throwing up, and then left the room. The Surveyor pushed the call bell again, CNA 4 entered the resident's room and asked the resident if he was in pain. Resident G responded not doing well. CNA 4 asked Resident G if he needed pain medication then left the room without waiting for a response from the resident. A few minutes later Licensed Vocational Nurse 1 (LVN 1) entered Resident G's room, asked him if he wanted a pain pill (never asking if he had pain, where his pain was or how bad it was), then asked him if he needed a breathing treatment. LVN 1 left the room and came back with a [MED] for pain. On 2/6/2020, at 9:30 a.m., during an interview, Resident H stated staff usually can not hear the call bell. On 2/6/2020, at 9:35 a.m., the Surveyor pushed the call bell in room [ROOM NUMBER], no one responded, however staff could be seen outside the room. On 2/6/2020, at 9:40 a.m., during an interview, CNA 5 stated he was in/near room [ROOM NUMBER] and he did not hear the call bell. CNA 5 stated anyone in the hallway should attend to the residents'. On 2/6/2020, at 10:10 a.m., during an interview, the Director of Nursing (DON) stated the facility's call lights had been malfunctioning; going on and off since 1/28/2020. She stated the Maintenance Supervisor was aware of the problem and was contacting outside sources for solutions. The DON stated all staff have been in-serviced by the Director of Staff Development (DSD) to check each room when they hear the call bells. She stated she was not aware of any complaints that the call bells weren't being responded to or that staff could not hear the call bells. On 2/6/2020, at 10:15 a.m., during an interview, the Director of Staff Development (DSD) stated the call lights began to malfunction on 1/28/2020, some worked and some didn't. The DSD stated she gave call bells to each of the residents who were alert enough to use them and in-serviced staff on all shifts to do frequent rounds and monitor residents who weren't able to ask for assistance. The DSD stated the call bells were audible from the hallway. On 2/2/2020, at 10:18 a.m., during an interview, the Administrator stated the call lights were malfunctioning; some of the lights on the board at the nursing station and above the residents' door's would turn on and other's would not and the board at the nursing station was not audible. The Administrator stated call bells were given to all the residents' and staff were instructed to walk the hallways and check the residents'. According to the Resident Census and Conditions of Residents form 672 the facility had a census of 116 residents who in part required the assistance of one or two staff and/or were totally dependent on staff for the following activities: Transferring: 69 required assistance, 39 dependent Toilet Use: 70 required assistance, 40 dependent Eating: 39 required assistance, 23 dependent Further review of the 672 form indicated the following: 16 residents occasionally or frequently incontinent of bladder and bowel function 11 residents on a urinary and bowel toileting program 6 residents who are bedfast all or most of the time 45 residents who ambulate with assistance or assistive devices 29 residents with contractures 3 residents with intellectual and/or developmental disability 78 residents with dementia 37 residents with behavioral healthcare needs On [DATE], at 1:50 p.m., during an interview, the Social Services Designee (SSD) stated along with call bells being located in the resident restrooms and showers residents who are independent and able to go to the restroom unassisted were instructed to alert staff when they need to go to the restroom and were given [MEDICATION NAME] to use in case of emergency. A review of the facility's policy and procedure entitled, Call Light, Use of, dated 2018, indicated the purpose is to respond promptly to resident's call for assistance and ensure the call system is in proper working order. All facility personnel must be aware of call lights at all times. For bedside call lights, a light and a sound will appear and be heard over the door of the resident's room and on the board at the nursing station. For emergency call lights in bathrooms and shower and tub rooms, a light and a continuous sound will appear over the door of the room and on the board at the nursing station. When providing care to the resident, be sure to position the call light conveniently for the resident to use. Tell the resident where the call light is and show him/.her how to use the call light. Be sure all call lights are placed within the reach of each resident, never on the floor or bedside stand.
F 0604 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure that each resident is free from the use of physical restraints, unless needed for**

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

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F 0604 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) **medical treatment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility's nursing staff failed to ensure one sampled resident (Resident A) was not barricaded in his bed by floor mats. This deficient practice resulted in Resident A's view being obstructed and an inability to get out of bed, and also had the potential for injuries. Findings: A review of Resident A's Admission Records indicated the resident was readmitted to the facility on [DATE], with [DIAGNOSES REDACTED]., anxiety disorder (extreme worry or fear), major [MEDICAL CONDITION] and [MEDICAL CONDITION] (a skin infection) of the left lower limb. A review of Resident A's Minimum Data Set (MDS) Assessment, dated 2/10/2020, indicated Resident A's cognitive skills for daily decision making were severely impaired. Resident A required extensive assistance with bed mobility, transferring, locomotion on and off the unit, dressing, eating, toilet use and bathing. He was not steady while moving from a seated to standing position, moving on and off the toilet or during surface to surface transfers. He was incontinent (involuntary voiding of urine and stool) of both bowel and bladder functions and had no history of falls. A review of Resident A's physician's orders [REDACTED]. A review of Resident A's physician's orders [REDACTED]. On 2/6/2020, at 9:06 a.m., during a tour of the facility, Resident A was observed in his room lying in bed. Resident A was noted in a fetal (the back is curved, the head is bowed, and the limbs are bent and drawn up to the torso) position at the head of his bed. His head was position near the left upper side rail and his feet were near the right upper side rail. Four large floor mats were observed folded and surrounding the resident's bed, two on each side. The resident was approached by the Surveyor and asked, how he was doing, the resident responded by mumbling something unintelligible. On 2/6/2020, at 9:08 a.m., during an interview, Certified Nursing Assistant 1 (CNA 1) stated Resident A had a behavior of trying to get out of bed unassisted and even tried to climb over to the resident in Bed B. CNA 1 stated they put the floor mats around his bed to keep him from getting up and falling. On 2/18/2020, at 8:05 a.m., Resident A was observed in his room lying in bed. Resident A was noted in a fetal (the back is curved, the head is bowed, and the limbs are bent and drawn up to the torso) position at the head of his bed. Resident A's head was positioned near the left upper side rail and his feet were near the right upper side rail. Four large floor mats were observed folded and surrounding Resident A's bed, two on each side. On 2/18/2020, at 8:10 a.m., during an interview, CNAs 1 and 3 stated Resident A was blind and had a behavior of trying to get up from bed unassisted. CNAs 1 and 3 stated the floor mats were to keep him from getting up and falling. On 2/18/2020, at 10:50 a.m., during a telephone interview, the Director of Nursing (DON) stated when she did her rounds at approximately 9:30 a.m., Resident A was not in bed but she did observe two landing pads near his bed. The DON stated she inquired with Registered Nurse Coordinator (RN 1) who told her the mats were folded against the resident's bed until the floor could be cleaned. The DON stated she also makes rounds at approximately 7 p.m., before she leaves the facility, and had not observed landing pads being used as restraints. The DON stated the landing pads are even with the resident's mattress and should be placed on the floor so that if gets out of bed he will land on the pads. A review of Resident A's clinical records indicated no assessment for restraints and no order for restraints. A review of the facility's policy and procedure, entitled Restraint Devises, Physical, dated 2018, indicated restraints will not be used as punishment or as a substitute for more effective medical and nursing care or for the convenience of the facility staff. The policy indicated physical restraints are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body. Physical restraints are used only as a last resort when alternatives have failed. Restraints are applied only with a physician's orders [REDACTED].
F 0919 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Make sure that a working call system is available in each resident's bathroom and bathing area.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an operable resident call system for 116 in-house residents. The facility's call system had been inoperable for 10 days (Cross referenced to F558). This deficient practice resulted in the needs of nine of nine residents (Residents A, B, C, D, E, F, G, H and I) not being met in a timely manner and had the potential to affect the needs of all residents who were in the facility whose call lights were inoperable and required assistance with care . A review of a Center for Medicare/Medicaid Services (CMS) Resident Census and Conditions form 672 indicated the facility had a census of 116 residents who in part required the assistance of one or two staff and/or were totally dependent on staff for the following activities: Residents who required assistance with transferring: 69 Residents who required assistance with toilet Use: 70 Residents who required assistance with eating: 39 Residents who were incontinent (inability to control) of bladder and bowel function: 16 Residents on a toileting program: 11 Residents who are bedfast all or most of the time: 6 Residents who ambulate with assistance or assistive devices: 45 Residents with contractures: 29 Residents with intellectual and/or developmental disability: 3 Residents with dementia: 78 Residents with behavioral healthcare needs: 37 Findings: On 2/6/2020 at 7:45 a.m., during an interview, Registered Nurse Supervisor 1 (RN 1) stated call lights in the facility had not been working for approximately two weeks. On 2/6/2020 at 8:05 a.m., during a tour of the facility, while standing in the hallway, several bells were heard ringing, however there was no visual indication of which rooms the sounds were coming from and/or which residents required assistance. Several staff were observed in the hallway trying to determine which room to enter. On 2/2/2020 at 8:10 a.m., the tabletop bell was rung several times in the following rooms and no staff responded: Rooms 106, 115, 116, 117, 117, 118, 202, 204, 204, 206, 206, 210, 212, 218, 218, 216, 220, 224. On 2/6/2020 at 9:06 a.m., a Resident I stated he had just retrieved his call bell from the floor near the head of his bed. The resident stated the bell had been missing since the day prior and he had just found it. On 2/6/2020 at 8:05 a.m., during a tour of the facility and concurrent interview, Resident B stated when Resident C pushes her call bell she (Resident B) has to push her call bell as well to increase the sound so staff can hear the bell. Resident B stated some staff are really helpful with checking on us but stated, It's hit or miss and it can take up to an hour at times to get assistance. On 2/6/2020 at 8:08 a.m., during an interview, Resident C stated she has been in the facility for approximately two weeks and the call light had not worked since her admission. Resident C stated it takes up to 1 1/2 hours to get help and sometimes she has to use her cell phone to call the front desk before they send someone to help her. On 2/6/2020 at 8:28 a.m., during an interview, Resident D stated it depends on who was assigned and what they were doing. Resident D stated the staff does not always hear the call bells. Resident D stated she was not sure how long it takes for staff to respond, but stated it can take a while sometimes. On 2/6/2020 at 8:36 a.m., during an interview, Resident E stated the call lights have not been working for about two weeks. Resident E stated she does not use the call bells because she usually walks to the doorway until someone sees her and then ask for assistance. Resident E stated she would prefer to use the call lights. On 2/6/2020 at 8:45 a.m., during an interview, Resident F's Responsible Party (RP) stated Resident F was just admitted to the facility during the night (2/5/2020). The RP stated they were told the call lights did not work and was given a tabletop call bell to use. However, the RP stated, when she pressed the call bell no one could hear it over the television and other noises in the facility, so no one responded. On 2/6/2020 at 8:47 a.m., while in room [ROOM NUMBER], the call bell was pressed two times. A nurse was observed standing near room [ROOM NUMBER], which was near room [ROOM NUMBER]. The staff did not respond to the call bell, activated by the Surveyor. On 2/6/2020 at 8:55 a.m., during an interview, Certified Nursing Assistant 3 (CNA 3) was asked if the call bell was audible, CNA 3 stated he was able to hear the call bells while in the hallway, but he stated it was difficult to determine where the sound of the call bell was coming from. On 2/6/2020 at 9:12 a.m., Resident G was observed lying in bed vomiting (eject matter from the stomach through the mouth) fluid and food in a trash can next to his bed. Resident G stated he was not doing well because he was nauseated and could not keep his food down. A call bell was observed on the resident's over bed table, however the over bed table was out of Resident G's reach. The call bell was activated by the Surveyor and CNA 4 came to the room, took the resident's food tray but did not ask him if he needed anything or notice he was actively vomiting. CNA 4 then left the room. The Surveyor activated the call bell again, CNA 4 reentered Resident G's room and asked the resident if he was in pain. Resident G responded, not doing well. CNA 4 asked Resident G if he needed pain medication then left the room without waiting for a response from Resident G. A few minutes later, Licensed Vocational Nurse 1 (LVN 1) entered Resident G's room, asked him if he wanted a pain pill never asking Resident G if he had pain, where the pain was or

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F 0919 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 2) level of pain. LVN 1 asked Resident G if he needed a breathing treatment left the room and came back with a [MED] for pain. On 2/6/2020 at 9:30 a.m., during an interview, Resident H stated the staff usually cannot hear the call bells. On 2/6/2020 at 9:35 a.m., the call bell was activated by the Surveyor in room [ROOM NUMBER] but no staff responded. The staff could be seen outside the door and in close proximity to room [ROOM NUMBER]. On 2/6/2020 at 9:40 a.m., during an interview, CNA 5 stated he was in/near room [ROOM NUMBER] and he did not hear the call bell. CNA 5 stated anyone in the hallway should attend to the residents'. On 2/6/2020 at 10:10 a.m., during an interview, the Director of Nursing (DON) stated the facility's call lights had been malfunctioning; going on and off since 1/28/2020. The DON stated the Maintenance Supervisor (MS) was aware of the problem and was contacting outside sources for solutions. The DON stated all staff have been in-serviced by the Director of Staff Development (DSD) to check each room when they hear the call bells . The DON stated she was not aware of any complaints about the call bells not being responded to or that the staff could not hear the call bells. On 2/6/2020 at 10:15 a.m., during an interview, the Director of Staff Development (DSD) stated the call lights began to malfunction on 1/28/2020, some of the call lights worked and some did not. The DSD stated she gave tabletop call bells to each of the residents who were alert enough to use them and in-serviced staff on all shifts to do frequent rounds and monitor residents who were not able to ask for assistance. The DSD stated the call bells were audible from the hallway. On 2/6/2020 at 10:18 a.m., during an interview, the Administrator (ADM) stated the call lights have been malfunctioning where some of the lights on the board at the nursing station and above the residents' doors would turn on and the others would not. The ADM stated the board at the nursing station was not audible. The ADM was informed of the tabletop call bells they were using could not be heard well and he added extra staff to monitor the halls to ensure the tabletop call bells were heard and residents' needs were met. On 2/6/2020 at 10:26 a.m., during an interview, the Maintenance Supervisor (MS) stated he called local companies who told him they would not be able to repair the call lights because it was an old system. The MS stated they called the call light manufacturer, who wanted him to send the hard drive to them so they could update it send it back. On 2/6/2020 at 12:30 p.m., during an interview, the ADM stated alert residents' who could independently use the restroom were instructed to ask the nursing staff to accompany them when they needed to go to the restroom. The ADM stated the nursing staff were instructed to stand by the door until the residents' were done, since the emergency call lights did not work. On [DATE] at 1:50 p.m., during an interview, the Social Services Designee (SSD) stated call bells were placed in the resident's restrooms and showers. The SSD stated residents who were independent and able to go to the restroom unassisted were instructed to alert staff when they needed to go to the restroom and were given [MEDICATION NAME] to use in case of an emergency. A review of the facility's policy and procedure (P/P), dated for the year of 2018 and titled, Call Light, Use of, indicated the purpose is to respond promptly to resident's call for assistance and ensure the call system is in proper working order. All facility personnel must be aware of call lights at all times. The P/P indicated the bedside call lights, a light and a sound will appear and be heard over the door of the resident's room and on the board at the nursing station. The emergency call lights in bathrooms and shower and tub rooms, a light and a continuous sound will appear over the door of the room and on the board at the nursing station. The P/P indicated when providing care to the resident be sure to position the call light conveniently for the resident to use, tell the resident where the call light is and show him/her how to use the call light. Be sure all call lights are placed within the reach of each resident, never on the floor or bedside stand.