STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555086	A. BUILDING _____ B. WING _____	03/08/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
KINGSLEY MANOR CARE CENTER	1055 N KINGSLEY DR LOS ANGELES, CA 90029

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F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure an integrated plan of care was developed in collaboration with the facility staff and the hospice (a type of health care that focuses on emotional and spiritual needs at the end of life) agency's staff for two of 15 sampled residents (Resident 17 and Resident 22). This deficient practice had the potential to prevent the residents from receiving qualified care from the facility and the hospice agency. Findings: A. A review of Resident 22's Admission Record indicated the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 22's physician's orders [REDACTED]. During a record review of Resident 22's medical records, no documented evidence was noted indicating that the resident's care plans were integrated by the facility nursing staff and the hospice agency staff together. During a concurrent interview and record review on 3/7/20 at 2:45 p.m. with Registered Nurse 1 (RN 1), RN 1 stated she was not able to provide the documented evidence that the facility nursing staff, and the hospice agency staff had coordinated developing the plan of care together. B. A review of Resident 17's Admission Record indicated the resident was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of Resident 17's Minimum Data Set (MDS- an assessment and care planning tool) dated 1/7/20, indicated Resident 17 was severely cognitively (thinking process) impaired and required extensive assistance with all her activities of daily living. A review of Resident 17's Hospice Certification of Terminal Illness indicated that Resident 17 was placed on hospice starting 12/31/17. During a review of Resident 17's medical records, no documented evidence was noted indicating that the resident's care plans were integrated by the facility nursing staff and the hospice agency staff together. During a concurrent record review and interview with the Director of Nurses (DON) on 3/8/20 at 9:14 a.m., DON stated she was not aware the hospice agency and the facility staff were to collaborate in the coordination of the plan of care for hospice residents. A review of the contract between the facility and the hospice agency dated 8/21/13, indicated on an on-going basis, the staff shall assist each other in meeting patient care goals for the comfort of the patient and the family.
F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a resident's urinary indwelling catheter (inserted tube that drains urine from your bladder into a bag outside your body) was secured for two of 15 sample residents (Resident 35, 192). This deficient practice placed the residents at risk to have potential dislodgement of the catheter that may result in trauma to the urethra (duct that transport urine from the bladder to the exterior of the body). Findings: A. A review of Resident 192's Admission Record indicated the resident was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. the bladder in male) gland). A review of Resident 192's physician's orders [REDACTED]. When Licensed Vocational Nurse 1 (LVN 1) checked the resident's catheter, the catheter was observed not secured to prevent the potential dislodgement of the catheter which can cause trauma to the urethra and pain from a pulling traction. During a concurrent interview with the LVN 1, LVN 1 stated the indwelling catheter should have been secured. B. A review of Resident 35's Admission Record indicated the resident was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of Resident 35's physician's orders [REDACTED]. During an observation on 3/8/20 at 9:40 a.m., Resident 35 was observed lying in his bed with an indwelling catheter in place. When Licensed Vocational Nurse 3 (LVN 3) checked the resident's indwelling catheter, the catheter was observed not secured to prevent the potential dislodgement of the catheter which can cause trauma to the urethra and pain from a pulling traction. During a concurrent interview with the LVN 3, LVN 3 stated the indwelling catheter should have been secured. A review of the facility's policy titled Catheter care, indwelling urinary Catheters revised on 8/2019, indicated to secure the catheter with tape or a stabilizer to the resident's leg and/or body unless contraindicated to prevent movement and urethral traction.
F 0700 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide bed side rails to one of fifteen residents (Resident 13) who needed the bed side rails for mobility. This deficient practice failed to meet the needs of the resident. Findings: During a review of Resident 13's medical record on 3/7/2020 at 3:30 p.m., indicated he was originally admitted to the facility on [DATE], ad re-admitted on [DATE], with [DIAGNOSES REDACTED]. During the resident group meeting on 3/7/20 at 2:33 p.m., Resident 13 stated the facility took his side rails off of his bed and he needs them to help him get in/out of bed. Resident 13 stated it helps with positioning while lying in his bed. During a review of Resident 13's Informed Consent Verification Form for Psychotherapeutic Medications and Restraint Use dated 5/16/17, the form indicated to use upper side rails for mobility due to weakness. A review of the Front Side Rails/Assist Bar Risk assessment dated [DATE], signed by the Inter Disciplinary Team (IDT-professionals from diverse fields who work in a coordinated fashion toward a common goal for the resident) under recommendations, it indicated that a bed side rail assist bar serves an enabler to promote independence in mobility. Resident 13 has expressed a desire to have the side rails raised while in bed. Side rails assist bar indicated due to medical need for mobility. A review of Resident 13's Plan of Care-Use of Side Rails/Assist Bars with review date of 3/20 indicated the resident requires use of 1/2 bed side rails as an enabler to assist with mobility. During a concurrent record review and interview with the Director of Nurses (DON) on 3/8/20 at 9:25 a.m., DON confirmed Resident 13 had no side rails and stated she will look into ordering him side rails. A review of the facility's policy and procedure Side Rails/Assist Bar, dated 4/2017, indicates that if the nurse, resident or resident representative feels that the resident would benefit from continual use of a bed/rail/assist bar in the up position, the Director of Nursing should be notified

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

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F 0700 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) and meet with the IDT to assess the resident for use of appropriate alternatives.
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 observation, interview and record review, the facility failed to ensure an ordered medication for allergies [REDACTED]. This deficient practice resulted in the patient not receiving her daily medication per physician's orders [REDACTED]. A review of Resident 30's Minimum Data Set (MDS, a standardized assessment and care-screening tool) dated 2/1/20, indicated the resident had intact cognitive (thinking process) skills for daily decision making, and needed extensive to total assistance from the staff for the activities of daily living except in eating. A review of Resident 30's Physician order [REDACTED]. LVN 1 stated she is unable to give Resident 30 the medication because it is not available. A review of the facility's policy and procedure titled Ordering and Receiving Non-Controlled Medications dated 2007, indicates all medication orders changes or discontinuations must be communicated to the pharmacy, timely, in order to provide the correct quantities.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** Based on observation, interview and record review, the facility failed to ensure a medication cart was not left unlocked when unattended by the authorized staff. This deficient practice had the potential for loss or diversion of mediations by unauthorized persons. Findings: During an observation of a medication pass on 3/7/20 at 9:00 a.m., Licensed Vocational Nurse 2 (LVN 2) went inside a resident's room while leaving the medication cart in the hallway unlocked. LVN 2 then went inside the bathroom to wash her hands. The medication cart was out of LVN 2's vision from 9:00 a.m. to 9:05 a.m. During a concurrent interview on 3/7/20 at 9:05 a.m. with LVN 2, LVN 2 stated she should have locked the medication cart when it was out of her vision. A review of the facility's general guidelines of Medication Administration dated 9/2018 indicated the medication art should be kept closed and locked when out of sight of the medication nurse.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to store food in accordance with professional standards of food service safety. This deficient food handling practice had the potential to result in food borne illnesses for the residents. Findings: On [DATE], at 9:00 a.m., during the initial tour of the kitchen with the Lead Cook, the following were observed inside two of the three refrigerators: Refrigerator #1 1. One opened container of butter/cream with no date. Refrigerator #2 1. 15 slices of regular ham stored in a plastic container dated [DATE]; 2. Two opened one-gallon tartar sauce with no date; 3. Four quarts container of tuna salad dated [DATE]; 4. One-gallon bottle of mayonnaise opened without label. 5. Turkey slice stored in a container with label date [DATE]. 6. 128-ounce container of mild salsa sauce that was opened but without label. 7. One gallon of barbecue sauce container that was opened without a label. On [DATE], at 9:30 a.m., an interview was conducted with the Lead Cook who confirmed the above items identified were not labeled with open date nor date prepared. The Lead Cook indicated opened items in the refrigerator must be labeled with name and open date/date prepared. He also stated that foods that was stored more than three days should be discarded. On [DATE], at 11:00 a.m., during an interview with the facility's Registered Dietician and Dietary Supervisor, the Registered Dietician stated whenever the food items are opened, the staff needs to label the item with the date opened. The Dietary Supervisor indicated that it was important to label food items with open date/date prepared to make sure food has not expired and remains safe to eat to prevent food borne illnesses. He further stated that foods kept more than 3 days in the refrigerator should be removed and discarded. A review of the facility's policy and procedure titled Labeling and Dating of Foods' dated ,[DATE], indicated food delivered to facility needs to be marked with a receive date and newly opened food items will need to be closed and labeled with an open date. A review of the facility's policy California Retail Food Code dated [DATE], indicated to limit the refrigerated shelf life to no more than 14 calendar days from packaging to consumption, except the time product is maintained frozen, or the original manufacturer's swell by or use date whichever occurs first.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility staff failed to observe infection control measures with two of 15 sampled residents (Resident 2 and 192) by failing to wash their hands after providing wound care. This deficient practice placed the resident at risk for infectious disease. Findings: A. A review of Resident 2's Admission Record indicated the resident was admitted on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 2's Minimum Data Set (MDS-a standardized assessment and care screening tool), dated 12/10/19, indicated the resident had severely impaired cognition (ability to make daily decisions). The MDS indicated the resident needed extensive one person assistance for activities of daily living such as transferring from bed to wheelchair, dressing, eating, toileting, and personal hygiene. During a record review of Resident 2's physician's orders [REDACTED]. During an observation on 3/8/20, at 10:45 a.m., Resident 2 was observed lying on her left side while her right leg was elevated on a pillow. Resident 2 was noted with a Stage II (skin has broken) right heel pressure sore (wound sustained from prolong pressure over a bony prominence) with no drainage. Licensed Vocational Nurse 1 was observed washing her hands. LVN 1 donned new gloves, wiped the right heel with normal saline with wet gauze and threw soiled gauze at trash can. LVN 1 then removed her soiled gloves, donned a new pair of gloves, cleansed the wound with normal saline. LVN 1 then threw the soiled gauze in the trash and removed her soiled gloves. LVN 1 donned new gloves and applied [MEDICATION NAME] blue on the wound. LVN 1 did not wash her hands after touching and cleaning the wound. During a concurrent interview with LVN 1 on 3/8/20 at 10:50 a.m., LVN 1 stated that she had forgot to wash her hands because she was nervous. B. A review of Resident 192's Admission Record indicated the resident was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of Resident 192's Weekly Pressure Injury Record dated 3/6/20, indicated the resident had wound on the left big toe. A review of Resident 192's physician's orders [REDACTED]. On 3/7/20, at 2:10 p.m., Licensed Vocational Nurse 1 (LVN 1) was observed providing treatment to Resident 192's wound on the left big toe. LVN 1 put on a pair of clean gloves to remove a soiled/stained (brownish color) dressing from the resident's left big toe. After removing the soiled dressing, LVN 1 placed it into the disposal bag and removed her gloves. Without washing/sanitizing hands, LVN 1 went to the treatment cart, opened the drawer, and took a bottle of normal saline (solution used to clean wounds). LVN 1 opened the normal saline bottle and poured the normal saline into two water cups that contained dry 4x4 gauze. LVN 1 put a clean pair of gloves on without washing or disinfecting her hands and preceded performing treatment on the left big toe. On 3/7/20, at 2:40 p.m. during an interview with LVN 1, LVN 1 stated she should have washed her hands after she removed gloves that had touched soiled dressing. A review of the facility's policy titled Hand Hygiene Program, 8/2017 indicated to perform hand hygiene before and after glove use, before and after dressing changes.
F 0912 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	**Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms.** Based on observation, interview and record review, the facility failed to ensure that nine of 34 resident rooms (Rooms 205, 206, 208, 301, 304, 306, 307, 309, and 310) met the square footage requirement of 80 square feet (sq. ft.) per resident in

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F 0912 **Level of harm -** Potential for minimal harm **Residents Affected -** Some	(continued... from page 2) multiple resident rooms. This deficient practice had the potential to result in inadequate space to provide safe nursing care and privacy for the resident. Findings: On 3/8/20, the Administrator (Admin) submitted the application for the Room Variance Waiver for nine resident rooms. The room variance letter indicated that these rooms did not meet the 80 square feet per resident requirement per federal regulation. The room waiver request showed the following: Room # Square Number of Square Ft. Per Footage Beds Resident 205 159.5 2 79.75 206 158.5 2 79.25 208 158.5 2 79.25 301 294 4 73.50 304 225.7 3 75.23 306 158 2 79 307 158 2 79 309 159.5 2 79.25 310 158 2 79 The minimum requirement for a 2 bedroom should be at least 160 sq. ft. The minimum requirement for a 3 bedroom should be at least 240 sq. ft. The minimum requirement for a 4 bedroom should be at least 320 sq. ft. During the Resident Council Meeting on 3/7/20 at 2:30 p.m., the residents did not voice any issues or concerns regarding their room size. During the recertification survey from 3/7/20 to 3/8/20, it was observed that the residents residing in the rooms with an application for variance had sufficient amount of space to move freely inside the rooms. There is adequate room for the operation and use of wheelchairs, walkers, or canes. The room variance did not affect the care and services provided by nursing staff for the residents.