| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **555071** | A. BUILDING _____ B. WING _____ | **08/28/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **SUNNYVIEW CARE CENTER** | **2000 W WASHINGTON BL LOS ANGELES, CA 90018** |

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) |
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| F 0608<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Develop and implement policies and procedures to ensure (1) employees report any suspicion of a crime against any resident, according to timelines; (2) post the notice of employee rights; and (3) prohibit and prevent retaliation for reporting.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interview and record review, the facility's administrative staff failed to Report an allegation of physical abuse to the Department of Public (DPH) for one sampled resident (Resident A). This deficient practice resulted in the inability of the DPH to investigate the allegation of abuse in a timely manner. Findings: A review of Resident A's Admission Records indicated Resident A was initially admitted to the facility on [DATE] and last readmitted on [DATE]. Resident A's [DIAGNOSES REDACTED]. A review of Resident A's Minimum Data Set (MDS), a care and screening tool, dated 4/20/2020, indicated Resident A had independent, reasonable, consistent cognition (thought process) and exhibited verbal behavioral symptoms directed towards others. On 8/25/2020 at 4:20 p.m., during an interview and on 8/26/2020, at 12:15 p.m. during a subsequent telephone interview, the Director of Nursing (DON) stated Resident A was alert and oriented to name, place, date, and time. The DON stated Resident A had a behavior of refusing care from nurses who she (Resident A) felt had done something she did not like. The DON stated they had to rotate nurses so they would not become burned out with Resident A's behavior and accusations towards them. The DON stated when Resident A reported that a certified nursing assistant (CNA 1) hit her in the shower they considered it a grievance and not an allegation of abuse because Resident A changed her story. The DON stated Resident A did not want to report it to the police and did not want them to pursue it and still wanted CNA 1 to care for her so they did not feel they needed to report it. A review of an Interdisciplinary Team ((IDT) group of different disciplines working together towards a common goal of a resident) Conference Record, dated 11/13/19, indicated Resident A reported CNA 1 hit her while she (Resident A) was receiving a shower. Resident A stated She hit me on my back, it wasn't hard. Continued review of the IDT record indicated Resident A was given a number to the local police department to file her complaint. Resident A responded, she did not want to press any charges and CNA 1 only hits her on her shower days and she does not mind having CNA 1 except during her showers. The IDT note indicated the IDT team offered Resident A alternative options for placement. Continued review of the IDT note indicated there was no written documentation that the DPH was notified of the allegation of abuse. A review of Resident A's Concern Record (Theft/Loss and Grievance Report), dated 11/13/19, indicated Resident A stated, I don't want (CNA 1) as my nurse on my shower days because she hit me twice, last time when giving me care. A review of the facility's undated policy and procedure (P/P) titled, Abuse Allegation Investigation, indicated for suspected abuse that does not result in serious bodily injury by a resident with a [DIAGNOSES REDACTED]. |
| F 0610<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Respond appropriately to all alleged violations.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interview and record review, the facility's administrative staff failed to investigate an allegation of physical abuse for one sampled resident (Resident A). This deficient practice resulted in the inability of the facility and the Department of Public Health (DPH) to determine in a timely manner if physical abuse occurred and had the potential for abuse to continue. Findings: A review of Resident A's Admission Records indicated Resident A was initially admitted to the facility on [DATE] and last readmitted on [DATE]. Resident A's [DIAGNOSES REDACTED]. A review of Resident A's Minimum Data Set (MDS), a care and screening tool, dated 4/20/2020, indicated Resident A had independent, reasonable, consistent cognition (thought process); and exhibited verbal behavioral symptoms directed towards others. On 8/25/2020 at 4:20 p.m., during an interview and on 8/26/2020, at 12:15 p.m. during a subsequent telephone interview, the Director of Nursing (DON) stated Resident A was alert and oriented to name, place, date, and time. The DON stated Resident A had a behavior of refusing care from nurses who she (Resident A) felt had done something she did not like. The DON stated they had to rotate nurses so they would not become burned out with Resident A's behavior and accusations towards them. The DON stated when Resident A reported a certified nursing assistant (CNA 1) hit her in the shower they considered it a grievance and not an allegation of abuse. The DON stated the Administrator was out of the facility for the next week and after looking through the Administrator's files the DON stated she could not find an investigation of Resident A's grievance. A review of an Interdisciplinary Team ((IDT) a group of different disciplines working together towards a common goal for a resident) Conference Record, dated 11/13/19, indicated Resident A reported CNA 1 hit her while she (Resident A) was receiving a shower. Resident A stated, She hit me on my back, it wasn't hard. Continued review of the IDT record indicated Resident A was given a number to the local police department to file her complaint. Resident A responded, she did not want to press any charges and CNA 1 only hits her on her shower days and she does not mind having CNA 1 except during her showers. The IDT note indicated the IDT team offered Resident A alternative options for placement. Continued review of the IDT note indicated there was no written documentation that an investigation was conducted. A review of Resident A's Concern Record (Theft/Loss and Grievance Report), dated 11/13/19, Resident A stated, I don't want (CNA 1) as my nurse on my shower days because she hit me twice, last time when giving me care. A review of the facility's undated policy and procedure (P/P) titled, Abuse Allegation Investigation, indicated to ensure that a complete and thorough investigation is conducted for all allegations of abuse. The policy indicated the facility shall complete a thorough investigation of all allegations of abuse. Upon completion of the investigation all supporting documents shall be placed in a file labeled Abuse Investigation. The file shall include the name of the resident involved and the date of completion of the investigation. |
| F 0842<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.**<br><br>Based on interview and record review, the facility failed to track incidents/accidents occurring in the facility on an incident/accident log. This deficient practice resulted in the facility's inability to monitor, trend, retrieve incident/accidents as they occurred and had the potential to continue. Finding: On 8/25/2020 at 5:30 p.m., during an interview, the Director of Nursing (DON) stated she did not have an incident/accident log available for review. The DON stated they had been very busy during the COVID (a highly contagious respiratory disease) outbreak and had not had time to track the incident/accidents that occurred in the facility since at least January 2020 on a log. The DON stated she had individual forms of what had occurred in the facility but would need a moment to gather them all. On 8/26/2020 at 3:11 p.m., via an email, the facility's Monthly Incident Report Log was received. A review of the Monthly Incident Report Log indicated the following: January 2020 - Four residents listed with only one indicating what the incident/accident was |

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

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| F 0842<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | (continued... from page 1)<br>February 2020 - Five residents listed with only three indicating what the incident/accident was March 2020 - Four residents listed with only two indicating what the incident/accident was April 2020 - Nine residents listed with only only four indicating what the incident/accident was May 2020 - Eight residents listed with none indication what the incident/accident was On 8/27/2020 at 12:15 p.m., during a telephone interview, the DON stated she listed verbal altercations that happened between the residents and if the resident did not make contact with the floor it was left blank. A review of the facility's undated policy and procedure (P/P) titled, Reporting Accident/Incidents, indicated the purpose is to provide a reporting system for accidents and incidents. The policy indicated accidents and incidents shall be reported to the charge nurse and documented on the accident/incident log as soon as they occur. Incident/accident reports shall be completed as soon as possible and forwarded to the DNS (DON) for review. The DNS and the DSD shalt review reports and then forward to the facility administrator for further review. Administrator shall log incidents/accident reports. Administrator, DNS, Assistant DNS, DSD and Medical Director shall review reports monthly at CQIC meeting. The Medical Director shall sign off on all incident/accident reports monthly. |