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PC reviewed & accepted by MR - eg 3/10/17

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055167	A. BUILDING _____ B. WING _____	02/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERNON HEALTHCARE CENTER	1037 W Vernon Ave, Los Angeles, CA 90037-2415 LOS ANGELES COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	The following reflects the findings of the Department of Public Health during a Complaint Investigation visit: CLASS A CITATION -- PATIENT CARE 94-3082-0013036-F Complaint(s): CA00521106, CA00520035, CA00520035, CA00520035 Representing the Department of Public Health: Surveyor ID # 3082, HFEN The inspection was limited to the specific facility event investigated and does not represent the findings of a full inspection of the facility. 42 CFR 483.10 (g)(14)(i)(A)-(D) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment) (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).		**RESIDENT #10** 1. Notification letter in regards to Resident #10 death on 10/19/16 submitted to Department of Health Services office on 2/4/17. Investigation initiated on 2/4/17. Conclusion of investigation letter was submitted to DHS on 2/15/17. 2. Department of Health, Police Department and local ombudsman office made aware of the allegation of abuse on 2/8/17 for Resident #10 in regards to allegation of abuse by restraining resident. 3. Investigation was initiated on 2/4/17. 4. RN #1 was interviewed on 2/9/17 by Administrator. RN #1 stated that the last time when he saw the resident was around 11:00 PM. The resident was laying on her back in Bed B in room 25. 5. RN#1 was interviewed by VPO on 2/14/17. RN #1 stated that he would not tolerate holding down a resident and there was no need to hold down resident as she was cooperative". 6. C.N.A. #5 was interviewed on 2/6/17 by Administrator and stated that around 4:00 AM C.N.A. #5 went to room 25 to attend to Resident #11, C.N.A. #5 attempted to but could not rouse Resident #10. C.N.A. #5 went to the station to inform LVN #5. 7. LVN #5 was interviewed on 2/6/17 by administrator and DON. LVN #5 stated	3/8/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE ADMINISTRATOR (X6) DATE 3/10/17

By signing this document, I am acknowledging receipt of the entire citation packet. Page(s). 1 thru 21

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. Except for nursing homes, the findings 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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	42 CFR 483.12(a)(1) The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. 42 CFR 483.12(c)(1)-(4) (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and		that when LVN #5 came into the room Resident #10 was in 25B on big bed in low position. MD1 was called by LVN#5 after paramedics pronounced Resident #10 dead. 8. LVN #4 was interviewed on 2/4/17 by Administrator. LVN #4 stated that C.N.A. #5 told LVN #5 that resident #10 in 25B was unresponsive. LVN #4 went to room 25 and saw Resident 10 in low bed on Resident 10 stomachs. LVN #4 stated that she got on her knees and initiated CPR. 9. Resident #11 was interviewed on 2/5/17 by Administrator. Resident #11 stated that Resident #10 "was always crying and said to me that she didn't feel so good, Later they moved her (resident #10) and laid her on the floor on a mattress really low, They tell me she was face down, the state people". 10. In-service provided to nursing staff on 2/4/17 & 2/6/17 by Director of Nursing and/ or Designee in regards to prompt notification of Resident's change of condition to their attending physician for immediate attention & intervention. 11. In-services provided to all nursing staff on 2/9/17/, 2/10/17, 2/11/17 and 2/12/17 by Director of Nursing and/or Designee in regards to understanding Challenging behavior, Behavior management, but not limited to impaired cognitive function associated	3/8/17

OBarrera ADMINISTRATOR 3/10/17

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	if the alleged violation is verified appropriate corrective action must be taken. 42 CFR 483.12(b)(1)-(3), 483.95(c)(1)(2) (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95,483.95(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property. "Neglect" means failure to provide good and services necessary to avoid physical harm, mental anguish, or mental illness (42 CFR § 488.301). 42 CFR 483.25 Quality of Care Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care.		with Dementia, with emphasis on proper handling and approach of Resident with altered behavior symptoms, but not limited to, aggressiveness & combativeness. 12. In-service provided to all nursing staff regarding under challenging behaviors on 2/9/17/, 2/10/17, by contracted QA consultant. a. Causes for challenging behavior i. General changes in behavior ii. Alzheimer's Disease b. Procedures for assessing and responding to behavior change or challenging behavior. c. Utilizing non pharmacological intervention d. Change of condition assessment **Addendum 02/28/17:** **12. An in-service will be conducted by the DON and or designee on or before 3/8/17 on the written protocol re morbidly obese resident with emphasis on the following but not limited to:** **a. Assistance with ADLs** **b. Transfers assistance** **c. Bed size** **d. Behavior changes management**	3/8/17

OJ Barrera ADMINISTRATOR 3/10/17

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	42 CFR 483.25 (f)(1) Mental and Psychosocial functioning. Based on the comprehensive assessment of a resident, the facility must ensure that— (1) A resident who displays mental or psychosocial adjustment difficulty, receives appropriate treatment and services to correct the assessed problem. 42 CFR 483.75(l)(1) Clinical Records (1)The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. On 1/26/17 at 9:52 a.m., an unannounced visit was conducted at the facility to investigate an anonymous complaint regarding a resident, who was put on her stomach while in bed and later died. Based on observation, interview, and record review, the facility failed to provide Resident 10 with the necessary care and services to attain or maintain the highest practicable physical, mental, psychosocial well-being, in accordance with comprehensive assessment and plan of care; to		13. A written protocol will be developed by the Administrator and or designee on or before 3/8/17 on the following: a.) How to investigate allegations of any unexpected death of a resident. b.) When to initiate an investigation after completing an Incident Report. c.) The Incident Report will be reviewed by the Administrator and or DON to determine and or initiate necessary investigation but not limited to unexpected death. d.) An in-service will be conducted by the DON and or designee in collaboration with the Administrator involving licensed nurses and department managers on the above items on or before 3/8/17. **HOW TO IDENTIFY OTHER RESIDENTS** 1. Licensed staff (RN/LVN) interviewed 60 alert interview-able residents on 2/8/17 for rough handling and name calling. No other residents were identified. 2. Non-interview able residents were assessed through a Facility wide skin sweep done on 2/2/17 by licensed nurses. No other residents affected.	3/8/17

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	conduct a comprehensive assessment during a change of condition; to ensure that Resident 10 received proper treatment and care for mental health disorders; to not abuse residents; to immediately inform and consult with the resident's physician when there was a change in the resident's physical, mental or psychosocial status; to develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents; and to thoroughly investigate all alleged violations involving abuse, neglect, or mistreatment; including but not limited to, failures to: 1. Conduct an assessment during a change of condition in Resident 10's behavior manifested by agitation and screaming, and episodes of three unwitnessed falls from the bed. 2. Ensure licensed nurses and certified nursing assistants (CNAs) provided appropriate care and interventions to manage Resident 10's aggressive behavior. 3. Notify Resident 10's attending physician of the resident's change of condition in behavior and the episodes of three unwitnessed falls in order to implement appropriate care and interventions for the resident. 4. Prevent staff-to-resident neglect and mistreatment by providing training to facility staff on how to manage aggressive behaviors of a mentally ill, obese person.		3. Resident's council meeting conducted by facility's Administrator & Director of Nursing with resident council president present and four other residents on 2/2/17 with Residents in regards to allegations of mistreatment & abuse. No other Residents affected. 4. Room Rounds done by Department heads for all Resident Room done on 2/2/17, with emphasis on staff mistreatment and possible inappropriate communication. No other Residents affected. 5. An anonymous hotline was re-posted conspicuously throughout the facility in public area such as dining room and nursing station for any concerns to be reported to an external third party for residents and staff. No reports made. No other residents affected. 6. Non-interview able residents were assessed through a Facility wide skin sweep done on 2/2/17 by licensed nurses. No other residents affected. **SYSTEMIC CHANGES** 1. The facility voluntarily contracted a qualified external independent monitor who is a RN and a licensed Nursing Home to perform the following tasks but not limited to:	3/8/17

ADMINISTRATOR 3/10/17

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	5. Ensure that all alleged violations involving neglect and mistreatment are reported by the staff immediately, but not later than 2 hours after the allegation is made to the administrator of the facility, to the Department (the Licensing and Certification Program), and the adult protective services. 6. Investigate thoroughly violations of neglect and mistreatment by a registered nurse (RN 1) and three certified nursing assistants (CNA 6, 8, and 9) when they were managing the aggressive behavior of Resident 10 by holding her down while the resident was in a prone position (a body position in which one lies flat with the chest down and back up) in bed to prevent the resident from falling from the low bed. Investigate thoroughly also the violations of neglect and mistreatment by a licensed vocational nurse (LVN 5) and CNA 5, who took over the care of Resident 10 during the night shift and allowed the resident to stay in a prone position until she was found unresponsive with no pulse on 10/19/16 at 4:16 a.m. 7. Investigate thoroughly the events that led to Resident 10's death. 8. Implement its policy and procedure to protect residents from neglect and mistreatment. Resident 10, who weighed more than 435.6 pounds (lbs) and who could not change her position in bed independently, had a behavioral episode (agitation) and falling from her bed three times on 10/18/16 from 5 p.m. to 6 p.m. Four facility staff members –		a. Conduct resident interview with emphasis on feedback regarding staff receptiveness and meeting their individual needs; b. Perform random record review to determine if necessary documentation is completed based on her observation and resident interviews This external independent monitor will be in place until the facility had achieved substantial compliance. A day time customer service liaison with a background in Social Services was hired on 2/6/17. The customer service liaison essential task would include the following but not limited to: c. Interview alert and interviewable residents if staff is responding to their requests d. Inquire if their medications i.e. pain medications are administered as ordered or given based on preferences or reaction to pain medication using pain assessment scale e. Ask about receptiveness of staff based on resident needs.	3/8/17

O Ibarra ADMINISTRATOR 3/10/17

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	RN 1, CNA 6, 8, and 9 - responded to the resident's behavior by placing her in a prone position and holding her down on a low bed. RN 1 did not conduct an assessment to determine if the resident was having a change of condition. The physician was not notified of the resident's aggressive behavior and her three episodes of falls. The physician, director of nursing, and the administrator were not informed that the resident was found unresponsive with no pulse in a prone position. The facility staff did not receive appropriate training to manage a behavioral episode of a mentally ill, obese resident. The facility did not conduct an investigation that led to the suspicious death of Resident 10. A review of Resident 10's face sheet (admission record) indicated Resident 10 was a 59-year-old female, who was admitted to the facility on and was readmitted on . Resident 10's diagnoses included and); and). The resident was pronounced dead at the facility on 10/19/16 at 4:24 a.m. A review of Resident 10's document titled, "Physician Orders for Life-Sustaining Treatment (POLST)," dated 6/3/16, indicated Resident 10 was		2. All new employees will be provided with abuse in service training during orientation by DSD 3. Abuse prevention and reporting training in service will be provided at least quarterly and or as needed to all staff by facility the Administrator 4. A 3rd party company MyInnerView has been contracted to provide an anonymous questionnaire to all residents and families to report any concerns of mistreatments and compliance on a quarterly basis. All results will be sent to the administrator for review quarterly. 5. An anonymous hotline is posted conspicuously throughout the facility in public area such as dining room and nursing station for any concerns to be reported to an external third party for residents and staff. Resident council will be reminded of the hotline posting on a monthly basis. 6. The facility has implemented a weekend Manger on Duty program which will include a Department Head assigned during business hours of the weekends as a manger to ensure any and all concern are addressed. Implemented the week of 2/13/17.	3/8/17

O Guerra ADMINISTRATOR 3/10/17

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	to receive full treatment (primary goal of prolonging life by all medically effective means). A review of Resident 10's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 9/2/16, indicated Resident 10 was alert and cognitively intact for decision making; required extensive assistance (resident involved in activity, staff provide weight bearing support) requiring two person assistance for bed mobility (how resident moved to and from lying position, turned side to side, and positioned body while in bed); and was totally dependent on transfers requiring two person assistance. A review of Resident 10's general acute care hospital (GACH) records titled, "Emergency Department Note-Physician," dated 10/11/16, and timed at 9:59 a.m., indicated Resident 10 weighed 435.6 pounds and was admitted to the GACH secondary to a history of frequent falls and increasingly agitated behavior at the care facility . A review of Resident 10's Initial History and Physical, dated 10/16/16, indicated Resident 10 had fluctuating capacity to understand and make decisions. A review of Resident 10's care plan titled, "Psychotropic Medication," dated 10/15/16, indicated Resident 10 had a and . The nursing interventions included but not limited to listening to any of Resident 10's concerns and to speaking to		7. Director of Staff Development will conduct screening every six months of active employees for criminal records and medical exclusions list, such as records of abuse via CDPH Licensing & Certification Verification Screening site. All personnel noted to be on exclusion lists will be terminated effective immediately upon discovery. 8. Facility customer satisfaction surveys which will be made available in the facility's lobby & nursing stations to all clients, but not limited to, Residents and their family members to express their grievances & concerns related facility services. Facility customer satisfaction survey results will be reviewed by Administrator and Social Service Designee during daily stand-up meeting (Monday- Friday) 9. Upon invitation, Facility Administrator and/or Designee will attend Resident's council meeting weekly with Residents to discuss concerns & grievances, concerning mistreatment. Ombudsman will be invited in writing by Administrator and/or Designee to attend weekly Resident's council if invited by Resident council participants. 10. A facility wide skin sweep will be done weekly by licensed nurses with all finding brought to DON. Addendum 03/01/17:	3/8/17

OPbarrera ADMINISTRATOR 3/10/17

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	Resident 10 in a calm voice. A review of Resident 10's care plan titled, "Activities of Daily Living," dated 10/17/16, indicated that Resident 10 was dependent on staff for bed mobility and that nursing interventions were to handle Resident 10 gently and observe joint limitations. A review of Resident 10's care plan titled, "Cognition," dated 10/17/16, indicated Resident 10 had altered thought process related to periods of confusion and disorientation. The nursing interventions included but were not limited to observing the resident for changes in mental status and reporting to the physician as indicated. A review of Resident 10's record titled "Activities of Daily Living (ADL) Documentation," dated 10/17/16, indicated that Resident 10 was dependent on staff for bed mobility. A review of Resident 10's Nurses Notes, dated 10/19/16 and timed at 8:36 a.m., indicated that a licensed vocational nurse (LVN 5) received a report from a certified nursing assistant (CNA 5) at 4:16 a.m. to go the Resident 10's room because something was not right. The nursing notes indicated that upon LVN 5's assessment of Resident 10, the resident was not breathing and had no pulse. Cardiopulmonary (heart and lungs) resuscitation (CPR, a medical procedure involving repeated compression of a patient's chest, performed in an attempt to restore the blood circulation and breathing of a person who has suffered cardiac arrest) was initiated and the 911		13. An in-service will be conducted by the DON and or designee on the written protocol re morbidly obese resident with emphasis on the following but not limited to on or before 3/8/17: a. Assistance with ADLs b. Transfers assistance c. Bed size d. Behavior changes management 14. An in-service will be conducted by the DON and or designee on or before March 8, 2017 on the importance of Reporting & Conducting a thorough investigation of any allegation of abuse, neglect regardless of their diagnoses but not limited to Dementia and other Mental Illnesses. 16. Medical Director will be involved on the following: a.) Change of Condition: If primary physician is not responding within 4 hours from the time a change of condition was determined licensed nurses will contact the Medical Director.	3/8/17

@Jpanera ADMINISTRATOR 3/10/17

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	emergency services was called. The paramedics/fire department emergency responders arrived and took over the resuscitation of Resident 10. The paramedics pronounced Resident 10 dead at 4:24 a.m. (eight minutes from the time the resident was found at 4:16 a.m. as unresponsive). LVN 5 notified Resident 10's attending physician (MD 1) of the resident's death and MD 1 spoke with the police regarding signing the resident's death certificate. A review of Resident 10's records titled "Prehospital Care Report Summary Los Angeles Fire Department (LAFD)," dated 10/19/16, and timed at 4:32 a.m., indicated that Resident 10 was found by LAFD unresponsive in bed at 4:21 a.m., and no CPR was initiated due to Resident 10 was found to have "Post-Mortem Lividity," (livor-mortis, a purple coloration of lower parts of the body, except in areas of contact pressure, appearing within 30 minutes to 2 hours after death, as a result of gravitational movement of blood within the vessels), and was in asystole (the absence of any heartbeat). Resident 10 was pronounced dead at 4:24 a.m., by a member of the LAFD. The records indicated that LAFD had responded to Resident 10 twice the week prior to Resident 10's death because Resident 10 had episodes of falling out of bed. The notes indicated that Resident 10 was last spoken to 4-5 hours prior to LAFD arrival and that an unidentified staff member of the facility "never" saw Resident 10 awake or communicating. On 1/26/17 at 10:09 a.m., during an interview, CNA 4 stated Resident 10 was incontinent and two		**b.) Allegation of Neglect/Abuse: Medical Director is expected to participate on the Facility QA Meeting to discuss Quality Care related topics which would include Allegations of Abuse/Neglect, Trending of Incidents/ Changes in Condition and other relevant issues. Medical Director will offer suggestions to improve trends and resident care outcomes.** **c.) Unexpected death and significant injuries of unknown origin of a resident will be shared by the DON and or Administrator or designee for his possible input and recommendation** **17. Facility currently identified 6 residents who are morbidly obese per their respective BMI. Each resident will be reassessed on or before March 08, 2017 by a licensed nurse in collaboration with IDT to address the following but not limited to:** **A. Co-morbidities** **B. ADL functioning** **C. Assistance with transfer**	3/8/17

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VERNON HEALTHCARE CENTER	1037 W Vernon Ave, Los Angeles, CA 90037-2416 LOS ANGELES COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	persons were needed to move her while in bed. CNA 4 stated that Resident 10 liked to be facing up while lying in bed and Resident 10 did not like to be in bed on her stomach. CNA 4 stated the facility staff needed to use a lifter (machine to assist with transfers) to transfer Resident 10 from bed to a wheelchair and from the wheelchair to the bed. On 1/28/17 at 2:23 p.m., during a telephone interview, Resident 10's family member (FAM 3) stated that Resident 10 required assistance to change position in bed. On 1/28/17 at 2:35 p.m., during an interview, CNA 7 stated that Resident 10 required total assistance with bed mobility. On 2/13/17 at 1 p.m., during a telephone interview, CNA 9, stated that on 10/18/16 at approximately 5 p.m., Resident 10 was found agitated and was found on the floor mats between bed C and bed B (Resident 10 was assigned to bed C). CNA 9 stated that RN 1, CNA 6, CNA 8, and CNA 9 used a linen sheet to lift Resident 10 and transferred Resident 10 back to bed C. CNA 9 stated he did not know the reason why Resident 10 was on the floor mats. During the interview, CNA 9 stated that on 10/18/16 at approximately 5:20 p.m., Resident 10 was found agitated and was found on the floor mats a second time between bed C and bed B. CNA 9 stated that RN 1 told CNA 6, CNA 8, and CNA 9 to put Resident 10 in bed B because bed B was lower than bed C. CNA 9 stated that RN 1 stated that		**D. Appropriate size of bed and wheelchair** **E. Possible behavior changes management** **MONITORING PROCESS** 1. All negative findings from 3rd party company MyInnerView will be presented to quarterly QA committee by administrator for recommendations and resolutions. Specific benchmarks will be discussed and set and reviewed at following monthly QA committee meetings to capture effectiveness of systematic change implemented for the next 12 months 2. All negative findings from the anonymous hotline will be presented to monthly QA committee by administrator for recommendations and resolutions. Specific benchmarks will be discussed and set and reviewed at following monthly QA committee meeting to capture effectiveness of systematic change implemented for the next 12 months 3. All Negative Findings from Resident council will be presented to monthly QA committee by activities director for recommendations and resolutions. Specific benchmarks will be discussed and reviewed at monthly QA	3/8/17

O Ibarra ADMINISTRATOR 3/10/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056167	A. BUILDING _____ B. WING _____	02/08/2017

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VERNON HEALTHCARE CENTER	1037 W Vernon Ave, Los Angeles, CA 90037-2416 LOS ANGELES COUNTY

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	bed B was lower than bed C and that it would prevent Resident 10 from falling again. CNA 9 stated he did not know the reason why Resident 10 was on the floor mats. During the interview, CNA 9 stated that on 10/18/16 at approximately 5:45 p.m. or 6 p.m., Resident 10 was found on the floor mat for the third time and that Resident 10 was very agitated, CNA 9 stated that CNA 6, CNA 8, and CNA 9 used a linen sheet to transfer Resident 10 to bed B. CNA 9 stated that Resident 10 was too heavy and was very agitated and was mumbling unknown words and that CNA 6, CNA 8, and CNA 9 did not have enough strength to carry Resident 10's weight and that Resident 10 just landed flat on her stomach in bed B. CNA 9 stated that RN 1 was aware that Resident 10 was positioned flat on her stomach in bed B and that RN 1 told CNA 6, 8, and 9 to leave her flat on her stomach. On 2/3/17 at 7:40 a.m., during an interview, CNA 3 stated that Resident 10 needed two (2) or more people to assist her with bed mobility and was not able to change positions by herself in bed. On 2/3/17 at 8:17 a.m., during an interview, a physical therapist (PT) stated that Resident 10 was not able to change from a prone (face down) position to supine (face up) position on her own. PT stated Resident 10 needed the assistance of two people with bed mobility. On 2/3/17 at 1:32 p.m., during an interview, Resident 11 (Resident 10's roommate) stated that		committee meeting to capture effectiveness of systematic change implemented for the next 12 months 4. All negative findings from family council meeting will be presented to monthly QA committee by activities director for recommendations and resolutions. Specific benchmarks will be discussed and reviewed at monthly QA committee meeting to capture effectiveness of systematic change implemented for the next 12 months. 5. All negative findings from room rounds will be reviewed by administrator and/or for recommendations and resolutions. Specific benchmarks will be discussed and reviewed at monthly QA committee meeting to capture effectiveness of systematic change implemented for the next 12 months 6. All negative findings from background/screening check will be presented to monthly QA committee by DSD for recommendations and resolutions. Specific benchmarks will be discussed and reviewed at monthly QA committee meeting to capture effectiveness of systematic change implemented for the next 12 months 7. All negative findings from facility customer satisfaction will be reviewed by administrator and/or designee at daily stand up meeting for recommendations and resolutions. Specific benchmarks will be discussed	3/8/17

QBarrera ADMINISTRATOR 3/10/17

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	Resident 10 was screaming for nurses to help her on 10/18/16 before 11 p.m., and that the nurses did not respond to Resident 10's call for help. Resident 11 stated that around 11 p.m., RN 1 came in the room with four other staff members and were holding Resident 10 down against her bed. Resident 11 stated Resident 10 was agitated and was screaming, and was requesting to see a doctor. Resident 11 stated that the facility staff should have listened when Resident 10 was calling for help. On 2/8/17 at 2:27 p.m., during an interview, CNA 7 indicated Resident 11 was very alert and was an accurate reporter. A review of Resident 11's clinical record indicated Resident 11 was admitted to the facility on and was readmitted on with diagnoses of). A review of Resident 11's History and Physical, dated 1/9/17, indicated Resident 11 had the capacity to understand and make decisions. A review of Resident 11's MDS, dated 12/20/16, indicated Resident 11 was cognitively intact for daily decision making. On 2/3/17 at 1:50 p.m., during an interview, RN 1 stated that he responded to Resident 10's call for		and reviewed at monthly QA committee meeting to capture effectiveness of systematic change implemented for the next 12 months 8. All negative findings from external independent monitor will be presented to monthly QA committee by administrator for recommendations and resolutions. Specific benchmarks will be discussed and set and reviewed at following monthly QA committee meeting to capture effectiveness of systematic change implemented for the next 12 months 9. All negative findings from weekly skin sweep will be presented to monthly QA committee by DON for recommendations and resolutions. Specific benchmarks will be discussed and set and reviewed at following monthly QA committee meeting to capture effectiveness of systematic change implemented for the next 12 months.	3/8/17

OBarrera ADMINISTRATOR 3/10/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	help (on 10/18/16). RN 1 stated that he did not assess Resident 10's condition and he did not check the resident's vital signs. RN 1 stated that Resident 10 was agitated and that RN 1 and other facility staff members held her down in bed between 11:15 p.m. to 11:30 p.m. (on 10/18/16), to prevent Resident 10 from falling from the low bed. RN 1 stated that Resident 10 was placed on a regular sized standard bed and that the bed was on its lowest position to prevent the resident from falling from bed. RN 1 stated that both side rails of Resident 10 were up. RN 1 stated that there was no documentation regarding Resident 10's agitation in the clinical record and that he did not inform the resident's doctor regarding the resident's episodes of aggression. During the interview, RN 1 stated "I do not recall," receiving training on obese residents with history of behavioral issues. On 2/6/17 at 12:44 p.m., during an interview, the maintenance supervisor (MS) stated that he was not aware that Resident 10 was using a regular standard size bed on 10/18/16. The MS measured a regular standard bed and stated that the width of a regular standard bed was 34 and ¾ inches. The MS stated Resident 10 would not be able to turn by herself to a prone positon while in a regular standard size bed due to the bed's width. On 2/3/17 at 3:14 p.m., during an interview, CNA 6 stated that he assisted RN 1 on 10/18/16 around 11 p.m. and RN 1 asked CNA 6 to reposition Resident 10 back to bed. CNA 6 stated that			3/8/17

O Banen Administrator 3/10/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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VERNON HEALTHCARE CENTER	1037 W Vernon Ave, Los Angeles, CA 90037-2415 LOS ANGELES COUNTY

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	Resident 10 was agitated and was screaming. CNA 6 stated that CNA 6, RN 1, and two other facility staffs (CNA 6 could not remember the names) repositioned the resident in bed but he could not remember what position Resident 10 was placed on. During the interview with CNA 9 on 2/13/17 at 1 p.m., she stated that Resident 10 landed on her stomach [prone position] in bed B during a transfer by RN 1, CNA 6, 8, and 9 from the floor mat to the bed on 10/ 18/16 at 5:45 p.m. or 6 p.m. Resident was found unresponsive in a prone position on 10/19/16 at 4:16 a.m. On 2/3/17 at 7:19 a.m., during an interview, CNA 5 stated she found Resident 10 lying on her stomach and unresponsive on 10/19/16 around 4:16 a.m. CNA 5 stated she called LVN 4 and LVN 5 for help and they assisted her to turn Resident 10 on her back. CNA 5 stated that Resident 10's bed was on its lowest positon. On 2/3/17 at 8:35 a.m., during a telephone interview, LVN 4 stated that she found Resident 10 lying flat on her stomach (on 10/19/16) and the resident was unresponsive and was on a regular size bed. LVN 4 stated she did not feel Resident 10's pulse. LVN 4 stated she had to kneel down because Resident 10's bed was on its lowest position. LVN 4 stated that she and other facility staff members turned Resident 10 to lie on her back and to begin chest compressions. LVN 4 stated she assumed that LVN 5 notified MD 1 regarding Resident 10's lying in a prone position.			3/8/17

Q Guerrero ADMINISTRATOR 3/10/17

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	On 2/3/17 at 7:59 a.m., during a telephone interview, LVN 5 stated that she was assigned to Resident 10 on 10/19/16 during the night shift. LVN 5 stated that she called 911 and notified MD 1 that the "fire department" emergency responders (paramedics) pronounced Resident 10 deceased. On 2/3/17 at 10:42 a.m., the director of nursing (DON) stated that Resident 10's clinical record did not indicate Resident 10 had any change of condition prior to her death. The DON stated that LVN 5 notified her of Resident 10's death but LVN 5 did not mention that Resident 10 was found unresponsive in a prone position on 10/19/16 at 4:16 a.m. During a concurrent interview, the DON stated that she was not expecting the licensed nurses to write an incident report for Resident 10's death because she did not believe it was a suspicious death. The DON stated there was no investigation done regarding Resident 10's death. When asked if the DON knew that Resident 10 was found not breathing and pulseless in a prone position, the DON answered, "Really? Who told you that?" The DON stated that Resident 10's death was not considered a coroner's case. On 2/6/17 at 12:55 p.m., during an interview, RN 2 stated that Resident 10's clinical record did not indicate that Resident 10 was screaming for help on 10/18/16 around 11 p.m. RN 2 stated that if any resident had any episodes of screaming or calling for help, the nurses were supposed to assess and			3/8/17

Ofarrera ADMINISTRATOR 3/10/17

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	document any change of condition, and the nurses needed to notify the doctor. RN 2 stated that there was no nursing assessment done for Resident 10 while the resident was having a screaming episode. On 2/3/17 at 10:23 a.m., the administrator (ADM) stated that Resident 10's death was not investigated because MD 1 did not tell him to investigate the death. The ADM stated he did not call MD 1 to discuss Resident 10's unexpected death. The ADM stated MD 1 did not refer the death to the coroner's office for an autopsy. The ADM stated that he assumed that Resident 10's death was not suspicious. ADM stated that the facility staff did not report to him that Resident 10s was in a prone position when found unresponsive. The ADM stated he assumed that he did not have to investigate and report Resident 10's death to the Department. On 2/3/17 at 12:01 p.m., MD 1 stated that he was not notified by LVN 4 or LVN 5 that Resident 10 was found lying in a prone position while unresponsive and pulseless (on 10/19/16). MD 1 stated he did not interview LVN 4 or LVN 5 as to what position Resident 10 was found. MD 1 stated that in his professional opinion as a medical doctor, if LVN 4 and LVN 5 told him that Resident 10 was found prone and unresponsive with no pulse, he would have called the police and started an investigation. MD 1 stated he would call Resident 10's prone position very suspicious and he would have ordered an autopsy. A review of Resident 10's death certificate indicated			3/8/17

@Barrera ADMINISTRATOR 3/10/17

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	the resident died on 10/19/16. The immediate cause of death was cardiac arrest (a sudden stop in effective and normal blood circulation due to failure of the heart to pump blood). The underlying cause leading to the immediate cause of death was coronary artery disease. No autopsy was conducted. A review of the facility's policy and procedure titled, "Unusual Occurrence Reporting," with a revision date of 8/1/12, indicated that unusual occurrences, such as death of a resident, needed to be reported to the appropriate agency within 24 hours. A review of the facility's policy and procedure titled, "Change of Condition Notification," with a revision date of 4/1/15, indicated that the facility required licensed nurses to assess a resident's change of condition and determine which nursing interventions were appropriate. A review of the facility's policy and procedure titled, "Abuse – Investigations," revised on October 5, 2015, indicated "If the Administrator received a report of an incident or suspected incident of resident abuse, mistreatment, neglect, or injuries of unknown source, the Administrator or designee will initiate an investigation immediately." The facility's "Abuse-Investigations" policy and procedure indicated the Administrator or designee will notify the law enforcement immediately by telephone of an initial report of alleged physical abuse resulting in serious bodily injury. Serious bodily injury means an injury involving extreme			3/8/17

O Barrera ADMINISTRATOR 3/10/17

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	assistants (CNAs) provided appropriate care and interventions to manage Resident 10's aggressive behavior. 3. Notify Resident 10's attending physician of the resident's change of condition in behavior and the episodes of three unwitnessed falls in order to implement appropriate care and interventions for the resident. 4. Prevent staff-to-resident neglect and mistreatment by providing training to facility staff on how to manage aggressive behaviors of a mentally ill, obese person. 5. Ensure that all alleged violations involving neglect and mistreatment are reported by the staff immediately, but not later than 2 hours after the allegation is made to the administrator of the facility, to the Department (the Licensing and Certification Program), and the adult protective services. 6. Investigate thoroughly violations of neglect and mistreatment by a registered nurse (RN 1) and three certified nursing assistants (CNA 6, 8, and 9) when they were managing the aggressive behavior of Resident 10 by holding her down while the resident was in a prone position (a body position in which one lies flat with the chest down and back up) in bed to prevent the resident from falling from the low bed. Investigate thoroughly also the violations of neglect and mistreatment by a licensed vocational nurse (LVN 5) and CNA 5, who took over the care of Resident 10 during the night			3/8/17

Q Pozanek ADMINISTRATOR 3/10/17

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	physical pain, substantial risk of death, or protracted loss or impairment of function of a bodily member, organ or of mental faculty, or requiring medical intervention, including but not limited to hospitalization, surgery, or physical rehabilitation. The Administrator or designee will also notify the Long Term Care Ombudsman and the Department by telephone and in writing within two (2) hours of initial report. The facility failed to provide Resident 10 with the necessary care and services to attain or maintain the highest practicable physical, mental, psychosocial well-being, in accordance with comprehensive assessment and plan of care; to conduct a comprehensive assessment during a change of condition; to ensure that Resident 10 received proper treatment and care for mental health disorders; to not abuse residents; to immediately inform and consult with the resident's physician when there was a change in the resident's physical, mental or psychosocial status; to develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents; and to thoroughly investigate all alleged violations involving abuse, neglect, or mistreatment; including but not limited to, failures to: 1. Conduct an assessment during a change of condition in Resident 10's behavior manifested by agitation and screaming, and episodes of three unwitnessed falls from the bed. 2. Ensure licensed nurses and certified nursing			3/8/17

OBarrera ADMINISTRATOR 3/10/17

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	shift and allowed the resident to stay in a prone position until she was found unresponsive with no pulse on 10/19/16 at 4:16 a.m. 7. Investigate thoroughly the events that led to Resident 10's death. 8. Implement its policy and procedure to protect residents from neglect and mistreatment. Violations of these regulations, jointly, separately or in any combination, presented either imminent danger that death or serious harm would result or a substantial probability that death or serious physical harm would result.			3/8/17

O Barrera ADMINISTRATOR 3/10/17

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

Post-Certification Revisit Report

State Form: Revisit Report

3/22/2017

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
055167	A. Building _____ B. Wing _____	03/10/2017 CITATION #: 940013036

Name of Facility	Street Address, City, State, Zip Code
VERNON HEALTHCARE CENTER	1037 W Vernon Ave, Los Angeles, CA 90037-2415

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item		(Y5) Date	(Y4) Item		(Y5) Date	(Y4) Item		(Y5) Date
ID Prefix	F309	Correction	ID Prefix	F157	Correction	ID Prefix	F225	Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC		03/10/2017	LSC		03/10/2017	LSC		03/10/2017
ID Prefix	F224	Correction	ID Prefix	F319	Correction	ID Prefix	F226	Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC		03/10/2017	LSC		03/10/2017	LSC		03/10/2017
ID Prefix	F514	Correction						
Reg. #		Completed						
LSC		03/10/2017						

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor	Date:
	[illegible]	3/22/17	[signature]	3/22/17
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 02/08/2017 V# 7ZJH11

_____ Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO