

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055525	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/07/2024
NAME OF PROVIDER OR SUPPLIER Crenshaw Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 1900 S Longwood Ave Los Angeles, CA 90016	

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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46144</p> <p>Based on observation, interview, and record review the facility failed ensure one out of three Resident (Resident 1) had a documented assessment for an injured right index finger after a notification of change of condition.</p> <p>This deficient practice of not having documented assessment placed Resident 1 at risk for worsening of injury of the right index finger.</p> <p>Findings:</p> <p>During a review of Residents 1's Admission Record (Face Sheet), the face sheet indicated Resident 1 was admitted to the facility on [DATE] and readmitted on [DATE]. Resident 1 diagnoses not limited to schizoaffective disorder (combination of psychosis and mood symptoms), bipolar disorder (a mental illness that causes dramatic shifts in a person's mood, energy, and ability to think clearly), and metabolic encephalopathy (a problem with the brain caused by a chemical imbalance in the blood).</p> <p>During a review of Residents 1's History and Physical (H&P), dated 4/9/2024, the H&P indicated, Resident 1 is able to make decisions for activities of daily living.</p> <p>During a review of Resident 1's Minimum Data Set ([MDS] a standardized assessment and care screening tool), dated 1/26/2024, MDS indicated the cognition of Resident 1 (the ability to think and process information) was able to recall information. The MDS indicated Resident 1 was dependent with Activities of Daily Living (ADLs) including rolling left and right, sit to stand, toileting hygiene.</p> <p>During an interview on 4/30/24 at 1:00 p.m. with Activities Director (AD) 1, AD 1 stated Resident 1 was in the activity room and stated that her right hand was hurting on 4/16/24 around 4:00 p.m. AD 1 stated Resident 1's right index finger was discolored (purplish). AD 1 stated I took Resident 1 to Licensed Vocational Nurse (LVN) 2 and reported Resident 1 had pain and discoloration to her right index finger.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 4/30/24 at 1:50 p.m. with Licensed Vocational Nurse (LVN) 1, Progress Nurses Notes, dated 4/16/24 was reviewed. The Progress Nurses Notes indicated there was no documentation of Resident 1 complaint of right index finger pain. LVN 1 stated there was no documentation on the Progress Nurses Notes that indicated Resident 1 had complained of right index finger hurting. LVN 1 stated it was important to have documented on 4/16/2024 Resident 1 had a complaint of right index finger pain. LVN 1 stated documenting in the Progress Nurses Notes lets the staff know what is going on with the Resident. LVN 1 stated having clear documentation will allow me to refer back to what is going on with Resident 1 so I can better assist Resident 1. LVN 1 stated not having documentation on what was going on with Resident 1 placed the Resident at risk for worsening of the injury.</p> <p>During a concurrent interview and record review on 4/30/24 at 1:50 p.m. with Licensed Vocational Nurse (LVN) 2, Progress Nurses Notes, dated 4/16/24 was reviewed. LVN 2 stated the Activity Director (AD) 1 had told me Resident 1's finger was hurting. LVN 2 stated Resident 1 was complaining of right hand and index finger pain. LVN 2 stated there was no documentation that Resident 1 had hand pain on 4/16/2024. LVN 2 stated it is important to have documented on 4/16/24 when the Activity Director (AD) 1 reported Resident 1 finger discomfort and what the finger looked like. LVN 2 stated the protocol when a resident has a complaint or injury, we are to document it in the Progress Nurses Notes. LVN 2 stated I did not follow up and report to the next shift about Resident 1 finger/hand discomfort. LVN 2 stated it was important to document because it covers yourself and it's a way to communicate to the other nurses of what's going on with the Residents.</p> <p>During a concurrent interview and record review on 4/30/24 at 1:50 p.m. with Director of Nursing (DON) 1, Progress Nurses Notes, dated 4/16/24 was reviewed. DON 1 stated it was reported on 4/16/24/ by the AD 1 to the LVN 2 that Resident 1 right index finger was injured. DON 1 stated there were no documentation on 4/16/24 there was an injury to Resident 1 right index finger. DON 1 stated it was reported on 4/17/24 Resident 1 had an injury of the right index finger. DON 1 stated the LVN 2 should have documented the pain, did a change of condition, and notified the doctor. DON 1 stated not reporting on 4/16/24 put Resident 1 as risk for worsening her injury.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Charting and Documentation, dated 7/2017, the P&P indicated, All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record .the following information must be documented in the resident medical record . objective observations, medication administrated, changes in the resident's condition, events, incidents, or accidents involving the resident.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Licensed Vocational Nurse Job Description, dated 3/2024 the P&P indicated, This position is responsible for assuring physicians' orders are followed and quality care is provided .Monitor condition changes and properly documents and follow-ups necessary .Assures that documentation is accurate and complete.</p>		