| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056237 | A. Building<br>B. Wing | 01/17/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Alden Terrace Convalescent Hospital | 1240 S Hoover St<br>Los Angeles, CA 90006 |

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 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36395<br><br>Based on interview and record review the facility failed to monitor the resident, who had a change in condition in accordance with professional standard of practice for one of three sampled residents (Resident 1). For Resident 1, who had a seizure (a sudden, uncontrolled jerking, blank stares, and loss of consciousness) on 1/14/25, and a physician order to continue to monitor Resident 1, the facility failed to monitor Resident 1 during the night shift on 1/14/25.<br><br>This deficient practice had the potential for Resident 1 to have had a seizure and not given treatment as indicated to ensure Resident 1 was safe.<br><br>Findings:<br><br>During a review of the Admission Record indicated the facility originally admitted Resident 1 on 2/1/23 and readmitted on [DATE] with diagnoses including epilepsy and diabetes mellitus.<br><br>During a review of the Minimum Data Set (MDS, a resident assessment tool) dated 10/29/24 indicated Resident 1 had mild cognitive impairment. Resident 1 needed supervision with oral hygiene, toileting, shower/bathe self, upper/lower body dressing, putting on/taking off footwear, personal hygiene, and setup with eating.<br><br>During a review of Resident 1's Orders-Administration Note dated 1/14/25 at 5:40 p.m., indicated Resident 1 had petit mal seizure (brief, sudden lapses of consciousness) of approximately 30 seconds. The Note indicated Resident 1's blood pressure was 76/47 millimeters of mercury (mm HG, unit of measurement, normal range is 120/60 mm HG). Resident 1's blood pressure was re-taken and indicated the blood pressure was 120/75 mm HG. The Note indicated Resident 1's nurse practitioner (NP, a registered nurse who had additional training and education in how to diagnose and treat disease) was notified and gave orders to monitor Resident 1. The Note further indicated .will continue to monitor as ordered . and notify the physician of any further changes or complications.<br><br>During a review of Resident 1's Care Plan initiated on 1/14/25 indicated Resident1 had an actual seizure of less than 30 seconds. The Care Plan goal included Resident 1 will have no injury until the next assessment. The Care Plan interventions included observe for seizure activity and notify the physician as indicated, assess for any change of condition, and notify the physician as indicated.<br><br>(continued on next page) |

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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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a telephone interview on 1/17/25 at 10:17 a.m., licensed vocational nurse (LVN 1) stated Resident 1 had a seizure on 1/14/25. LVN 1 stated she notified Resident 1's NP and the NP gave order to continue to monitor Resident 1. LVN 1 stated she continued to monitor Resident 1 by taking Resident 1's vital signs (measure of the basic functions of the body), asked Resident 1 if Resident 1 was dizzy and continue to monitor Resident 1 for seizure to ensure Resident 1 was fine.<br><br>During a concurrent interview and record review on 1/17/25 at 11:46 a.m., Resident 1's vital signs and nursing documentation dated 1/14/25 was reviewed with the director of staff development (DSD). DSD stated Resident 1 had a seizure on 1/14/25 and the seizure was considered a change of condition. DSD stated Resident 1 should be monitored for seizure and monitoring would include vital signs. DSD agreed there were no vital signs taken and no nursing documentation on 1/14/25 during the night shift. DSD stated it was important to monitor Resident 1 for seizure and vital signs because Resident 1 may have changes and may need to transfer Resident 1 to the hospital for further evaluation.<br><br>During a review of the facility Policy titled Change of Condition reviewed on 5/21/24, indicated a change of condition is a sudden or marked difference in resident's that included vital signs and behavior (change to lethargy, agitated, non-responsive) and level of consciousness. The same Policy indicated documentation of change in condition shall be performed by the licensed nurse accordingly: (includes the following)<br><br>1. Documenting for at least 72 hours or longer if condition change warrants.<br><br>2. Documenting vital signs each shift.<br><br>3. Re-assess resident condition as needed.<br><br>During a review of the facility Policy titled Charting and Documentation reviewed on 5/21/24, 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 same Policy indicated the following information is to be documented in the resident medical record that included objective observations and treatments or services performed. |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36395<br><br>Based on interview and record review the facility failed to ensure resident medical records are accurate in accordance with professional standard of practice for one of three sampled residents, (Resident 1). For Resident 1, the facility failed to ensure the monitoring and documentation for seizure (a sudden, uncontrolled jerking, blank stares, and loss of consciousness) activity on 1/14/25 during the night shift was accurate.<br><br>This deficient practice resulted in incomplete and inaccurate medical record for Resident 1.<br><br>Findings:<br><br>During a review of the Admission Record indicated the facility initially admitted Resident 1 on 2/1/23 and readmitted on [DATE] with diagnoses including epilepsy (sudden bursts of electrical activity in the brain cause seizure or fits) and diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing).<br><br>During a review of the Minimum Data Set (MDS, a resident assessment tool) dated 10/29/24 indicated Resident 1 had moderately impaired cognitive skills. Resident 1 needed supervision with oral hygiene, toileting, shower/bathe self, upper/lower body dressing, putting on/taking off footwear, personal hygiene, and setup with eating.<br><br>During a review of the Medication Administration Record (MAR, daily documentation record used by licensed nurse to document medications and treatments given to a resident) dated 1/25 indicated to monitor Resident 1 for seizure activity every shift. The MAR indicated to enter zero (0) if no seizure and one (1) if Resident 1 had a seizure. On 1/14/25, number one (1) was entered in the MAR during the night shift.<br><br>During a concurrent telephone interview and record review, on 1/17/25 at 9:38 a.m., the MAR was reviewed with licensed vocational nurse (LVN 2). The MAR indicated LVN 2 entered number 1 on the box dated 1/14/25 during the night shift, indicating Resident 1 had a seizure. LVN 2 stated Resident 1 did not have a seizure on 1/14/25 during the night shift. LVN 2 stated he made a mistake with his documentation.<br><br>During an interview on 1/17/25, at 11:06 a.m., registered nurse supervisor (RNS 1) stated Resident 1 did not have a seizure on 1/14/25 during the night shift. RNS 1 stated LVN 2 should have entered zero (0) for no seizure activity instead of the number one (1). RNS 1 stated LVN 2 made a mistake during the documentation on 1/14/25.<br><br>During a review of the facility Policy titled Charting and Documentation reviewed on 5/21/24 indicated the medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. The same Policy indicated documentation in the medical record will be objective (not opinionated or speculative), complete and accurate. |