STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555057	A. Building B. Wing	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Las Flores Convalescent Hospital	14165 Purche Ave. Gardena, CA 90249

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 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** 36331 Based on interview and record review the facility failed to document and implement a physician telephone order to flush urinary catheter (a tube placed in the body to drain and collect urine from the bladder), monitor characteristics of urine and document urine output for 1 of 4 sampled residents (Resident 1). These failures resulted in Resident 1 being admitted to the general acute care hospital (GACH) with bladder distention (when the pouch that holds your urine is enlarged) and infection. Findings: A review of Resident 1 ' s admission record, dated 5/15/24, the admission record indicated Resident 1 was initially admitted on [DATE] and readmitted [DATE], with diagnosis of benign prostate hyperplasia ([BPH]a condition in men in which the prostate gland is enlarged and not cancerous) with lower urinary tract symptom ' s, adult failure to thrive, and cardiomegaly (enlargement of the heart). A review of Resident 1 ' s Minimum Data Set (MDS-an assessment and care planning tool) dated 5/16/24, the MDS indicated Resident 1 had clear speech, the ability to express ideas, wants, and understands. The MDS indicated Resident 1 required substantial (helper does more than half the effort) assistance with oral hygiene, toileting hygiene and upper body dressing. A record review of Resident 1 ' s Bowel & Bladder Evaluation, dated 4/20/24. The Bowel & Bladder Evaluation indicated Resident 1 was a possible candidate for B&B Program based on alertness and oriented, not continent (the ability to retain a bodily discharge voluntarily) of both bowel and bladder and has risk factor of using a catheter. During a concurrent interview and record review on 5/29/24 at 11:21 a.m. with Registered Nurse (RN 1), Resident 1 ' s Order Summary Report, dated 4/30/24, was reviewed. The order summary report indicated a physician order dated 4/19/24, to monitor intake and output every shift for 30 days, and to monitor catheter urinary drainage bag: color, consistency, odor, hematuria (blood in the urine), bladder distention, burning sensation every shift, document + equals signs and symptoms of urinary tract infection ([UTI] infection in the urine), O equals no signs and symptoms. The physician order indicated to notify the medical doctor if signs and symptoms are present. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 5/29/24 at 11:21 a.m. with RN 1, the Medication Administration Record, dated April 2024, was reviewed. A record review of the medication administration record indicated staff documented output as X2 on April 20th through April 28th on the day and evening shifts, and night shifts on April 23, 24, 25th, 26th, 27th, 28th, and 29th. The record review indicated on the night shift, April 20 and April 21 staff documented Resident 1 ' s output as X1. RN 1 stated staff documented Resident 1 ' s output according to number of diaper changes and the output is not monitored correctly and may lead to bladder distention. During a concurrent interview and record review on 5/29/24 at 11:21 a.m., with RN 1, the Treatment Administration Record, dated April 2024 was reviewed. The Treatment Administration record indicated staff documented a checkmark instead of documenting + (s/s/of UTI) or O (no s/s of UTI). RN 1 stated staff did not document according to the medical doctor ' s order and did not take care of the resident. During a concurrent interview and record review on 5/29/24 at 12:22 p.m. with the wound treatment nurse (LVN 1), Resident 1 ' s progress note, dated 4/21/24 at 12:40 p.m., was reviewed. The progress note indicated RN 2 spoke with the medical doctor regarding bloody urine in Resident 1 ' s catheter tubing and the medical doctor ordered to have the nurse flush catheter tubing and leave urinary catheter in place for 10-14 days. During a concurrent interview and record review on 5/29/24 at 12:55 p.m. with LVN 1, Resident 1 ' s Order Summary Report, dated 4/30/24, was reviewed. The order summary report did not indicate a physician order dated 4/21/24 to flush the catheter tubing and leave urinary catheter in place for 10-14 days. LVN 1 stated she could not recall flushing Resident 1 ' s catheter tubing, and not flushing Resident 1 ' s tubing would be a delay in treatment. A review of Resident 1 ' s Change of Condition Evaluation, dated 4/30/24, the change of condition indicated Resident 1 had abdominal distention and the medical doctor ordered to transfer Resident 1 to the GACH for further evaluation and treatment. A review of Resident 1 ' s GACH record, dated 4/30/24, the emergency department course indicated Resident 1 ' s urinary catheter balloon was inflated in his urethra (a tube through which urine moves from the urinary bladder out of the body) blocking drainage of urine. The GACH record indicated the urinary catheter was removed and a new urinary catheter was inserted and almost 1800 cc of urine output was noted with instant relief. A review of Resident 1 ' s care plan, dated 4/21/24, indicated Resident 1 has a urinary catheter and is at risk for dislodgement, obstruction, UTI, pain at urethra, and impaired mobility. The care plan goal indicated Resident 1 will be free from catheter-related trauma and no signs and symptoms of UTI through review. The care plan interventions included to monitor/record/report to medical doctor for signs and symptoms of UTI: pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, and change in eating pattern. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facilities policy and procedure (P&P) titled, Documentation-Nursing, dated May 1, 2018, indicated the purpose of this policy is to provide documentation of resident status and care given by nursing staff. The P&P indicated nursing documentation will be concise, clear, pertinent, and accurate. The P&P indicated narrative charting, as outlines in specific policies and procedures will be used for initial treatments or procedures. And checklists, flow charts, and other documentation tools will be used as appropriate. The P&P indicated medication administration records and treatment administration records are completed with each medication or treatment completed and documentation will be completed by the end of the assigned shift. A review of the facility ' s P&P titled Catheter-Care of, dated May 1, 2018, indicated each resident who is incontinent of urine is identified, assessed, and provided appropriate treatment and services to achieve or maintain as much normal urinary function as possible; a resident, with or without a catheter, receives the appropriate care and services to prevent infections to the extent possible. The P&P indicated daily catheter care includes recording urinary output and reporting any signs or symptoms of UTI to the attending physician.