

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056326	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
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NAME OF PROVIDER OR SUPPLIER BURLINGTON CONVALESCENT HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 845 S.BURLINGTON AVENUE LOS ANGELES, CA 90057
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F 000	<p>INITIAL COMMENTS</p> <p>The following reflects the findings of the California Department of Public Health during the investigation of a complaint.</p> <p>Complaint Number: CA00967129</p> <p>The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility.</p> <p>One deficiency was issued for complaint number: CA00967129 (Refer to F842).</p>	F 000	<p>Disclaimer:</p> <p>The signing of this plan of correction is not an admission or agreement of this statement of deficiencies and plan of correction. In fact, this plan of correction is submitted exclusively to comply with state and federal law. This plan of correction constitutes Facility's written credible allegation of compliance for the deficiencies noted.</p>	7/3/25
F 842 SS=D	<p>Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5)</p> <p>§483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.</p> <p>§483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized</p> <p>§483.70(h)(2) The facility must keep confidential all information contained in the resident's</p>	F 842	<p>F 842 Accurate and Complete Resident Records</p> <p>Corrective Action:</p> <p>RN responsible for the documentation for resident is no longer employed at the facility.</p> <p>CNA responsible for the ADL documentation for resident 1 is no longer employed at the facility.</p> <p>On 6/26/25, DSD provided in-service to the Licensed nurses and CNAs regarding the importance of accurate, complete and timely documentation of all care provided including ADL assistance with emphasis on new admissions to prevent inaccurate and incomplete documentation.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Jeffrey Huang</i>	TITLE Administrator	(X6) DATE 7/3/25
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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.

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F 842	<p>Continued From page 1 records, regardless of the form or storage method of the records, except when release is-</p> <p>(i) To the individual, or their resident representative where permitted by applicable law;</p> <p>(ii) Required by Law;</p> <p>(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;</p> <p>(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.</p> <p>§483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.</p> <p>§483.70(h)(4) Medical records must be retained for-</p> <p>(i) The period of time required by State law; or</p> <p>(ii) Five years from the date of discharge when there is no requirement in State law; or</p> <p>(iii) For a minor, 3 years after a resident reaches legal age under State law.</p> <p>§483.70(h)(5) The medical record must contain-</p> <p>(i) Sufficient information to identify the resident;</p> <p>(ii) A record of the resident's assessments;</p> <p>(iii) The comprehensive plan of care and services provided;</p> <p>(iv) The results of any preadmission screening and resident review evaluations and</p>	F 842	<p>Identification of Other Residents at Potential Risk:</p> <p>On 6/25/25, Medical Records designee reviewed all new admission charts from the last 30 days to ensure complete, timely and accurate documentation from the licensed nurses and CNAs to reflect all care and assistance provided. No other gaps or inaccuracies were identified; no other residents were found to be affected or at risk.</p> <p>Measures to Prevent Recurrence:</p> <p>Medical Records designee to audit the medical record of all new admissions within 72 hours to ensure timely, accurate and complete documentation is in place. The findings will be submitted to the DON or designee for immediate corrective action and re-education as needed.</p> <p>On 6/26/25, DSD provided in-service to the Licensed nurses and CNAs regarding the importance of accurate, complete and timely documentation of all care provided including ADL assistance with emphasis on new admissions to prevent inaccurate and incomplete documentation.</p>	7/3/25	

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F 842	<p>Continued From page 2</p> <p>determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and record review the facility failed to maintain record that is complete and accurate for one of three sampled residents (Resident 1). For Resident 1 the facility failed to:</p> <ol style="list-style-type: none"> 1. Provide assistance with activities of daily living (ADLs) on 11/11/22. 2. Document nursing services that were provided to Resident 1 on 11/11/22 from 7 p.m. to 12:30 a.m. <p>These deficient practices resulted in incomplete and inaccurate medical record for Resident 1.</p> <p>Findings:</p> <p>During a review of the Admission Record indicated the facility admitted Resident 1 on 11/11/22 with diagnoses including respiratory failure (impaired gas exchange between the lungs (breathing organ) and the blood) and chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing).</p> <p>During a review of Resident 1's Admission Assessment indicated the facility admitted Resident 1 on 11/11/22 at 7 p.m. The Assessment indicated Resident 1 was confused. Resident 1 was dependent with eating/nutrition, personal hygiene and grooming. Resident 1 was incontinent of bowel and bladder.</p>	F 842	<p>Medical Records designee to conduct a monthly audit of all current resident charts to ensure timely and complete documentation and all necessary assessments are in place including care and ADL assistance. Immediate corrective action and re-education to be provided as needed.</p> <p>ADON or designee to review all new admission charts within 72 hours to ensure residents are provided appropriate ADL care and assistance with accurate documentation in place. Immediate corrective action will be provided as needed.</p> <p>Monitoring of Performance:</p> <p>The DON or designee will conduct weekly audits of 5 random resident charts for 4 weeks then monthly for 2 months, ensuring nursing and ADL care documentation is present, timely, complete and accurate.</p> <p>The findings from the audit will be reported to the QAPI Committee monthly for 3 months for review and recommendations to ensure compliance is achieved and maintained.</p>	7/3/25	

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F 842	Continued From page 3 During a concurrent interview and record review on 6/12/25 at 12:01 p.m., Resident 1's Admission Assessment was reviewed the registered nurse supervisor (RNS 1). RNS 1 stated the facility admitted Resident 1 on 11/11/22 at 7 p.m. RNS 1 stated the nurses should make rounds at least every two to three hours, check on how Resident 1 was doing and make sure Resident 1 was "okay " . RNS 1 stated she was unable to find documentation that the nurses made their rounds. RNS 1 stated it is important to document what " ...we did for the patient (Resident 1). " RNS 1 stated the documentation communicates how Resident 1 was doing during the shift. During a concurrent interview and record review, on 6/12/25 at 1:26 p.m., Resident 1's Documentation Survey Report (record of ADLs and assistance provided to residents) for 11/22 was reviewed with the director of staff development (DSD). DSD stated she was unable to find documentation that the certified nursing assistant (CNA) provided care to Resident 1. DSD stated even if Resident 1 was a new admit on 11/11/22, the CNA should do frequent rounds to find out how Resident 1 was doing. DSD stated the CNA should document what was done for the patient that included if Resident 1 had voided or was turned. During a review of the facility Policy titled "Activities of Daily Living (ADLs), Supporting " , reviewed on 12/18/24 indicated residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). The same Policy indicated appropriate care, and	F 842		

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F 842	<p>Continued From page 4</p> <p>services will be provided for residents who are unable to carry out ADLs independently with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with:</p> <ul style="list-style-type: none"> a. hygiene (bathing, dressing, grooming and oral care) b. Mobility (transfer and ambulation, including walking) c. elimination (toileting) d. dining (meals and snacks) e. communication (speech, language and any functional communication systems). <p>During a review of the facility Policy titled "Charting and Documentation " reviewed on 12/18/24 indicated all services provided to the resident, progress toward the care plan goals or any changes in the resident's medical, functional or psychosocial condition shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. The same Policy indicated the following information is to be documented in the resident medical record:</p> <ul style="list-style-type: none"> a. objective observations b. medications administered c. treatments or services performed d. changes in the residents' condition e. events, incidents or accidents involving the resident and f. progress toward or changes in the care plan goals and objectives <p>The same Policy indicated the documentation in the medical record will be objective (not opinionated or speculative), complete and accurate.</p>	F 842			

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