

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 555729	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/18/2020
NAME OF PROVIDER OF SUPPLIER ARCADIA CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP 1601 S BALDWIN AVE. ARCADIA, CA 91007	
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 0602 Level of harm - Minimal harm or potential for actual harm Residents Affected - Few	<p>Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</p> <p>Based on interview and record review, the facility failed to ensure personal medications were not discarded upon discharge for one of one sampled resident (Resident 1). This deficiency denied Resident 1's responsible party (RP) the opportunity to access to the resident's personal medications. Findings: A review of Resident 1's Admission Record indicated the facility admitted the resident on [DATE], with [DIAGNOSES REDACTED]. A review of Resident 1's Minimum Data Set (MDS, a standardized assessment and care-screening tool), date [DATE], indicated the resident cognitive skills was severely impaired, required extensive assistance to total dependence with one- person physical assistance in bed mobility, transfers and personal hygiene. A review of the Order Summary Dated [DATE] indicated to administer Tarceva (a medication to [MEDICAL CONDITION]) tablet 100 milligrams (mg) one tablet a day for [MEDICAL CONDITION]. Included in the order was, Family will provide medication, please notify family to refill. A review of Progress Notes dated [DATE] at 2:06 a.m., indicated Resident 1 was transferred to a general acute care hospital (GACH) due to respiratory distress (difficulty in breathing) on [DATE] at 1:30 a.m. Family reported to the facility on [DATE] that Resident 1 passed away on [DATE]. A review of Progress Notes dated [DATE], the facility's Social Service Director (SSD) received a grievance from RP that the facility disposed Resident 1's [MEDICAL CONDITION] medication. During record review with the Assistant Director of Nursing (ADON) on [DATE], at 8:00 a.m., the Destruction of Non-Narcotic Medication Sheet dated [DATE], did not include Tarceva for Resident 1. On a concurrent interview, the ADON stated the facility discarded resident's Tarceva. During an interview on [DATE] at 9:00 a.m., the SSD stated that Resident 1's RPs filed a grievance regarding discarding the resident's medications. The SSD stated that the medications were indeed discarded for Resident 1. The SSD stated the facility offered to reimburse the resident's medications, however, the RPs told the SSD It is not necessary. During an interview on [DATE] at 2:00 pm, with the Licensed Vocational Nurse (LVN) stated that Registered Nurse 1 (RN 1) requested him to call and inform Resident 1's RP that the resident's medication was accidentally discarded. During a phone interview on [DATE], 12:30 pm, RN 1 stated that the facility's staff accidentally destroyed Resident 1's medications. The Director of Nursing (DON) stated after the facility heard that the staff went ahead and destroyed the resident's remaining medications after the facility heard that the resident expired. The DON stated that the facility returns and documents in the Disposal of Medications log for personal medications brought in by residents' personal medications in by residents and or RPs. The DON stated that staff did not follow the policy and procedure. A review of the facility's undated policy statement titled Medication Ordering and receiving From Pharmacy, indicated If the family does not pick up those medications within thirty (30) days, the facility may destroy them in accordance with established policies.</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.