Printed: 10/04/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER		(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	O(3) DATE SUF COMPLETI	
		054083		B. WING		08/0	2/2018
	ovider or supplier COMMUNITY MENTAI	L HEALTH CENTER		ESS, CITY, STA UTH AVALO GELES, CA	ON BLVD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTK (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(XS) COMPLETION DATE
B 000	INITIAL COMMENTS			B 000			
	conducted by federal 7/30/18 to 8/1/2018. of the survey was 47. patients was eight (8)	ertification survey was consultant surveyors from the first. The sample of active. Two (2) discharged death patient were addent and discharge.	day				
B 103	HOSPITALS CFR(s): 482.61 The medical records hospital must permit and intensity of the translitution. This Condition is not	unished services in the met as evidenced by:	atric gree	B 103	The Chief of Social Services reviewed the Bio-psy assessment currently used with each of the effect identified (Patients 1, 2, 3, 4, 5, 6, 7 and 8). Kedra using the Askesta PsychConsuft EHR system & Bi assessment (Attachment # 02) which is less compthe Netsmart MyAvatar EHR system & Psychosoo Kedran is currently in the process of transitioning if Netsmart which is set to faunch on 11/13/2018. The Chief of Social Services reviewed the Netsmar Psychosooial Assessment which will be used by the Workers to complete a comprehensive assessment (Attachment # 01). The Chief of Social Services determined that the Network of the Network o	nd patients n is currently opsychosocial rehensive than ial assessment, from Askests to rt MyAveter no Social at of the patient letsment red at the time of r social work.	11/13/2018
·	failed to: I. Ensure the psycho the conclusions and I the anticipated social and discharge planni (8) active sample pati 8) did not have the ar social worker. As a re professional patient p necessary for informe decisions was not ave II. Ensure that Psych A. Were performed in	esychosocial information ed treatment planning allable. (Refer to B108) hatric Evaluations: a a timely manner for two patients (N1 and N2) a	clude ed to ent ight and		formulating a treatment plan and discharge plan. The Chief of Social Services will conduct an in-ser on 10/24/2018 (Attachment # 03) to review Stands the State Operations Manual (Attachment # 04) to Social Workers collect and properly document the information about home plans, family editudes, oo and social history and understand where the Informitied in on the current Astests Biopsychosocial asteuring this Interim period of transition to the Netsmassessment which has clear areas in which the abwill be collected. Netsmart will launch on 11/13/20 (Refer to B109)	rds listed by ensure that necessary mmunity resource nation should be sessment sert Psychosocial ove information	
LABORATOR	Y DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIV	E'S SIGNATURE		TITLE		(XS) 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 clied, an approved plan of correction is requisite to continued program participation.

10-19-18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	054083		-13.			COMPLETED	
		054083		B. WNG		08/02/2018	
	OVIDER OR SUPPLIER		STREET ADDRE	SS, CITY, STA	TE, ZIP CODE		
KEDREN	COMMUNITY MENTAL	. HEALTH CENTER		JTH AVALO ELES, CA			
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY		GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION	
B 103	Continued From page	e 1		B 103			
B 103	psychiatric assessme patients prior to their This failure delays the symptoms with psych professional therapies. B. Included an estima with supporting clinica eight (8) active sample compromises the data are determined and firesponse to treatmen measured. (Refer to full.) Provide adequate one (1) of three (3) di subsequently assault roommate (E1). In accensure that an adequate prompt review by the Board of the circumst event were complete actions. Without takin immediate actions to future recurrence of the health and safety of a may be jeopardized. IV. Ensure the discharcompleted in a timely physician within 14 dof five (5) discharged and for three (3) of the review summaries (N deficiency results in a timely manner final dimedications, the course	ents completed on these discharge from the facility attention of patients' memoral evidence for six (6) of the patients This deficier abase from which diagram which changes in the interventions may be 3110) treatment and monitoring scharge diagram which changes in the interventions may be 3110) treatment and monitoring scharged patients (N1) and murdered his/high didition, the facility failed atter oot cause analysis are in Morbidity and Mortances surrounding this did to implement correcting appropriate and mitigate risks and previous hese unsafe practices, all newly admitted patier (Refer to B125) arge summaries are manner and signed by ays of discharge for the patients (D1, D3, and the patients) are of the patients (D1, D3, and the patients) and the patients (D1, D3, and the patients) are of the patients (D1, D3, and the patients) are of the patients (D1, D3, and the patients) are of the patients (D1, D3, and the patients) are of the patients (D1, D3, and the patients) are of the patients (D1, D3, and the patients) are of the patients (D1, D3, and the patients) are of the patients (D1, D3, and the patients) are of the patients (D1, D3, and the patients) are of the patients (D1, D3, and the patients) are of the patients (D1, D3, and the patients) are of the patients (D1, D3, and the patients) are of the patients (D1, D3, and the patients) are of the patients (D1, D3,	d ry if ncy noses ing for who er d to s and ality ve ent the nts / the ee (3) D4) to e in a mary	B 103			
		esting, anticipated prob ith outpatient providers					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE. ZIP CODE		
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				GELES, CA			
(X4) ID	SIIMMARYST	FATEMENT OF DEFICIENCIES		<u>.</u>	PROVIDER'S PLAN OF CORRECTION	NI.	(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	REFIX (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION DATE
B 108	Continued From page	e 2		B 108	Chief of Social Services will conduct an in-service		11/13/2018
B 108	DEVELOPMENT OF			B 108	training on 10/24/2018 with all Inpatient Social		
	ASSESSMENT/DIAG	NOSTIC DATA			Service staff (Attachment # 03) to review the Standards clearly defined by the State Operations		
	CFR(s): 482.61(a)(4)		1		Manual (Attachment # 04).		
					Chief of Social Services will train Social Workers or where on their current Askesis PsychConsult	י	
	The social service red	ords, including reports	of		Biopsychosocial Assessment document		
		ts, family members, an			(Attachment # 02) they will include specific		
		an assessment of home	e		information related to home plans, family attitudes, community resource contacts and social history.		
	plans and family attitudes, and community resource contacts as well as a social history.)		Chief of Social Services will also review and train		
			.		the Social Workers on the new Netsmart MyAvatar Psychosocial Assessment (Attachment # 01) that		
	71: 0: 1 1:		1		will be launched on 11/13/2018 and which clearly		
	This Standard is not	•			identifies the specific areas that Social Service will capture the standard information that we are		
		eview and staff intervieusure that the Psychoso			required to have (home plans, family attitudes,		
	•	it (8) out of eight (8) act			community resource contacts & social history).		
	sample patients (1, 2,						
	included anticipated S						
	•	, critical and profession	al				
		nformation necessary f			This documentation will be monitored weekly		
	informed treatment pla	anning decisions was r	not		by the Chief of Social Services and the Director of Quality		
	available to the treatn	nent teams.			Management through the Utilization Review process	i.	
	Findings include:				Plan of Correction for each deficiency cited under		
	A. Record Review				CFR(s): 482.61 (a)(4) is the following: (1-8)		
	A. Record Review				,, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
		itted for "danger to othe	ers				
	and gravely disabled"				On page 27 of the Netsmart MyAvatar Psychosocial		11/13/2018
		ment completed on 6/2 pated roles for social wo			Assessment (Attachment # 01) the Social Work staff	f will identify	
	staff in formulating int	erventions for inpatient			problems, determine short/long term goals, determin	e Social/Clinical	
	treatment.				work goals for the Social Worker, identify current ps	ychological	
	2. Patient 2 was adm and gravely disabled"	itted for "danger to other	ers		Issues that need interventions and provide a clinical	-	
		ment completed on 7/1:	3/18		Impression. During interim transition before 11/13/20	16 Netsmart	
	did not identify anticip	ated roles for social wo	ork	i	launch, Social Work staff will manually write in the ab	oove information	
	staff in formulating interestment.	erventions for inpatient			collected onto page 5 of the Askesis PsychConsult B	liopsychosocial	:
	0 Deficies 0				Assessment (Attachment # 02) in the "Evaluation & I	nitial Discharge	
	3. Patient 3 was adm	itted for "gravely disabl	ed"		Summary* section.		

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/O IDENTIFICATION NUMBE		1 '	LE CONSTRUCTION	(X3) DATE SUR COMPLETI	
		054083		B. WNG		08/02	2/2018
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRE	SS. CITY, STA	ITE, ZIP CODE		
KEDREN (COMMUNITY MENTAL	L HEALTH CENTER	4211 SOL	JTH AVAL	ON BLVD		
**********				ELES, CA			
							
(X4) ID		TATEMENT OF DEFICIENCIES	CI II ATODY	ID	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION
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1.00	0.1.200.10.		1	17.0	DEFICIENCY)		
D 100	Continued From page			D 400			
B 108	Continued From page				On page 27 of the Netsmart MyAvatar P	-	11/13/2018
	•	chosocial Assessment			Assessment (Attachment # 01) the Socia	al Work	
	completed on 12/14/17 did not identify anticipated		pated		staff will identify problems, determine		
	roles for social work staff in formulating		İ		short/long term goals, determine Social/	Clinical	
	interventions for inpatient treatment.				work goals for the Social Worker, identify	y current	
			i.		psychological issues that need intervent	ions and	
		nitted for "danger to sel			provide a clinical summary/impression. [-	
		7/7/18. The Psychosoc			interim transition before 11/13/2018 Net	smart	
		ed on 7/10/18 did not id	lentify		aunch, Social Work staff will manually w		
	anticipated roles for s				the above information collected onto pag	ge 5 of the	
	formulating intervention	ons for inpatient treatm	ent.		Askesis PsychConsult Biopsychosocial	Assessment	
			_		(Attachment # 02) in the "Evaluation & Ir	nitial	
		nitted for "danger to oth	ers "		Discharge Summary" section.		
		chosocial Assessment					
		3 did not identify anticip	ated				
	roles for social work s	•			On page 27 of the Netsmart MyAvatar F	svchosocial	11/13/2018
	interventions for inpar	uent treatment.	İ		Assessment (Attachment # 01) the Soci	•	
	6 Dationt 6 was adm	nitted for " gravely disat	al a all!		staff will identify problems, determine		
	on 7/8/18. The Psych		pied		short/long term goals, determine Social/	Clinical	
		did not identify anticipa	tod		work goals for the Social Worker, identif		
	roles for social work s		rea		psychological issues that need intervent		
	interventions for inpa	-			provide a clinical summary/impression.	-	
	increditions for inpu	aont a caunche.			interim transition before 11/13/2018 Net		
	7 Patient 7 was adm	nitted for "danger to sel	fand		launch, Social Work staff will manually v		
		7/23/18. The Psychoso			the above information collected onto pagaskesis PsychConsult Biopsychosocial		
		ed on 7/24/18 did not id			(Attachment # 02) in the "Evaluation & I		i
	anticipated roles for s		Citaly		Discharge Summary" section.	inuai	
		ons for inpatient treatm	ent				
		iono ioi inputone tiodan	J		On page 27 of the Netsmart MyAvatar F	•	11/13/2018
	8. Patient 8 was adm	nitted for "danger to sel	fand		Assessment (Attachment # 01) the Soci	al Work	
		7/25/18. The Psychoso			staff will identify problems, determine		
		ed on 7/26/18 did not id			short/long term goals, determine Social/		
	anticipated roles for s		,		work goals for the Social Worker, identif	•	
		ions for inpatient treatm	ent.		psychological issues that need intervent		
		iei iripadein deddii			provide a clinical summary/impression.	-	[
	B. Staff Interview				interim transition before 11/13/2018 Net launch, Social Work staff will manually v		
					the above information collected onto page		
	In a meeting with the	acting Director of Soci	al I		Askesis PsychConsult Biopsychosocial		
		at 1:00 p.m., the above			(Attachment # 02) in the "Evaluation & I		
		riewed. She agreed wit			Discharge Summary" section.		
							I

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRE	SS. CITY. STA	TE. ZIP CODE			
	COMMUNITY MENTAL	HEALTH CENTER		UTH AVAL				
				GELES, CA				
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ŧD	PROVIDER'S PLAN OF CORRECTION)N	(X5)	
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B 108	Continued From page	e 4		B 108	On page 27 of the Netsmart MyAvatar F		11/13/2018	
	above findings and fu	rther stated, "Social wo	ork		Assessment (Attachment # 01) the Soci	al Work		
	has a critical role in th	e treatment of patients	i."		staff will identify problems, determine short/long term goals, determine Social/	Clinical		
B 110	PSYCHIATRIC EVAL	UATION		B 110	work goals for the Social Worker, identif			
	CFR(s): 482.61(b)			2	psychological issues that need intervent			
	,				provide a clinical summary/impression. I	During		
	Each patient must red	ceive a psychiatric			interim transition before 11/13/2018 Net			
	evaluation.				launch, Social Work staff will manually v			
					the above information collected onto pagaskesis PsychConsult Biopsychosocial			
	This Standard is not	mat as avidanced by:			(Attachment # 02) in the "Evaluation & I			
		ew and interview, the fa	acility		Discharge Summary" section.			
	failed to:	on and interview, the it	ZOIIILY					
			į		Psychiatric Evaluation CFR(s): 482.61(b)) this		
	I. Provide comprehen psychiatric evaluation				standard was not met as the Psychiatric	Evaluation		
	- •	is. Specifically, the is had no assessments	that	reviewed had no assessments than include member				
	included memory fund	ctioning for six (6) of eig	ght		functioning there by compromising the c	lata base		
		ents (2, 3, 5, 6, 7 and 8 romises the database f			from which diagnosis are determined ar	d treatment		
		determined and from w	1		interventions measured.			
	changes in response may be measured.	to treatment intervention	ons		Correction Action Plan			
	Findings include:				The Physician involved has been subject	cted to		
	I I ack of timely never	niatria avalvations			disciplinary action pending peer review.	The Board		
	Lack of timely psych	nauto evaluations			of Directors has appointed a Medical Di	rector		
:	A. Record Review				Inpatient Psychiatry who will work with t			
	1. Patient N1 was adr	mitted on 11/2/17 at 3:3	30		of Quality Management to implement a	monitoring		
		OS [not otherwise spec			tracking system to include tracers to tra	ck, trend		
	and danger to self." T (undated) stated, "Clic	The Root Cause Analys	sis		and redirect Physicians on a daily basis	to ensure		
	[spouse] to urgent car	re clinic for psychiatric			that all the required diagnostic fields ar	e completed		
		easingly unpredictable			and in addition the tracking will address	timely		
		d hearing voices telling self/herself] and [spou	I		completion of the Psychiatric Evaluation	s to ensure		
	reported client was fo	und with a knife attemp	oting		that patient care is expeditiously delive	red.		
		er genitals]." There was nt completed prior to the			Delinquent deficiencies before they leav	e the		

	OF DEFICIENCIES F CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA			(2) MULTIPLE CONSTRUCTION . BUILDING		(X3) DATE SURVEY COMPLETED	
		054083		B. WING		08/02	2/2018	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRE	SS, CITY, STA	TE, ZIP CODE			
KEDREN	COMMUNITY MENTAL	HEALTH CENTER	4211 SOL	JTH AVAL	ON BLVD			
Lo				ELES, CA	90011			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
B 110	110 Continued From page 5			B 110				
	patient being taken by police for allegations of		of		hospital on that day. In addition data ar	rivea from		
	murder on the evening	g of 11/2/17.			QAPI will be presented at the Medical E	xecutive		
i	2 Patient N2 was add	mitted on 11/2/17 at 4:0	n		Committee			
		Mood Disorder and dan	I		Meeting and the committee will determine	ne the		
		use Analysis (undated)			necessity for Peer Review.			
		sed feeling depressed,			An administrative discharge note has be	en placed		
		erself] with plans to sta pencils." There was no			on all three of the records of the patient	s involved in		
		nt completed prior to the			the sentinel event. Competently medic	al records		
	patient being transfer	red to another facility o			would audit records on a daily basis for			
	11/3/17 at 2:30 p.m.					completion and will notify the delinquent Physicians		
	B. Interview				of their deficiencies. The Medial Directo	•		
						•		
		m., the Medical Directo	2		Services is responsible for the enforcement			
		niatric assessments we se facility does not have			rules. To ensure that all patients are exp	•		
	psychiatrists on duty		•		seen and evaluated the hospital has en			
					physician and a psychiatric practitioner	to admit and		
	II. Lack of comprehen				evaluate patients between 6:00 pm and	11:00 pm to		
	psychiatric evaluation	IS			support the physician providing admission	on coverage		
	A. Record Review				between 7:00 am and 6:00 pm. Any ad	missions	'	
					arriving between 11:00 pm and 7:00 am	admission		
	7/14/18) did not include	tric Evaluation (dated de any assessment of t	the		orders to include 1:1 observation.			
	patient's memory.				Such admissions will be fully evaluated	by the		
	2. Patient 3's Psychia	tric Evaluation (dated ude any assessment of	the		psychiatric team at 7:00 am the followin	g day.		
	patient's memory.	. ,			1. Appropriate disciplinary action will be	taken		
	3. Patient 5's Psychia	tric Evaluation (dated			pending peer review.			
		de any assessment of t	he		2. Appropriate disciplinary action will be	taken		
	patient's memory.	•				vanon		
	A Patient Sta Daughia	trio Evoluation (detect			pending peer review.			
	4. Patient 6's Psychia 7/8/17) did not include	eric Evaluation (dated any assessment of th	e		3. Appropriate disciplinary action will be	e taken		
	patient's memory.	, accessinone of the	_		pending peer review.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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KEDREN	COMMUNITY MENTAL	HEALTH CENTER		UTH AVALO GELES, CA			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		GULATORY	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD B TAG CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		D BE	(X5) COMPLETION DATE
B 110	Continued From page	e 6		B 110	4. Appropriate disciplinary action will be	e taken	
	5. Patient 7's Psychia				pending peer review.		
	=	de any assessment of t	he		5. Appropriate disciplinary action will be	e taken	
	patient's memory.				pending peer review.		
	6. Patient 8's Psychia				6. Appropriate disciplinary action will be	e taken	
		de any assessment of t	he		pending peer review.		
	patient's memory.						
	B. Interview						
		n.m., the Medical Direct was not assessed in the n.					
B 125	TREATMENT PLAN			B 125	The rounding policy procedure has bee	n revised to	10/23/2018
	CFR(s): 482.61(c)(2)				ensure consistence rounding in the hos	1	
		ed by the patient must t	e		in addition a separate policy denoting the	•	
	documented in such a active therapeutic effort	a way to assure that all			patients will be placed on a SPCIII (leve		
	active therapeutic end	onts are included.			admitted and will remain on this level of		
					until evaluated by attending Psychiatris	t or Clinical	
	This Standard is not a Based on record revie	met as evidenced by: ew, document review, a	nd		Psychologist.		
	interviews, the facility	failed to provide adequ	ıate		(Attachment 10)		
		ring for one (1) of three	(3)				
		N1) who subsequently red his/her roommate (I	E1).				
	In addition, the facility	failed to ensure that a					
		analysis and a prompt dity and Mortality Board	wore				
	completed to address	the circumstances	14010				
	surrounding this even	t and to implement					
	immediate actions to	thout taking appropriate mitigate risks and prevention	e and ent	,			
	future recurrence of u	nsafe practices, the he	alth				
	and safety of all newly jeopardized.	y admitted patients may	/ be				
	Findings include:		İ				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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NAME OF PR	OVIDER OR SUPPLIER	<u> </u>	STREET ADDRE	SS, CITY, STA	TE, ZIP CODE	·	
KEDREN	COMMUNITY MENTAL	HEALTH CENTER	4211 SOL	JTH AVALO	ON BLVD		
				ELES, CA			
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B 125	Continued From page	e 7		B 125			
	A. Record Review						
•	Patient N1 was admit for "Psychosis NOS a undated Root Cause brought in by [spouse psychiatric evaluation unpredictable behavior voices telling [him/her and [spouse] reported knife attempting to genitals]." There was assessment complete taken by police for allevening of 11/2/17. In significant discrepance monitored by staff. The noted 30 minute check indicated that the patiminutes, and the facilipatients were to be must be furthermore, there was discharge summary discharge to the policithe treatment of acute psychotropic medication.	or. Client stated hearing of to harm [himself/hers of client was found with [self-mutilate his/her not a psychiatric ad prior to the patient be egations of murder the addition, there was a sy in how often N1 was an ursing assessment else, the rounds sheet ent was monitored every 15 minutes not a progress note ocumenting the time of the ent was monitored every 15 minutes not a progress note ocumenting the time of the ent was monitored every 15 minutes not a progress note ocumenting the time of the ent was monitored every 15 minutes not a progress note ocumenting the time of the ent was monitored every 15 minutes not a progress note ocumenting the time of the ent was progress note ocumenting the time of the ent was progress note ocumenting the time of the ent was a progress note ocumenting the time of the ent was a progress note ocumenting the time of the ent was a progress note ocumenting the time of the ent was a progress note ocumenting the time of the ent was a progress note ocumenting the time of the ent was a progress note ocumenting the time of the ent was a progress note ocumenting the time of the ent was a progress note ocumenting the time of the ent was a progress note ocumenting the time of the ent was a progress note ocumenting the time of the ent was a progress note ocumenting the ent was a progress note ocumenting the ent was a progress note ocumenting the ent was a progress note ocumenting the ent was a progress note ocumenting the ent was a progress note ocumenting the ent was a progress note ocumenting the ent was a progress note ocumenting the ent was a progress note ocumenting the ent was a progress note ocumenting the ent was a progress note ocumenting the ent was a progress note ocumenting the ent was a progress note ocumenting the ent was a progress note ocumenting the ent was a progress note ocumenting the ent was a progress note ocumenting the ent was a progress note ocumenting the ent was a progress note ocumenting the ent was a progress note ocumenting the ent was a progress note ocument	e was or gelf] a eing to be eits. or feed the				
	of the undated Root C	d the surveyors with a cause Analysis titled s document did not incl			At the time of the Sentinel Event, th key positions that were vacant at the f CQI Director, Risk Manager, and Patie	acility (i.e.	06/18/2018, 08/24/2018
	dates when meetings contributing factors su environmental. There		ailure		Manager. This played a role in the tho of the documentation as there was no was familiar with the RCA process in t	roughness one who	& 10/15/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		054083		B. WNG		08/02	/2018
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRE	SS, CITY, STA	TE, ZIP CODE		
KEDREN COMMUNITY MENTAL HEALTH CENTER 4211		4211 SOL	JTH AVALO	ON BLVD			
			LOS ANG	ELES, CA	90011		
(X4) ID	SIMMADYS	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	N.	(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION DATE
B 125	Continued From pag	e 8		B 125	at that time. There is now a CQI Direct	tor as of	
	to monitor, evaluate of	or medicate the patients	s in		06/18/2018 and Patient Safety Manag	er as of	
	the document. Therei				8/24/2018 with several years experier	1	
	corrective actions ide	ntified to address these	•		patient safety, risk management, and	I	
	issues to prevent furt	her reoccurrences.			process. There is now a very robust F		
					in place and staff are initially trained of		
		did not review this deat			process prior to starting an RCA (Atta		
		s from the Mortality and	đ		In addition, our Sentinel Event policy on 10/15 2018	was updated	
	Morbidity Board as of	August 1, 2018.			Attachment 7).		
	3 Patients N1 was n	elaced on every 30-mini	ute		,		10/15/2018
	•	RN's Mental Health Nu			Per our updated Sentinel Event pol		10/15/2016
		ent" dated 11/2/17 at 5			Mortality and Morbidity (M&M) review conducted on all deaths and presente		
	-	was no physician order			and the Governing Board. (Attachmer		
	denoting "Precautions				and the coverning board. (Alasimo	,	
		ated 11/2/17 at 5:45 p.n					
		elephone orders and we	ere			į	
	not signed by a physi		1				
		according to the rounds					
		every 20 minutes. The					
		ls for Patient Observati I 12/2017, stated, "Ever					
		located by the staff me					
		with documentation as					
		ty on the Rounds form					
	according to the local	•					
	4. The facility did not	have a Death Review I	Policy				
	or Procedure and use	ed the undated Sentent	ial		4. The Sentinel Event (SE) policy was	updated to	10/15/2018
	Event Procedure # 60	009 [no date] which did	not		include the M&M standard operating p	rocedure	
	address homicides in				on 10/15/2018. This was distributed to	staff on	
	procedure also did no	ot address the manager	ment		10/19/2018.		
	•	ed and unexpected dea	aths				
	by medical staff or mo	ortality review board.					
	5. There were no do	cuments to review to			E Immediately after the CE the fellowing account	wara ahannad 4-	
		cility took actions to mit	igate		5. Immediately after the SE the following processes to the facility (Attechment 8):	- 1	
	the risks to prevent re				prevent re-occurrence in the facility (Attachment 8): Staff appointed a Process Improvement Team to per		
	•				related to the SE; all admitted patients were placed of		
	C. Staff Interviews				observation until they were seen by an admitting phy		
					will be responsible for ensuring that all one-to-one or		l.;

	OF DEFICIENCIES F CORRECTION	(AT) PROVIDENSOPPLIENCEIA		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		054083		B. WNG		08/0	2/2018
	OVIDER OR SUPPLIER COMMUNITY MENTAL	HEALTH CENTER		SS, CITY, STA ITH AVALO ELES, CA	ON BLVD		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
B 125	1. On 8/1/18 at 10:15 interviewed the CEO they agreed that they mitigate risk to the pa is trying to have the upatient room doors withis has not been con CEO reported he had root-cause-analysis. Could have been man 2. On 8/1/18 at 11:00 interviewed the Direct and he/she agreed the vague and did not prothe event including the factors such as huma 3. On 8/1/18 at 10:00	a.m., the surveyors and Medical Director a had not taken actions tient. The CEO explain nit remodeled, replace ith flexi glass windows apleted. Furthermore, to not reviewed the The CEO state, "Things aged much better. I a.m., the surveyor tor of Quality Improveme root-cause-analysis would an in-depth analy e analysis of contribution and environmental. a.m., the Director of are correct. The observe with the policy."	to ed he the but he s ment was sis of	B 133	discussions took place regarding the redesign of the greater visibility of the patients in their rooms which upgrade to an electronic monitoring rounding system by the facility. In addition, mirrors will be strategically rooms enabling staff to have full view of the patients bed at all times. (Attachment 9). 1. discussions took place regarding the of the unit to ensure greater visibility of in their rooms which resulted in the upgelectronic monitoring rounding system to adopted by the facility. In addition, mirror strategically placed in the rooms enabling have full view of the patients in each bed at all times. (Attachment 9). 2. There is now a very robust RCA process prior to starting an RCA (Attach in addition, our Sentinel Event policy was on 10/15 2018 (Attachment 7).	resulted in the m being adopted by placed in the s in each redesign the patients rade to an being brs will be any staff to eass this ment 6).	
	The record of each particle discharged must have includes a recapitulat hospitalization. This Standard is not Based on record revie interview, the facility of discharge summaries and signed within 14 (3) of five (5) sample D3, and D4) and for the discharged patients (I death (E1). This defice	e a discharge summary ion of the patient's met as evidenced by: ew, document review, a	bed hree 1,	·	The Chief of Social Services will conductin-service training on 10/24/18 with all Inpatient Social Service staff (Attachmet to review the standards for discharge su as documented by the State Operations (Attachment # 04). The Chief of Social Service Aftercare & Discharge Summary documentation in discharged charts were ensure that the document is completed at the chart within the standard of 14-days discharge for all patients. The Chief of Services will use the Social Service After Discharge Summary Review tool (Attact do document discrepancies and provide feedback to Social Service staff immedia Services Staff will be required to make of to deficiencies before 14-day due date.	ent #03) commaries Manual Services will ekly to and filed in of cocial creare & comment # 05) necessary ately. Social	10/24/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		054083		B. WNG		08/02	2/2018
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRE	SS, CITY, STA	TE. ZIP CODE	<u></u>	
KEDREN	COMMUNITY MENTAL	HEALTH CENTER	4211 SO	UTH AVAL	ON BLVD		
				GELES, CA			
	010414010	TATEMENT OF DEFICIENCIES			r		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	COMPLETION DATE	
B 133	Continued From page	e 10			Signature by a physician: A glitch in the		11/13/2018
	current medications, t	the course of treatment			Askesis PsychConsult system does allow		
	summary of relevant I	labs and testing, anticip	ated		Psychiatrist to co-sign the discharge doo The new Netsmart MyAvatar has the fun		
	problems and dischar	ge plan with outpatient			route the discharge summary to the Psy		
	providers.				co-signature upon completion. Kedren is		
	Findings include:				to begin using the Netsmart MyAvatar sy 11/13/2018.		
	A. Record Review				The Chief of Social Services will revie Discharge Summary documentation ir	n discharged	
	1 D1's discharge sun	nmary (discharge dated	.		charts weekly to ensure that the docume		
		e summary dated 6/29/			completed and filed in the chart within the pf 14-days of discharge for all patients.	e standard	
		ithin 14 days and was r			or 14-days or discharge for all patients.		
	signed by the physicia				2. The Chief of Social Services will revise	w Δffercere	
					& Discharge Summary documentation in		
	2. D3's discharge sun	nmary (discharge dated	ı		charts weekly to ensure that the docume	ent is	
		e summary dated 7/2/1			completed and filed in the chart within the	ne standard	
		ithin 14 days and was r			of 14-days of discharge for all patients.		
	signed by the physicia						
					3. The Chief of Social Services will revie		
		nmary (discharge dated			& Discharge Summary documentation in discharged charts weekly to ensure that the document is		
		e summary dated 7/2/1			completed and filed in the chart within the		
		ithin 14 days and was r	ot		of 14-days of discharge for all patients.		
	signed by the physicia	an.					
		2/17) had no discharge			4. The Chief of Social Services will revie & Discharge Summary documentation in		
	summary.				charts weekly to ensure that the docume	ent is	
	5 N2 (discharged 11)	3/17) had no discharge			completed and filed in the chart within the	e standard	
	summary.	3/17) nad no discharge	'		of 14-days of discharge for all patients.		
	Summary.						
	6. E1 (death 11/2/17)	had no discharge sum	mary		5. The Chief of Social Services will revie		
	(& Discharge Summary documentation in charts weekly to ensure that the document		' I
	B. Document Review				completed and filed in the chart within the		
					of 14-days of discharge for all patients.		
	An undated facility do	cument titled "Discharg	je i				
	Summaries" stated, "I	Entire chart to be fully			6 The Chief of Social Services will service	w Aftamam	
	completed by 14 days	s from discharge." [Note	e:		6. The Chief of Social Services will review Aftercare & Discharge Summary documentation in discharged		
	This document had no	o date.]			charts weekly to ensure that the docume		
					completed and filed in the chart within th		
	C. Interview				of 14-days of discharge for all patients.		

	OF DEFICIENCIES F CORRECTION	IVI) EKONIDEROSOFFICIEROCKIA			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	:	054083		B. WING		08/02	2/2018	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRE	SS, CITY, STA	TE, ZIP CODE			
KEDREN	COMMUNITY MENTAL	HEALTH CENTER	4211 SOI	JTH AVALO	ON BLVD			
			LOS ANG	ELES, CA	90011			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	(X5) COMPLETION DATE		
B 133	Continued From page	e 11		B 133				
	agreed that the discha	a.m., the Medical Direct arge summaries were gned by the physician. lave been done."						
B 142				B 142	MEDICAL STAFF CFR(s): 482.62(b) F The Board of Directors has appointed			
	The number and qual	lifications of doctors of			Director Inpatient Psychiatry who will w	ork with the		
		athy must be adequate	to		Director of Quality Management to implement a			
	provide essential psyc	chiatric services.				toring tracking system to include tracers to		
					track, trend and redirect Physicians on			
	This Standard is not met as evidenced by: Based on record review and staff interviews the facility failed to deploy psychiatrists to ensure psychiatric assessments were completed for two (2) of two (2) added patients (N1 and N2) admitted after hours. Specifically, the facility failed to provide 24-hour psychiatric coverage when the facility admits acutely and unstable mentally ill patients without a qualified psychiatrist assessment to provide appropriated psychotropic medications, observations and monitoring of patient's condition. This failure delays the treatment of acutely mentally ill patients with psychotropic medications and potentially		failed en the ill		to ensure that all the required diagnost completed and in addition the tracking timely completion of the Psychiatric Evensure that patient care is expeditious. Delinquent deficiencies before they lead hospital on that day. In addition data a QAPI will be presented at the Medical Committee Meeting and the committee determine the necessity for Peer Revi An administrative discharge note has be	will address aluations to ly delivered. ve the arrived from Executive e will ew.		
		without being properly			on all three of the records of the patien	nts involved		
	medicated with antips medications.	sychotic or other psychi	iatric		in the sentinel event. Competently m	edical		
	medications.				records would audit records on a daily	basis for		
	Findings include:				accuracy and completion and will notify	y the		
	A. Record Review			;	delinquent Physicians of their deficient Medial Director of Inpatient Services is			
	p.m. for "Psychosis N The Root Cause Anal "Client was brought ir	Imitted on 11/2/17 at 3: IOS and danger to self. lysis (undated) stated, in by [spouse] to urgent	" care		for the enforcement of these rules.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
054083			B. WING		08/02/2018		
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRE	SS. CITY, STAT	TE, ZIP CODE		
KEDREN COMMUNITY MENTAL HEALTH CENTER 4211 SOUTH AVALON BLVD LOS ANGELES, CA 90011							
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		(D	PROVIDER'S PLAN OF CORRECTION	ON .	(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX TAG	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	COMPLETION DATE
B 142	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		B 142	To ensure that all patients are expeditiseen and evaluated the hospital has exphysician and a psychiatric practitioner and evaluate patients between 6:00 proportion of the physician providing a coverage between 7:00 am and 6:00 provided Any admissions arriving between 11:00 provided 1:00 provide	IND BE COMPLETE DATE itiously engaged a er to admit om and 11:00 g admission 0 pm. 00 pm and 1:1		
	agreed the psychiatri	.m., the Medical Directoric assessments were not have	ot				

STATEMENT-OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
054083			B. WING		08/02/2018		
NAME OF PROVIDER OR SUPPLIER STREET ADD				SS, CITY, STA	TE, ZIP CODE	<u> </u>	
KEDREN COMMUNITY MENTAL HEALTH CENTER 4211 SOUTH AVALON BLVD LOS ANGELES, CA 90011							
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
B 142	Continued From page 13			B 142			
	psychiatrists on duty after hours.						
B 144	144 MEDICAL STAFF			B 144	MEDICAL STAFF CFR(s): 482.62(b)(2)	: POC	
	CFR(s): 482.62(b)(2)				The Board of Directors has appointed a Medical		
	The director must monitor and evaluate the quality and appropriateness of services and treatment provided by the medical staff.				Director Inpatient Psychiatry who will work with the		
					Director of Quality Management to implement a		
					monitoring tracking system to include tracers to		
					track, trend and redirect Physicians on a daily basis		
	This Standard is not met as evidenced by:				to ensure that all the required diagnostic fields are		
Based on record review and interview, the Medical Director failed to:				completed and in addition the tracking will address			
!					timely completion of the Psychiatric Eve	iatric Evaluations to	
	Ensure that: Psychiatric Evaluations:				ensure that patient care is expeditiously delivered.		
	A. Included an estimation of patients' memory with supporting clinical evidence for six (6) of eight (8) active sample patients This deficiency compromises the database from which diagnoses				Delinquent deficiencies before they leave the		
					hospital on that day. In addition data arrived from		
					QAPI will be presented at the Medical Executive		
	are determined and from which changes in response to treatment interventions may be measured. (Refer to B110)				Committee Meeting and the committee will		
					determine the necessity for Peer Review.		
	·				An administrative discharge note has b	een placed	
	II. Provide adequate treatment and monitoring for one (1) of three (3) discharged patients (N1) who subsequently assaulted and murdered his/her roommate (E1). In addition, the facility failed to ensure that an adequate root cause analysis and a prompt review by their Morbidity and Mortality Board of the circumstances surrounding this event were completed to implement corrective actions. Without taking appropriate and immediate actions to mitigate risks and prevent future recurrence of these unsafe practices, the health and safety of all newly admitted patients may be jeopardized. (Refer to B125)				on all three of the records of the patients involved		
					in the sentinel event. Competently me	edical	
					records would audit records on a daily	basis for	
					accuracy and completion and will notify	the	
					delinquent Physicians of their deficiencies. The		
					Medial Director of Inpatient Services is	responsible	
					for the enforcement of these rules.		
					To ensure that all patients are expedition	ously	
					seen and evaluated the hospital has er	ngaged a	
	III. Ensure the discharge summaries are completed in a timely manner and signed by the physician within 14 days of discharge for three (3)				physician and a psychiatric practitioner	to admit	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
054083			B. WNG		08/02/2018		
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRE	SS, CITY, STA	TE, ZIP CODE		
KEDREN COMMUNITY MENTAL HEALTH CENTER 4211 SOUTH AVALON BLVD LOS ANGELES, CA 90011							
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY TAG OR LSC IDENTIFYING INFORMATION)				ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDERICIENCY)	D BE	(X5) COMPLETION DATE
B 144	Continued From page 14 of five (5) discharged patients (D1, D3, and D4) and for (3) of (3) added patients to review summaries (N1, N2, and E1). This deficiency results in a failure to communicate in a timely manner final diagnosis, current medications, the course of treatment, a summary of relevant labs and testing, anticipated problems and discharge plan with outpatient providers. (Refer to B133) IV. Ensure adequate deployment of psychiatrists so that psychiatric assessments were completed for two (2) of two (2) added patients (N1 and N2) admitted after hours. Specifically, the facility failed to provide 24-hour psychiatric coverage when the facility admits acutely and unstable mentally ill patients without a qualified psychiatrist assessment to provide appropriated psychotropic medications, observations and monitoring of patient's condition. This failure delays the treatment of acutely mentally ill patients with psychotropic medications and potentially dangerous behaviors without being properly medicated with antipsychotic or other psychiatric medications. (Refer to B142) NURSING SERVICES CFR(s): 482.62(d)(1) The director must demonstrate competence to participate in interdisciplinary formulation of individual treatment plans; to give skilled nursing care and therapy; and to direct, monitor, and evaluate the nursing care furnished.		the labs large 3) trists eted I N2) failed en the ill tropic f	B 144	and evaluate patients between 6:00 pm pm to support the physician providing a coverage between 7:00 am and 6:00 p Any admissions arriving between 11:00 7:00 am admission orders to include 1:00 observation. Individual Responsible: Director of Psyc Inpatient Services	6:00 pm and 11:00 viding admission d 6:00 pm. In 11:00 pm and clude 1:1	
	Based on document in Director of Nursing fat N1 was monitored act monitoring document	met as evidenced by: review and interview, th illed to ensure that Pati cording to policy and the s were consistent with y resulted in the patient	ent nat the				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1''	LE CONSTRUCTION	X3) DATE SURVEY COMPLETED		
	054083			B. WNG	B. WNG 08/0:			
NAME OF PROVIDER OR SUPPLIER STREET ADDI			STREET ADDRE	RESS, CITY, STATE, ZIP CODE				
KEDREN COMMUNITY MENTAL HEALTH CENTER 4211 SOUTH AVALON BLVD LOS ANGELES, CA 90011								
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDENCY)	D BE COMPLE	ETION	
B 148	Continued From pag	e 15		B 148				
	being monitored inappropriately and potentially compromising his/her safety. (Refer to B125)							
B 152	B 152 SOCIAL SERVICES CFR(s): 482.62(f)			B 152	Chief of Social Services will conduct an	in-service		
					11/13/2018 training on 10/24/2018 with all Inpatient			
		ctor of social services v es the quality and	vho		Social Service staff (Attachment # 03) to review the			
	monitors and evaluates the quality and appropriateness of social services furnished.				Standards clearly defined by the State Operations			
					Manual (Attachment # 04).			
	This Standard is not met as evidenced by: The Director of Social Work failed to ensure the				Chief of Social Services will train Social Workers on			
					where on their current Askesis PsychConsult			
		teness of services prov			Biopsychosocial Assessment document			
	by the social work staff. Specifically, the Director failed to assure that the Psychosocial Assessments included the anticipated social work roles in treatment for eight (8) of eight (8) (1, 2, 3, 4, 5, 6, 7, and 8) active sample patients. This				(Attachment # 02) they will include spec	ific		
					information related to home plans, fami	y attitudes,		
					community resource contacts and socia	l history.		
	· ·	k of professional social	1		Chief of Social Services will also review	and train		
	information in treatme	ent planning. (Refer to	B108)		the Social Workers on the new Netsma	t MyAvatar		
					Psychosocial Assessment (Attachment	# 01) that		
					will be launched on 11/13/2018 and wh	ch clearly		
					identifies the specific areas that Social	Service will		
					capture the standard information that w	e are		
	·				required to have (home plans, family at	itudes,		
					community resource contacts & social I	istory).		
			į					