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Department of

SOCIAL SERVICES

Community Care Licensing

COMPLAINT INVESTIGATION REPORT

Facility Number: 197605820
Report Date: 06/28/2022
Date Signed: 06/28/2022 12:12:15 PM

Substantiated

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY **COMPLAINT INVESTIGATION REPORT**	**CALIFORNIA DEPARTMENT OF SOCIAL SERVICES** **COMMUNITY CARE LICENSING DIVISION** **CCLD Regional Office, 21731 VENTURA BLVD. #250** **WOODLAND HILLS, CA** 91364

This is an official report of an unannounced visit/investigation of a complaint received in our office on **06/21/2022** and conducted by Evaluator Ashley Smith

	COMPLAINT CONTROL NUMBER: 29-AS-20220621092445

FACILITY NAME:	SUNRISE OF WESTLAKE VILLAGE			**FACILITY NUMBER:**	197605820
ADMINISTRATOR:	HOWELL, ZACHARY			**FACILITY TYPE:**	740
ADDRESS:	3101 TOWNSGATE RD			**TELEPHONE:**	(805) 557-1100
CITY:	WESTLAKE VILLAGE	**STATE:** CA		**ZIP CODE:**	91361
CAPACITY:	124	**CENSUS:** 74		**DATE:**	06/28/2022
		UNANNOUNCED		**TIME BEGAN:**	09:40 AM
MET WITH:	Zak Howell			**TIME COMPLETED:**	12:15 PM

ALLEGATION(S):

1	Staff are restraining resident in care
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INVESTIGATION FINDINGS:

1	Licensing Program Analyst (LPA) Ashley Smith arrived unannounced to conduct an initial 10-day visit.
2	The LPA met with Executive Director Zak Howell and explained the reason for the visit.
3	
4	During today's visit, the LPA conducted a tour at 11:40 a.m., interviewed staff at 9:52 a.m., 10:05 a.m.,
5	10:22 a.m., and 10:45 a.m., and interviewed a hospice nurse at 11:01 a.m. In addition, the LPA
6	conducted a file review and collected documents.
7	
8	Regarding the allegation, it was alleged that on several occasions, staff have restrained Resident #1
9	(R1). It was alleged that staff have placed R1 in bed facing the wall, pulled R1's pants to their ankles, and
10	placed a pillow in between R1's knees. There was a concern that with these measures in place, R1 is
11	rendered immobile and cannot reposition on their own.
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Substantiated	Estimated Days of Completion:

NAME OF LICENSING PROGRAM MANAGER: Jeralyn Ann Pfannenstiel
NAME OF LICENSING PROGRAM ANALYST: Ashley Smith
LICENSING PROGRAM ANALYST SIGNATURE: **DATE:** 06/28/2022

I acknowledge receipt of this form and understand my licensing appeal rights as explained and received.

FACILITY REPRESENTATIVE SIGNATURE: **DATE:** 06/28/2022

This report must be available at Child Care and Group Home facilities for public review for 3 years.

Control Number 29-AS-20220621092445

FACILITY NAME: SUNRISE OF WESTLAKE VILLAGE **FACILITY NUMBER:** 197605820
VISIT DATE: 06/28/2022

NARRATIVE

Interviews and record review revealed that R1 is currently on hospice, and because R1 has skin integrity challenges, R1 has an order on file for heel protectors. A file review confirmed the order for the heel protectors, and an interview with a hospice nurse confirmed that upon visiting R1, R1 is always observed wearing the heel protectors. Staff confirmed that R1 is repositioned every two hours, as R1's skin is susceptible to redness. As such, staff claimed that if R1 is observed facing the wall, staff believe R1 is facing the wall for a short period of time as R1 is repositioned every two hours. During today's visit, the LPA observed R1, and observed that R1 was wearing their prescribed heel protectors. R1 was observed lying on their back and did not appear to be in distress.

However, interviews and a review of the facility's progress notes confirmed that at least on one occasion - on 06/05/2022 - R1 was found in bed with their pants around their ankle, and a pillow was observed between their legs. Whereas the pillow was used to prevent further skin integrity challenges, staff agreed that R1's pants should have either stayed on or been completely removed. The presence of R1's pants around their ankles restricts R1's movement, thus unintentionally restraining R1. As a result of this incident, Reminiscence staff will receive an in-service training regarding the proper use of postural supports and maintaining a restraint-free environment. Based on the investigation, there is sufficient evidence to support the claim that staff are restraining resident in care. This allegation is deemed Substantiated at this time.

Pursuant to Title 22 Division 6 Chapter 8 of the CA Code of Regulations, the following deficiencies were cited (refer to LIC 9099-D). Exit interview conducted, today's reports and appeal rights were reviewed and issued.

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STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY	CALIFORNIA DEPARTMENT OF SOCIAL SERVICES COMMUNITY CARE LICENSING DIVISION CCLD Regional Office, 21731 VENTURA BLVD. #250 WOODLAND HILLS, CA 91364
COMPLAINT INVESTIGATION REPORT (Cont)	

FACILITY NAME: SUNRISE OF WESTLAKE VILLAGE **FACILITY NUMBER:** 197605820
DEFICIENCY INFORMATION FOR THIS PAGE: **VISIT DATE:** 06/28/2022

Deficiency Type POC Due Date / Section Number	DEFICIENCIES		PLAN OF CORRECTIONS(POCs)	
Type A 06/30/2022 **Section Cited** CCR 87468.1(a)(2)	1 2 3 4 5 6 7	87468.1(a)(2) Personal Rights of Residents in All Facilities. (a) Residents in all residential care facilities for the elderly shall have all of the following personal rights: (2) To be accorded safe, healthful and comfortable accommodations, furnishings and equipment. This requirement is not met as evidenced by:	1 2 3 4 5 6 7	The Administrator has agreed to do the following: 1. An internal investigation will begin to identify the staff person(s) involved. Staff will receive a write-up and additional training. CCL to be notified of this action no later than 6/30/2022
	8 9 10 11 12 13 14	Based on interview and record review, the licensee did not comply with the section cited above, as R1 was not afforded safe and comfortable accommodations as they were restrained on at least one occasion, which poses an immediate health and safety risk to residents in care.	8 9 10 11 12 13 14	2. All staff in the Reminiscence Unit will complete additional training pertaining to the proper use of postural supports and alternatives to restraints. Training to be completed no later than 7/5/2022.
	1 2 3 4 5 6 7		1 2 3 4 5 6 7	
	1 2 3 4 5 6 7		1 2 3 4 5 6 7	

Failure to correct the cited deficiency(ies), on or before the Plan of Correction (POC) due date, may result in a civil penalty assessment.

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