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

PRINTED: 10/17/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555030	A. BUILDING _____ B. WING _____	10/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLLEGE VISTA CONV HOSPITAL	4681 EAGLE ROCK BLVD. LOS ANGELES, CA 90041

(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the Department of Public Health during a Licensing and Recertification Survey. Representing the Department of Public Health: [redacted], RN-HFEN [redacted], RN-HFEN Total Population: 49 Sample Size: 13 Highest S/S = E	F 000	This Plan of Correction constitutes my written credible allegation of compliance for the deficiencies noted. This is a disclaimer statement for SNF Plan of Correction. States that this POC is not in agreement with the DHS conclusions. 2012 OCT 25 PM 1:[illegible]	
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to accommodate the residents need by not allowing the resident to continue using a small personal refrigerator in her room and monitor the temperature as needed for one out of 13 sample residents (1). Findings:	F 246	Resident 1 was immediately offered use of the refrigerator in the lounge which is specifically designated for use by residents only. All needs for refrigerator use by residents were assessed and evaluated by the facility interdisciplinary team to ensure compliance with accommodation of resident needs. The entire facility staff was in-serviced by the assistant administrator regarding accommodation of resident needs including need for use of the resident refrigerator. The Assistant Administrator and Director of Nursing will monitor compliance on a monthly basis through quality assurance facility rounds to ensure sustained	10/8/12 10/10/12 10/10/12 10/20/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [redacted] TITLE INTERIM ADMINISTRATOR (X6) DATE 10/25/12

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 246	Continued From page 1 On October 5, 2012, at 5: 30 p.m., during the initial tour of the facility the Surveyor observed in Room 3 a personal refrigerator that belonged to Resident 1. Inside the refrigerator there were three small cartons of milk shake containing 118 milliliters (ml) each and two bottles of Glucerna milk shake containing 237 ml's each. There was no thermostat inside the refrigerator and/or a temperature log maintained by the facility to ensure the foods inside the refrigerator were stored at the right temperature in order to prevent the potential for food borne diseases. On the same day and time, during an interview with Resident 1's family member who was sitting in Room 3, Bed-B, she stated the milk shakes and Glucerna shakes were for her the resident since she was not eating very well. During an interview with the Director of Nurses (DON) who was present during the tour stated the facility does not have a thermostat for residents personal refrigerator and there was no daily log maintained. On October 6, 2012, at 7: 56 a.m., during rounds the resident's refrigerator was removed from her room. When asked, the DON indicated since the facility did not have a policy to monitor the resident's personal refrigerator and no one to maintain the daily log, the facility instructed the resident's family to take the refrigerator away from the room. On October 6, 2012, at 8:15 a.m., during an interview with the Maintenance Supervisor, he stated the facility do not have a policy for	F 246	practices. The Quality Assurance Committee will monitor compliance on a quarterly basis to evaluate effectiveness.	10/20/12

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F 246	Continued From page 2 residents personal refrigerator monitoring or to maintain a daily temperature monitoring log. The resident was not allowed the continued use of her personal refrigerator.	F 246		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by:	F 278	A correction MDS was immediately submitted for Resident #12 and Resident #13 with the status of the pneumonia vaccine codes correctly coded 1. The Director of Nursing reviewed all current facility residents MDS vaccine status section to identify if any other resident MDS vaccination status update was indicated to ensure compliance. The Director of Nursing provided a one-on-one in-service with the MDS Licensed Vocational Nurse regarding assessment accuracy and accurate MDS coding to ensure systemic change. The facility DON and Interdisciplinary Team will monitor sustained compliance through monthly MDS Quality Assurance Audits. The facility Quality Assurance Committee will evaluate achieved effectiveness quarterly.	10/10/12 10/20/12 10/20/12 10/20/12 10/20/12

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F 278	Continued From page 3 Based on interview and record review, the facility failed to ensure that the residents' pneumo vaccination status were assessed accurately to reflect the actual status of the residents on the Minimal Data Set (MDS) assessment for two out of 13 sample residents (12, 13). Findings: a. According to the admission record, Resident 12 was admitted to the facility on October 24, 2011, with diagnoses that included atrial fibrillation, diabetes mellitus, and coronary artery disease. A review of the resident's MDS dated November 6, 2011, and August 8, 2012, indicated the pneumo vaccine was coded 0/3 which meant the resident's pneumo vaccine was not updated because the pneumo vaccination was not offered. A review of the Pneumonia Vaccine Administration Record Sheet indicated the Pneumo vaccine was administered on October 29, 2011. On October 7, 2012, at 12:40 p.m. during an interview with Licensed Vocational Nurse 2 (LVN 2), she stated the pneumo vaccination was administered on October 29, 2011, so the pneumo vaccination status of MDS dated November 6, 2011, and August 8, 2012, were coded incorrectly, and should have been coded 1. b. According to the admission record, Resident 13 was admitted to the facility on June 7, 2012, with diagnoses that included chronic obstructive pulmonary disease, diabetes mellitus, and End	F 278		

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F 278	Continued From page 4 Stage Renal Disease. A review of the resident's MDS dated November 6, 2011, and July 4, 2012, indicated the pneumo vaccine was coded 0/2 which meant the resident's pneumo vaccine was not updated because it was offered but declined. A review of the Pneumonia Vaccination Screening indicated the resident had received the pneumonia vaccination on April 8, 2012. On October 7, 2012, at 12:40 p.m. during an interview, LVN 2, stated the resident had received the pneumo vaccination on April 8, 2012, and the MDS dated July 4, 2012, was coded incorrect and it should have been coded 1.	F 278		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: c. According to the admission record, Resident 11 was admitted to the facility on September 6, 2012, with diagnoses that included diabetes mellitus (DM) type II, End Stage Renal Disease (ESRD), renal dialysis status. The Minimum Data Set (MDS) assessment dated	F 309	Resident's 11, 2, 3 were all provided immediately with an emergency kit at bedside to manage a potential emergency bleeding in addition to the emergency kit located in the treatment cart and emergency supplies in the medication room. The care plan for Resident #2 for care and precaution of hemodialysis intervention section was updated immediately to include handling emergency bleeding from the shunt. The facility Interdisciplinary Team reviewed the need for bedside emergency kits and care plans of all current residents receiving hemodialysis as well as facility	10/10/12 10/10/12 10/10/12

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F 309	Continued From page 5 September 19, 2012, indicated the resident had intact cognition, and needed extensive assistance from the staff except in eating. The resident had a physician's order dated September 13, 2012, for dialysis scheduled three times a week and not to take shower due to permacatheter. On October 5, 2012, at 6:10 p.m. during a tour with Licensed Vocational Nurse 2 (LVN 2), there was no emergency kit observed in the resident's room. During an interview with LVN 2 at the same time, she confirmed there was no emergency kit provided in the resident's room. LVN 2 stated the emergency kit was located in the treatment cart. On October 7, 2012, at 7:45 a.m., the resident was in her bed and her permacatheter with dressing was observed on her right upper chest. During an interview with certified nursing assistant 1 (CNA 1) at the same time, CNA 1 stated there was no emergency kit in the resident's room and she would use the bed linens or tissues or paper towels from the bathroom when there was bleeding observed from the resident's permacatheter. On October 7, 2012, at 3:40 p.m. during an interview with Registered Nurse 1 (RN 1), he agreed the emergency kit should have been provided in the resident's room. A review of the facility's policy of the Nursing Emergency of Hemorrhage indicated the supplies to control hemorrhage were included thick pads of sterile gauze, sanitary pads or abdominal pads, tourniquets, blood pressure cuff, scarf or belt	F 309	policy and procedures compliance. The Director of Nursing and Director of Staff Development in-serviced all licensed nurses and CNA's regarding assessment, indications, actions, interventions, care plans, need for emergency kit at bedside associated with possible emergency bleeding from a shunt or permacatheters. The DON, Nursing Supervisors, Charge Nurses and DSD will monitor sustained compliance integration through daily quality assurance facility resident rounds. The facility Quality Assurance Committee will evaluate effectiveness quarterly.	10/10/12 10/20/12 10/20/12

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F 309	Continued From page 6 gloves. Based on observation, interview and record review, the facility failed to ensure that residents with arteriovenous shunt (AV shunt is a passageway, artificial or natural, that allows blood to flow from an artery to a vein without going through a capillary network) for hemodialysis treatment and had and permacatheter (used for temporary access for dialysis) had an Emergency Kit at the bed side to manage a potential emergency bleeding for three out of 13 sample residents (2, 3, 11). Findings: a. According to the admission record, Resident 2 was admitted to the facility on June 1, 2012, with diagnoses that included diabetes mellitus (DM) type II, End Stage Renal Disease (ESRD), renal dialysis status. The Minimum Data Set (MDS) assessment dated September 13, 2012, indicated the resident had [redacted], and needed extensive assistance from the staff for all her activities of daily living (ADL). The resident had a physician's order dated June 1, 2012, for hemodialysis scheduled three times a week on Mondays, Wednesdays and Fridays. The care plan dated June 1, 2012, for care and precaution of Hemodialysis, the approach indicated if the shunt site is bleeding call the attending physician. However, the plan of care did not include interventions on how to handle	F 309		

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F 309	Continued From page 7 emergency associated with bleeding from the shunt. On October 5, 2012, at 6:10 p.m. during a tour with the Director of Nurses (DON), there was no emergency kit observed in the resident's room. During an interview with DON at the same time, he confirmed there was no emergency kit provided in the resident's room. DON stated the emergency kit was located in the treatment cart. On October 7, 2012, at 7:45 a.m., the resident was in her bed and her A-V shunt was observed on her left upper arm. During an interview with certified nursing assistant 2 (CNA 2) at the same time, CNA 2 stated there was no emergency kit in the resident's room and she would use the bed linens when there was bleeding observed from the resident's shunt or she would run to the nurses station to tell the charge nurse. b. According to the admission record, Resident 3 was admitted to the facility on June 1, 2012, with diagnoses that included diabetes mellitus (DM) type II, End Stage Renal Disease (ESRD), renal dialysis status and chronic obstructive pulmonary disease (COPD). The Minimum Data Set (MDS) assessment dated May 30, 2012, indicated the resident had intact cognition, and needed limited assistance from the staff for all her activities of daily living (ADL). The resident had a physician's order dated April 1, 2012, for dialysis scheduled three times a week on Tuesdays, Thursdays and Saturdays. On October 5, 2012, at 7:10 p.m. during a tour	F 309		

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F 309	Continued From page 8 with the Director of Nurses (DON), there was no emergency kit observed in the resident's room to manage potentila bleeding. On the same day and time during an interview with the DON, he confirmed there was no emergency kit provided in the resident's room. The DON stated the emergency kit was located in the treatment cart at the nurses station. Also there are tourniquets in the medication room that can be use.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a pressure relieving device was provided to a resident who had developed Stage II pressure ulcer to promote wound healing and prevent the development of new ulcer for one random resident (15). Findings: On October 7, 2012, at 1:05 p.m. during Resident 15's treatment observation on both buttocks area.	F 314	Resident #15 physician was immediately contacted with recommendation in a pressure relieving mattress. The physician's order was obtained and carried out timely. The care plan approach was appropriately updated to reflect positive action. The facility interdisciplinary team reviewed all care plans and physician's orders of all current residents to identify any residents needing additional pressure relieving devices, and ensure compliance. The Director of Nursing in-serviced all licensed nurses and CNA's regarding pressure sore prevention and healing promotion to ensure systemic changes promote positive outcome resident practices. The DON, Nursing Supervisors, Charge Nurses and DSD will monitor sustained performance through quality assurance daily resident rounds.	10/10/12 10/10/12 10/10/12 10/10/12

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F 314	Continued From page 9 the resident was observed lying in a regular bed with vinyl blue Chux under her body. According to the admission record, Resident 15 was admitted to the facility on July 2, 2012, with diagnoses that included hypertension, arthritis, and urinary retention. The Minimum Data Set (MDS) assessment dated July 15, 2012, indicated the resident was sometimes able to make herself understood and was able to understand others. The resident needed extensive to total assistance from the staff in the activities of daily living, but did not have unhealed pressure ulcers. A review of the Decubitus Report dated October 2, 2012, indicated there were Stage II pressure sore identified on both right and left buttocks. There was a plan of care developed on October 2, 2012, for the presence of pressure sore Stage II on buttocks. However, the approach plans did not include providing pressure relieving device in the bed. On October 7, 2012, at 3:40 p.m. during an interview with Registered Nurse 1, he stated the pressure relieving mattress should have been provided to the resident to prevent further deterioration of the skin. A review of the facility's Skin and Pressure Ulcer Protocol for Stage II Pressure ulcer indicated to provide pressure reducing/relieving devices to bed.	F 314	The Quality Assurance committee will monitor and evaluate effectiveness on a quarterly basis.	10/20/12
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER	F 315		

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F 315	Continued From page 10 Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a resident's urinary indwelling catheter was secured to prevent potential dislodgement of the catheter that may result in a trauma to the urethra, and failed to assess and to notify the physician the resident's tea colored cloudy urine with sedimentation collected into the urinary drainage bag for one random sample resident (15). Findings: According to the admission record, Resident 15 was admitted to the facility on July 2, 2012, with diagnoses that included hypertension, arthritis, and urinary retention. The Minimum Data Set (MDS) assessment dated July 15, 2012, indicated the resident was sometimes able to make herself understood and was able to understand others. The resident needed extensive to total assistant in the activities of daily living, and was always	F 315	The indwelling catheter for Resident #15 was immediately secured per facility nursing policy and procedure. Resident #15 physician was immediately contacted regarding the assessment of the drainage in the urinary drainage bag. The physician orders were carried out timely. The Interdisciplinary Team reviewed all residents with indwelling catheters to determine if any resident care actions were needed to ensure compliance. The DON and DSD in-serviced the licensed nurses and CNA's on indwelling catheter resident care practices including securing, assessment and notifying the physician to ensure systemic changes. The DON, Nursing Supervisors and Charge Nurses will monitor sustained performance through quality assurance resident rounds every shift. The Quality Assurance committee will evaluate effectiveness quarterly.	10/10/12 10/10/12 10/10/12 10/10/12 10/20/12

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F 315	Continued From page 11 incontinent in urine and bowel. A review of the Decubitus Report dated October 2, 2012, indicated there were Stage II pressure sore identified on both right and left buttocks. The resident had a physician's order dated October 3, 2012, for indwelling catheter 14 French (Fr)/5 cubic centimeter (cc). There was a plan of care developed on October 3, 2012, for the use of indwelling catheter secondary to presence of pressure ulcer on buttocks. The approach plans included to do indwelling catheter care as ordered and to monitor urine for color, sediments, blood and to call the physician as necessary. On October 7, 2012, at 1:05 p.m. during Resident 15's treatment observation on both buttocks area by Licensed Vocational Nurse 2 (LVN 2), the resident was observed lying in her bed with indwelling catheter in place. The resident's urine had sediments and was tea colored. The indwelling catheter was not secured and it was tensed because a part of the indwelling catheter was stuck under the resident's buttocks making the catheter taut from the urethral meatus (opening). The resident's urine collected in the drainage bag was cloudy and had sedimentations. During an interview with LVN 2 who was performing the treatment, she stated the indwelling catheter should have been secured. Also, there was no documented evidence the tea colored urine with sedimentation was notified to the physician as care plan indicated.	F 315		

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F 315	Continued From page 12 A review of the facility's policy /procedure of Indwelling catheter care indicated to secure the catheter to thigh with tape or catheter strap.	F 315		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure placement of gastrostomy tube (GT) was checked before medications were administered via GT, failed to ensure a licensed nurse who administered medications through a resident's gastrostomy tube (GT) followed procedures to prevent the entrance of excess air into the resident's stomach and potentially causing distention for one out of 13 sample residents (8). Findings: a.1. According to the admission record, Resident 8 was admitted to the facility on May 26, 2011, with diagnoses that included cardiovascular accident (CVA) with hemiparesis, dysphagia and gastrostomy status.	F 322	Resident #8 gastrostomy tube (GT) was immediately checked for placement and patency to ensure appropriate treatment, prevention and services. The Director of Nursing evaluated all licensed nurses clinical practices with residents with GT in regards to medication administration, placement check and patency check along with Lopez valve practices to identify any other practice actions. The DON and enteral consultant conducted an in-service for all licensed nurses regarding all aspects of GT clinical nursing practice to ensure compliance. The DON and enteral consultant will monitor systemic changes through quality assurance resident rounds specifically residents with GT on a random weekly basis. The Quality Assurance committee will evaluate effectiveness quarterly.	10/8/12 10/20/12 10/20/12 10/20/12 10/20/12

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F 322	Continued From page 13 The Minimum Data Set (MDS) Assessment dated June 8, 2012, indicated the resident was [redacted] needed extensive to total assistance from the staff in activities of daily living, and needed feeding tube for nutrition. The resident had a physician's order dated May 26, 2011, to check tube feeding placement and patency every shift. On October 6, 2012, at 8 a.m. during medication pass observation via GT for Resident 8, Licensed Vocational Nurse 2 (LVN 2) did not check placement/patency of the resident's GT. During an interview with LVN 2 at the same time, she stated she should have checked the placement of the GT. A review of the facility's procedure of the Enteral Medication Administration indicated to verify tube placement by inserting a small amount of air into the tube with the syringe and to listen to the stomach with a stethoscope for gurgling sounds. a.2. On October 6, 2012 at 7:55 a.m., during the medication pass observation, Resident 8 was observed in his bed with a GT in place, and there was a Lopez valve connected. Licensed Vocational Nurse 2 (LVN 2) was observed administering the eleven morning medications using a syringe barrel. LVN 2 turned off the pumping machine and administered the medications. Between administering medications, LVN 2 did not pinch GT or turn off the Lopez valve to prevent air from entering the resident's stomach. LVN 2 clamped the Lopez valve when she flushed GT with water. However, she allowed	F 322		

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F 322	Continued From page 14 the air to enter the resident's stomach by opening the Lopez valve first and then pouring the water. During an interview with LVN 2 at the same time, she stated she should have pinched or clamped the GT between administering different medications and flushing the GT with water. A review of Nursing Standard Practice indicates that in order to prevent air from entering the stomach during administration of medications, the nurse should pinch the GT before all the medication drained from the neck of the syringe barrel then, pour the next dosage of medication into the barrel. (Swearingen & Howard, Photo Atlas of Nursing Procedures, Third Edition, Pages 267-269).	F 322		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the residents' environment free of accident hazards by not securing televisions that could cause the potential for accidents in resident's rooms. Findings:	F 323	The televisions in rooms 1-A, 4-C, 6-B, 8-A, 9-A, 9-B, 10-B, 20-A, 20-C and 22-C were immediately secured to prevent potential accidents. All current facility televisions were inspected to identify other potential hazards and ensure compliance. The Administrator provided a one-on-one in-service with the maintenance worker regarding securing of all facility televisions to ensure systemic changes. The Administrator will monitor sustained performance through facility quality assurance environmental rounds on a random weekly basis.	10/10/12 10/20/12 10/20/12 10/20/12

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F 323	Continued From page 15 On October 5, 2012, between 5:50 p.m. to 6:30 p.m. during a tour of the facility, with Licensed Vocational Nurse 2 (LVN 2), the televisions in Rooms 1-A, 4-C, 6-B, 8 -A, 9 - A, 9 -B, 10-B, 12-B, 20-A, 20-C, 22-C were observed not secured to prevent potential accidents. During an interview with LVN 2, she stated the televisions should have been secured. A review of the facility's Maintenance and Plant operations indicated to make a routine daily inspection of the facility to ensure all fixtures are securely fastened, that the facility is clean and in good repair.	F 323	The Quality Assurance committee will evaluate effectiveness on a quarterly basis.	10/20/12
F 328 SS=E	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure residents received the correct volume of oxygen as directed in the physician's order and failed to ensure	F 328	The oxygen flow rate for Resident 5 and Resident 6 were immediately adjusted to 2 liters per minute via nasal cannula. The HHN tubing for Resident 6 was immediately changed and appropriately labeled. The HHN tubing and oxygen for Resident 5 was immediately replaced and appropriately labeled. All current residents with orders for oxygen and/or HHN treatments were assessed to identify other resident clinical practice needs and any action to be taken with rate administration, placement or labeling.	10/10/12 10/10/12 10/10/12 10/20/12

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F 328	Continued From page 16 respiratory care equipment such as oxygen tubes, and hand held nebulizer (HHN) tubes were properly labeled with dates and changed to prevent potential infection for two out of 13 sample residents (5, 6). Findings: a. According to the admission record, Resident 5 was admitted to the facility on October 3, 2012, with diagnoses that included pneumonia, atrial fibrillation, and congestive heart failure. The resident had a physician's order dated October 3, 2012, to administer oxygen at two liters per minute via nasal cannula as necessary for shortness of breath. There was a plan of care developed on October 3, 2012, for the use of oxygen due to shortness of breath and one of the approach plans was to have oxygen available if needed. On October 5, 2012, at 6 p.m. during an initial tour with Licensed Vocational Nurse 2 (LVN 2), the resident was in his bed sleeping receiving oxygen at 4 liters per minute. On October 7, 2012, at 7:35 a.m. the resident was observed receiving oxygen at 3.5 liters per minute. During an interview with Registered Nurse I on the same day at 7:55 a.m., after reviewed the physician's order, he stated the resident should have received the oxygen at 2 liters per minute as the physician ordered. b. According to the admission record, Resident 6 was admitted to the facility on September 21,	F 328	The DON in-serviced all licensed nurses regarding oxygen administration, oxygen tubing and HHN tubing, treatment and labeling to ensure compliance. The DON will monitor through quality assurance resident rounds on a weekly basis to ensure sustained clinical practices. The Quality Assurance committee will evaluate effectiveness quarterly.	10/20/12 10/20/12 10/20/12

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F 328	Continued From page 17 2012, with diagnoses that included aspiration pneumonia, acute respiratory failure, and hypertensive heart disease. The resident had a physician's order dated September 21, 2012, to administer oxygen at two liters per minute via nasal cannula as necessary for shortness of breath. There was a plan of care developed on September 21, 2012, for the use of oxygen due to shortness of breath and one of the approach plans was to have oxygen available if needed. On October 5, 2012, at 6 p.m. during an initial tour with LVN 2, the resident was in his bed sleeping and receiving oxygen at 4 liters per minute. On October 7, 2012, at 3:40 p.m. during an interview with RN 1, he stated the resident should have received the oxygen at 2 liters per minute as the physician ordered. c. On October 5, 2012, during a tour of the facility between 5: 50 p.m. to 6:30 p.m. in the presence of Licensed Vocational Nurse 2 (LVN 2), the following was observed. 1. Resident 6's HHN tubing was labeled on September 9, 2012. 2. Resident 5's HHN tubing and oxygen tubing were not labeled with date applied or changed. During an interview with LVN 2, she stated the HHN should have been changed every 7 days and the respiratory equipment should have been labeled with dates.	F 328		

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F 328	Continued From page 18 A review of the facility's policy for the Oxygen equipment indicted the tubing should be replaced every week or as needed.	F 328		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the kitchen was in good repair, and to ensure that foods were not stored beyond expiration date and used during best by date. Findings: On October 5, 2012, at 5:10 p.m., following was observed at the kitchen in the presence of dietary assistant 1. 1. There was chipping on the wall right above sink sized three inch by one inch. 2. Two cans of Chow Mein Noodle (one pound) was found in a dry storage room indicated best by April 29, 2012.	F 371	The expired kitchen dry food and food in refrigerator were immediately disposed of appropriately. The expired food in the resident's food refrigerator in the nurses lounge were disposed of appropriately. A temperature log was placed on the resident's food refrigerator in the nurses lounge. The wall chip above the sink in kitchen was repaired immediately. The 14 inch gap between floor and screen door leading outside the kitchen was replaced quickly. The Dietary consultant assessed the kitchen as a whole identifying any potential conditions needing action. The Dietary consultant in-serviced the entire kitchen staff regarding dry and refrigerated food, storing food, expired food monitoring and disposal, kitchen repairs and sanitary conditions to ensure compliance.	10/8/12 10/8/12 10/8/12 10/8/12 10/8/12 10/10/12 10/20/12

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F 371	Continued From page 19 3. One bag of Parmesan cheese (5 pound) half filled and opened on July 28, 2012, was found in a refrigerator. 4. One box of coconut flakes (10 pounds) opened on January 30, 2012, was in refrigerator. 5. One bag of corn tortilla (5.15 pound) was in a refrigerator expired on September 26, 2012. 6. There was an approximately 1/4 inch gap observed between the kitchen floor and screen door leading outside, and one fly was observed flying and landing on the kitchen equipment. During an interview with Dietary Assistant 1 at the same time, he stated the expired food should haven been removed. A review of the facility's policy and procedure of the Food Storage (additional policies for shelf life of dry and refrigerated storage) indicated as follows: If there is no expiration date on the package for the items such as cheese, discard packing, label date, and add a use by date not to exceed one month from the date opened. Expired foods shall be discarded immediately. b. On October 6, 2012, at 9 a.m., during the observation of the Resident's food refrigerator in the Nurses Lounge, inside the refrigerator were three jars of yogurt 6 ounces of 170 grams each that belonged to Resident 10, the yogurt had expired on August 1, 4, and 12, 2012, respectively. There was no temperature log	F 371	The Dietary consultant will monitor the dry and refrigerated food on a random weekly and monthly basis to ensure systemic changes are occurring. The Quality Assurance committee will evaluate effectiveness on a quarterly basis.	10/20/12 10/20/12

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F 371	Continued From page 20 maintained to ensure that foods stored in the refrigerator were maintained at the right temperature.	F 371		
F 425 SS=E	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure multiple medications would not be crushed together and administered through a gastrostomy tube (GT) in order to prevent the clogging of the GT and the potential for drug interactions (8), failed to shake a bottle of liquid multi-vitamin with minerals before pouring the medication in accordance with	F 425	Resident's #8, #10, and #16 were immediately assessed for possible signs or symptoms of potential drug interactions and for possible gastrostomy tube (GT) clogging. All current facility residents with GT and with physician's orders for eye drops and liquid medication orders were assessed for identification of potential needed practice actions. The Pharmacy consultant conducted an in-service with all licensed nurses regarding nursing practice and procedures for administering multiple medications into a GT, shaking liquid medication, and nursing practice and procedure of administration of eye drops to ensure compliance. The DON and Pharmacy consultant will monitor compliance through quality assurance medication pass observations on a random weekly and monthly basis for sustained systemic changes with nursing practice and procedures. The facility medication administration policy and procedures will be reviewed for any need for revision or amendment.	10/8/12 10/20/12 10/20/12 10/20/12 10/20/12

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F 425	Continued From page 21 the the manufacturer's instructions (10), for two out of 13 sample residents and failed to ensure eye medication was administered in accordance with accepted standard of nursing practice for one random sample resident (16). Findings: a. According to the admission record, Resident 8 was admitted to the facility on May 26, 2011, with diagnoses that included cardiovascular accident (CVA) with hemiparesis, dysphagia and gastrostomy status. The Minimum Data Set (MDS) Assessment dated June 8, 2012, indicated the resident was [redacted], and needed extensive to total assistance from the staff in activities of daily living. On October 6, 2012, at 7:55 a.m., during medication pass observation for Resident 8, Licensed Vocational Nurse 2 (LVN 2) crushed the following medications together in a small plastic envelope. 1. Norvasc 10 milligrams (mg) one tablet. 2. Metoprolol Tartrate 50 mg one tablet 3. Thiamin 100 mg two tablets. 4. Lasix 20 mg one tablet. 5. [redacted] 0.25 mg one tablet. 6. Calcium 500 mg with vitamin D one tablet. LVN 2 transferred all the crushed six crushed medications in a thirty cubic centimeters (cc) medication cup and added water, then poured the medications into a barrel of syringe connected to a GT.	F 425	The Quality Assurance committee will evaluate effectiveness quarterly.	10/20/12

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According to the current standard of nursing practice it is required to "Avoid mixing medications intended for administration through an enteral feeding tube. Most clinicians know they should not mix different drugs in the same IV bag or syringe without first ensuring the drugs' stability and compatibility; the same rule applies for solid and liquid dosage forms. It is hard enough to predict the stability for any one drug product altered for administration through a feeding tube; when more than one drug is administered at the same time, predicting stability and compatibility becomes even more difficult. Thus, when more than one drug is scheduled for administration, they must be given separately. The potential for drug-drug interactions [as well for those involving excipients (ensuring that the active ingredient stays "active.] increases when two or more dosage forms are crushed together. Crushing involves applying significant force to a drug product, and it increases the amount of particulates surface area available for interaction. Either can accelerate changes in the molecular structure and result in altered physical and chemical properties; such risks increase exponentially when more than one drug, with its excipients (active ingredient) is crushed." (American Journal of Nursing: Drug Administration, Through Enteral Feeding Tube, Joseph I. Boullata, PharmD. October 2009, Vol. 109 No. 10 pages 34-42).

During an interview with LVN 2 on October 6, 2012, at 8:30 a.m., she stated that she was not aware of the need to crush and administer the different medications separately to prevent

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F 425	Continued From page 23 compatibilities between medications and to prevent possible clogging. b. According to the clinical record, Resident 8 had a physician's order dated June 23, 2011, for multivitamin with minerals solution 5 cc to be administered daily. On October 6, 2012, at 7:55 a.m., during a medication pass observation, LVN 2 poured 5 cc of liquid multivitamin with mineral from a bottle. However, LVN 2 did not follow the manufacture's instruction that indicated to shake the bottle well before pouring. LVN 2 read the instructions on the bottles and stated she made a mistake and should have shaken the bottles before pouring. c. According to the admission record, Random Resident 16 was admitted to the facility on July 2, 2012, with diagnoses that included atrial fibrillation and glaucoma. The resident had a physician's order dated July 2, 2012, for Timolol 0.5 milligram (mg) one drop to both eyes two times a day. There was another order dated September 12, 2012, for Dorzolamide HCL 2 percent one drop to both eyes two times a day, and Brimonidine 0.15 percent one drop to both eyes two times a day. On October 6, 2012, at 9:05 a.m. during an observation of eye medication administration for Resident 16 by LVN 3, she instilled first eye medication directly on eye ball of the right and left eye after she pulled the resident's upper lid upward one by one. LVN 3 let go of the upper lid right after she instilled the eye medication. LVN 3 repeated two more times for two other eye	F 425		

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F 425	Continued From page 24 medications after she had waited five minutes each time. A review of the current standard of nursing practice indicates that the nurse expose the lower conjunctiva sac by exerting gentle traction on the area that is distal to the center of the lower eye lashes. This will form a pocket into which the nurse would instill the medication into the center of the conjunctiva sac. At the same time, apply a gentle pressure to the inner canthus to minimize the potential for systemic absorption through the tear duct (Swearingen & Howard, Photo Atlas of Nursing Procedures, Third Edition, Pages 83-85). On October 7, 2012, at 3:40 p.m. during an interview with RN 1, he stated the eye drop should have been instilled in the lower eyelid pocket instead instilling directly on the eyeball. A review oaf the facility's policy and procedure of Eye Drops Administration indicated to pull the lower eyelid down and away from the eyeball to form a pocket. To instruct resident to look upward, and place one drop into the pocket, continuing to hold the eyelid for a moment to allow the medication to distribute. d. According to the Admission record Resident 10, was re-admitted to the facility on March 18, 2012, with diagnosis that included diabetes mellitus, dysphagia and gastrostomy tube placement. a. On October 6, 2012, at 7: 55 a.m., during the medication administration observation, the Licensed Vocational Nurse 1 (LVN 1) was observed administering multiple medications to Resident 10, LVN 1 was observed crushing 10 different tablets medications together and poured	F 425		

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COLLEGE VISTA CONV HOSPITAL	4681 EAGLE ROCK BLVD. LOS ANGELES, CA 90041

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F 425	Continued From page 25 all of them into one cup. LVN 1 stirred the mixture together and administered through Resident 10's GT. The following medications were crushed together: 1. Clonidine 0.1 mg 1 tablet via GT two times a day. 2. Norvasc 10 mg 1 tablet via GT daily 3. Altace 10 mg 1 capsule via GT daily 4. Asprin 81 mg 1 tablet via GT daily 5. Plavix 75 mg 1 tablet via GT daily 6. Colace 100 mg 1 tablet via GT two times a day 7. Cozaar 100 mg 1 tablet via GT daily 8. Lopressor 25 mg 1 tablet via GT two times a day 9. Rantidine 150 mg 1 tablet via GT two times a day 10. Oscal with Vitamin D 500 mg 1 tablet via GT two times a day. These medications were all crushed together and administered together through GT. On that same day at 11 a.m., during an interview with LVN 1, she stated according to the facility's pharmacy consultant the licensed nurses no longer have to crush and administer multiple medications separately because these medications would be mixed in the stomach either way separately or not. On that same day at 11: 15 a.m., during an interview with the Director of Nursing (DON) he stated according to the guidelines for enteral administration of multiple medications through GT, each medication has to be crush and administered separately, however, the facility's consulting pharmacist verbally instructed the licensed nurses to crush and administer multiple medications together. The Don indicated this verbal statement was never confirmed in writing by the consulting pharmacist.	F 425		

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F 425	Continued From page 26 According to the facility's policy titled "Administration of Medications through an Enteral Tube" not dated indicated if administering more than one medication, flush with 5 to 10 ml of warm water between medications. See literature reference under (a) above.	F 425		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441	The basin, urinal and HHN tubing for Resident 3 were disposed of and the new health care equipment were labeled with the resident's room and bed number immediately. The facility drafted a policy and procedure for health care equipment identification to ensure prevention of potential spread of infection. The infection control coordinator made quality assurance infection control facility rounds to identify any and all possible affected care area equipment needs. The DON in-serviced the licensed nurses and CNA's on infection control practices including disposal of and labeling of health care equipment to ensure compliance. The DON will monitor sustained resident care equipment infection control performance practices on a random weekly and monthly basis through quality assurance resident rounds. The Quality Assurance committee will evaluate effectiveness quarterly.	10/8/12 10/20/12 10/20/12 10/20/12 10/20/12 10/20/12

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F 441	Continued From page 27 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that health care equipments such as basin, urinal and hand held nebulizer tubing were properly identified and dated to prevent the potential development and transmission of infection for one random selected residents (14). Findings: On October 5, 2012, at 6 p.m., during the initial tour of the facility, the following was observed: 1. In Room 10 there was a basin sitting on the floor under the resident's dresser with residents clothing inside that was not labeled to identify the user. There were two residents residing in the room. 2. There was a urinal Resident's 3 bed side. The urinal was not labeled to identify the user. The room was shared by two residents. 3. There was a hand held nebulizer tubing inside a plastic bag hanging at the bed side with label or date of use and when it should be changed on it. During an interview with Resident 3 on October 5, 2012 at 6: 20 p.m., Resident 3 stated he has the urinal for one year and he took it to dialysis treatment three day a week. He used the urinal at the center, washed it and brought it back to the facility to be used again when he went for dialysis	F 441		

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F 441	Continued From page 28 treatment. Resident 3 went on to indicate he had been in the facility for two years now and he was given two urinals, the first one was very dirty and was thrown away. During an interview with the Director of Nurses (DON), he stated the basin and the urinal belonged to Resident 3 but it should have been labeled with the resident's room and bed number for identification. The DON did not comment about Resident using one disposable urinal for one year. The facility was not able to provide policy and procedure on how to ensure that health care equipment such as bedpans, urinals and hand held nebulizer tubing should be identified in order to prevent the potential for spread of infection.	F 441		
F 500 SS=D	483.75(h) OUTSIDE PROFESSIONAL RESOURCES-ARRANGE/AGRMNT If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or an agreement described in paragraph (h)(2) of this section. Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and the timeliness of the services.	F 500	An immediate call was placed to the dialysis center for Resident #11 to confirm the physician's order for Wednesday subcutaneous injection at the dialysis center of Darbepoetin Alfa for Resident #11's physician. The Interdisciplinary Team reviewed physician's orders for all current residents receiving hemodialysis to identify any practice needs or action to be taken. The DON gave an in-service to all licensed nurses regarding hemodialysis center communication, physician's orders and documentation to ensure compliance.	10/8/12 10/20/12 10/20/12

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F 500	Continued From page 29 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to communicate with the Dialysis Center staff regarding administration of Darbepoetin Alfa injection 25 microgram (mcg)/0.42 milliliter (ml) at the dialysis center every Wednesday for one out of 13 sample residents (11). Findings: According to the admission record, Resident 11 was admitted to the facility on September 6, 2012, with diagnoses that included diabetes mellitus (DM) type II, End Stage Renal Disease (ESRD), renal dialysis status. The Minimum Data Set (MDS) assessment dated September 19, 2012, indicated the resident had intact cognition, and needed extensive assistance from the staff except in eating. The resident had a physician's order indicated the following: 1. Hemodialysis treatment three times per week (Monday, Wednesday, Friday) dated September 13, 2012 2. Darbepoetin Alfa injection 25 microgram (mcg)/0.42 milliliter (ml) to be given subcutaneously every week on Wednesday at the dialysis center September 6, 2012. There was a plan of care developed on September 19, 2012, for the risk of low hemoglobin and hematocrit as the resident had anemia. One of the approach plans was to give medication as ordered.	F 500	The Medical Records designee will monitor performance compliance and systemic changes through quality assurance medical record review audits on a random weekly and monthly basis. The Quality Assurance committee will evaluate effectiveness on a quarterly basis.	10/20/12 10/20/12

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F 500	Continued From page 30 A review of the Nurses Dialysis Communication Record dated September 12, 19, 26, 2012, and October 3, 2012, indicated there was no documented evidence the facility and the dialysis center had communicated regarding the administration of above medication. On October 7, 2012, at 3:40 p.m. during an interview with Registered Nurse 1, he was not able to find documented evidence that indicated the medication was administered at the dialysis center. RN 1 stated the facility nurse should have communicated with the dialysis staff regarding the administration of that medication to ensure the resident was administered that medication. A review of the Nursing Home Dialysis Transfer Agreement indicated the dialysis center shall provide to the facility information on aspects of the management of a designated resident s care related to the provision of dialysis services.	F 500		