Accepted by 36417, RN on 10/18/2016.

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FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055344	A. BUILDING _____ B. WING _____	R 09/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY VILLA CLAREMONT HEALTH	590 S. INDIAN HILL BLVD. CLAREMONT, CA 91711

(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 California Department of Public Health during a Follow-up survey. Representing the Department: 36417, RN, HFEN 35893, RN, HFEN 37379, RN. HFEN Total Sampled Residents: 15	{F 000}	Country Villa Claremont submits this response and Plan of Correction as part of the requirements under State and Federal law. The Plan of Correction is submitted in accordance with specific regulatory requirements; it shall not be construed as admission of any alleged deficiency cited or any liability. Preparation, submission and/or execution of this Plan of Correction does not constitute admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in this statement. Correction is prepared, submitted and/or executed solely because it is required by the provision of federal and state law. The provider reserves the right to challenge the cited findings if at anytime the provider determines that the disputed findings are relied upon in a manner adverse to the interest of the provider either by the governmental agencies or third party. Any changes to provide policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the federal rules of evidence code sections 1151 and should be inadmissible in any proceeding on that basis.	10/31/2016
F 322 SS=E	Highest Severity and Scope: E 483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that – (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) 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.	F 322	F 322 NG TREATMENT/ SERVICES – RESTORE EATING SKILLS Residents 29 and 30 were checked by the Director of Nursing Services (DNS) on 9/21/16 regarding G-tube placement and residual, no negative outcome noted. On 9/21/16, the DNS checked other residents who are on G-tube, no other residents are affected by the same deficient practice. On 9/22/16, the DNS and the Director of Staff Development (DSD) provided a 1:1 in-service and skills competency to LVN 3 and LVN 6 regarding the checking of G-tube placement and residuals prior to medication administration. The license nurses were in-serviced on 9/22/16 by the DNS and DSD regarding the checking of G-tube placement and residuals prior to medication administration. The DNS and/ or designee assigned by the DNS will review new admissions with G-tube orders regarding checking of G-tube placement and residuals prior to medication administration during the clinical meeting 5 times a week for 3 months.	10/31/2016

2016 OCT 13 AM 11:15
LOS ANGELES COUNTY HEALTH FACILITIES DIVISION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jan M. Ottens	Administrator Country Villa Claremont	10/13/2016

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 322	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility's staff failed to ensure that 2 of 11 sample residents (Randomly Selected Resident- RSR 29 and RSR 30) was provided proper gastrostomy tube care (G-tube- a tube inserted through a small incision in the abdomen into the stomach and is used for long-term nutrition and medication administration). The licensed nurse failed to check the resident's residual volume (amount of fluid volume in the stomach) prior to the administration of medications. This failure had the potential to affect health and safety of the residents. Findings: During an medication pass observation on 9/21/16 at 8:15 a.m. for RSR 29, LVN 3 was observed giving medications to the resident without checking the residuals. A review of the face sheet for RSR 29 indicated the resident was admitted to the facility on 5/6/16 with the diagnoses that included muscle weakness, hemiplegia (paralysis of one side of the body) and cerebrovascular disease (disease that affects the circulation of blood to the brain), and has a gastrostomy tube (GT- a tube passed into a resident's stomach through the abdominal wall to provide a means of feeding). The minimum data set (MDS- a standardized assessment and care planning tool) dated 8/6/16 indicated RSR 29 was assessed as having memory problems and was totally dependent in	F 322	The DSD and/or designee assigned by the DSD will conduct weekly random checks on residents with G-tube orders regarding checking of placement and residuals prior to medication administration. The DSD and/or designee assigned by the DSD will have a weekly log of her findings for 3 months. Any findings will be addressed with the license nurses for immediate follow-up. The RN Supervisor will validate the findings and will be corrected accordingly. Random checks of G-tube placement and residuals prior to medication administration per MD order will be done by the DSD and/ or designee assigned by the DSD quarterly and bi-annually thereafter for compliance. Policy, procedure, and processes will be evaluated annually and as needed. The DNS and/or designee assigned by the DNS will trend and analyze checking of G-tube placement and residuals prior to medication administration. A report will be submitted to the Continuous Quality Improvement Meeting for 3 months for further evaluation and/ or recommendation.	10/31/2016

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F 322	Continued From page 2 carrying out all activities of daily living from facility staff. During an interview with LVN 3 on 9/21/16 at 7:45 a.m., she stated that she forgot to check GT residuals prior to administering medications. She further stated that had she checked the residuals and if the residual output was higher than 60 milliliters (ml) then the physician should be called and the medication held. During a medication pass observation on 9/21/16 at 9:15 a.m. for RSR 30, LVN 6 was observed administering GT medications without checking residuals. On the same time and date LVN 6 acknowledged that he forgot to check the GT residuals. A review of the face sheet for RSR 30 indicated the resident was admitted on 5/9/13 and re-admitted on 2/17/16 with the diagnoses that included muscle weakness, dysphagia (difficulty swallowing) and pneumonia (lung inflammation caused by infection). The MDS dated 8/15/16 for RSR 30 indicated that the resident memory recall was intact and totally dependent in carrying out all activities of daily living from facility staff. During an interview on 9/21/16 at 10:40 a.m., with the director of staff development (DSD), she stated that the residuals should be checked prior to administering any GT medications and held if the residual amount was a large amount and the physician should be notified. She also stated that all staff was aware of checking residuals.	F 322		10/31/2016

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F 322	Continued From page 3 The facility's undated policy and procedures titled "Feeding tube- Administration of Medication", stated that medications are administered appropriately and safely when the resident has a feeding tube in place. The policy indicated that prior to administering medications the placement and residuals should be checked.	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, interview and record review the facility failed to ensure that accident hazard prevention measures were in place for 2 of 15 residents (Residents 25 and 23). For resident 25 the facility failed to identify interventions on the care plan of resident's specific behavioral problems of chewing and biting of items in Resident 25's environment, which had the potential for Resident 25 to sustain an injury or choke on a foreign object. For Resident 23, the facility failed to ensure that the resident's bedside was clear of clutter and equipment, which had the potential for the resident and staff to trip or block the bedside space that may be needed to assist the resident	{F 323}	F 323 FREE OF ACCIDENT HAZARDS/ SUPERVISION. DEVICES The care plan for Resident 25 was updated by the Interdisciplinary Team (IDT) on 9/22/16 and subsequently to address her behavioral problems of chewing and biting items. An IDT meeting was held on 9/22/16 with Resident 25's brother regarding her interests and chewing behavior. Resident 23's bedside clutter and equipment was discussed with resident by the IDT on 9/22/16 so assistance can be easily provided to him in case of an emergency or natural disaster. The IDT did their room rounds as assigned by the Administrator which included checking for safety hazards but not limited to keeping resident's rooms free of clutter as much as possible. The IDT met with Resident 23 on 9/29/16 and 10/12/16 which addressed his bedside clutter and equipment to avoid safety hazards and keep his room free of clutter. The IDT will conduct facility rounds at least 3 times a week to identify any issues regarding chewing/ biting items and room clutter/ equipment for 3 months. The Administrator and/or designee assigned by the Administrator will conduct random checks twice a week for 3 months. Random checks of chewing/ biting behaviors and room clutter/ equipment will be done quarterly and bi-annually thereafter for compliance. Policy, procedure and processes will be evaluated annually and as needed.	10/31/2016

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{F 323}	Continued From page 4 during an emergency. Findings: a. During an initial tour with LVN 7 on 9/20/16 at 1:53 p.m., Resident 25 was observed chewing bed linens and call bell. On the concurrent interview LVN 7 stated that resident exhibited this behavior very often since admission which was 7/3/10. During an interview with CNA 6 on 9/21/16 at 9:05 a.m., stated the facility staff takes away the linens from the Residents mouth when this behavior is exhibited. CNA 6 was unable to tell how often the resident exhibited the behavior. A record review of Resident 25's admission record indicated that the resident was admitted on 7/13/10 with diagnoses includes but not limited to history of traumatic brain injury (Injury of brain which occurs as a result of sudden trauma), Urinary Tract Infection (Infection occurs at any part of urinary system), Metabolic brain injury (Temporary or permanent damage of the brain sue to accident or disease). A review of Resident 25's MDS (Minimum data set), resident assessment and care planning tool, dated 7/25/16, identified the resident was not cognitively competent enough to identify the risks and behave accordingly. During an interview with LVN 6 on 7/22/16 at 8:32 a.m., mentioned that Resident 25 had this behavioral problem since Residents admission in 2010. LVN 6 stated the staff would give pain medication to the resident assuming the resident was in pain. LVN 6 further stated that the pain	{F 323}	Trending and Analysis on chewing/ biting behaviors and room clutter/ equipment will be done by the Administrator and/ or designee assigned by the Administrator. This report will be submitted to the Continuous Quality Improvement Meeting monthly for 3 months, quarterly and bi annually or as needed thereafter for compliance.	10/31/2016

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{F 323}	Continued From page 5 medication "works" for the resident and would stop chewing. A review of the careplan identified the problem of biting, chewing the linens, towels and own clothes on on 5/5/16, however there was no monitoring or supervision developed as part of the intervention when the biting, chewing the linens, towels and own clothes were exhibited. The administration of the pain medication was not identified. b. During the initial tour on 9/20/16 in the presence of LVN 8 and Administrator 2, it was observed that Resident 23's bedside between the bed and the wall was cluttered with equipment including 2 fans, a wheel chair, a shower chair, a cart with a television on it, and other items that were occluding the walkway. It was observed in the room that Resident 23 had a room mate to his right side of the bed. The clutter was to his left side of the bed. LVN 8 was asked if staff would be able to easily get to the cluttered side of the bed in the case of an emergency such as a medical emergency, an environmental emergency such as a fire, or natural disaster such as an earthquake. LVN 8 confirmed that assistance would not be easily provided to Resident on his left side of the bed during the case of an emergency or natural disaster.	{F 323}		
{F 441} SS=D	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.	{F 441}	A posted sign to "check with the nurses before entering" was placed at the door of Resident 24 on 9/20/16 to remind staff and visitors to observe infection control measures. The unlabeled wash basin in Resident 23's room was disposed and replaced with a new wash basin with a label by LVN 8 on 9/20/16. The fracture pan on Resident 31's room was disposed accordingly on 9/20/16.	10/31/2016

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{F 441}	Continued From page 6 (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. (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 infection control measures were implemented for 3 out of 15 sampled residents (Resident 24, Resident 23, and Resident 31). For Resident 24, the facility	{F 441}	The Director of Nursing (DNS) and Director of Staff Development (DSD) re in serviced the nursing staff on 9/20, 9/23, and 9/26/16 about the posted sign at the door of each resident's room who are on isolation so staff or visitors are aware they need to check with the nursing staff regarding isolation precautions and unlabeled basins or pans in the shared bathrooms. The Interdisciplinary Team (IDT) will conduct room rounds to each assigned room by the Administrator at least 3 times a week. The Director of Staff Development (DSD) and/ or designee assigned by the DSD will conduct resident's room rounds at least 3 times a week to observe if isolation signs are posted so precautions are followed and there are no unlabeled basins or pans in the shared bathrooms. Any findings will be corrected as identified and reported to the Director of Nursing Services (DNS) and Administrator for follow-up. Random checks of infection control related issues such as posted signs outside isolation rooms and unlabeled basins/pans will be done by the Director of Staff Development (DSD) and/or designee assigned by the DSD monthly x 3 months, quarterly and bi-annually thereafter for compliance. Policy, procedure and processes will be evaluated annually and as needed. Trends and issues concerning infection control practices will be reported by the DSD/ designee on a monthly basis to Quality Assurance (QA) Committee for analysis, management, and further evaluation x 3months, quarterly, and bi annually or as needed thereafter for compliance.	10/31/2016

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{F 441}	Continued From page 7 failed to provide a sign at the door to indicate that isolation precautions should be used with this resident. For Residents 23 and 31, the facility failed to ensure that their personal hygiene supplies were labeled. These failures had the potential for the spread of infection to other residents. Findings: a. The face sheet for Resident 24 indicated the resident was admitted on 9/12/16 with the diagnosis that included urinary tract infection, muscle weakness, and dysphagia (difficulty swallowing). During initial tour on 9/20/16 at 2:35 p.m., Resident 24 was observed with no sign posted at the front of the door. During an interview with licensed vocational nurse (LVN 6) on 9/20/16 at 2:45 p.m., LVN 6 stated that Resident 24 was placed on contact isolation for methicillin-resistant staphylococcus aureus (MRSA-infection is caused by a type of staph bacteria that's become resistant to many of the antibiotics used to treat ordinary staph infections). LVN 6 also stated that there should be a sign posted at the front of the resident's room that says "check with nurse's before entering." This was used to prevent the spread of infection so that anyone entering the room would be told by the staff to use proper protective gear (gown, gloves and goggles) before entering the room. The physician's order dated 9/13/16 indicated to place Resident 24 on contact isolation for MRSA in the wound, blood, and nares. The undated plan of care for contact isolation	{F 441}		

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{F 441}	Continued From page 8 identified the goal for Resident 24 was to observe and maintain contact isolation precautions every shift. The undated policy and procedure titled "infection control- policies and procedures" stated to provide infection control policies and procedures to maintain a safe, sanitary and comfortable environment for personnel, residents, visitors and the general public. b. During the initial tour on 9/20/16 in the presence of LVN 8, it was observed Resident 23's room had a wash basin with no label who it belonged to. There were two residents in room 23. LVN 8 stated each residents were supplied with wash basin for individual use. LVN 8 also confirmed there was no label on the wash basin as to who it belonged to. c. During the initial tour on 9/20/16 in the presence of LVN 8, it was observed in Resident 31's restroom that there was fracture pan without a resident-identifying label on it (a fracture pan is a bed pan that is more narrow and flat compared to a regular bed pan to allow for easier insertion under the buttocks for patients who have a difficulty in turning while in bed. Bed pans are used for residents to defecate or urinate in when unable to use a regular toilet or bedside commode). LVN 8 confirmed there was no label on the fracture pan.	{F 441}		10/31/2016
{F 460} SS=D	483.70(d)(1)(iv)-(v) BEDROOMS ASSURE FULL VISUAL PRIVACY Bedrooms must be designed or equipped to	{F 460}		

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{F 460}	Continued From page 9 assure full visual privacy for each resident. In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that full visual privacy was available at the same time for a shared room (Room 26). For room 26, the hanging privacy curtains did not fully surround both resident beds in the shared room, which had the potential to violate the residents privacy. Findings: During the initial tour on 9/20/16, it was observed that there were two privacy curtains hanging from the ceiling in room 26. One curtain extended to provide full visual privacy between each resident. LVN 8 was asked if the curtain at the foot of the bed for the residents extended far enough to ensure that each resident was covered. LVN 8 extended the curtain and confirmed that the curtain was not long enough to cover both residents at the same time; with the curtain fully extended, the beds for both 26 A and 26 B were not completely covered and were still visible.	{F 460}	9/20/16 Maintenance Supervisor placed an additional privacy curtain in room 26 in order to provide full visual privacy to residents in said room. The additional curtain fully surrounded both resident beds in the shared room. No negative outcome to the resident related to the deficient practice. Other resident rooms were inspected by Maintenance Supervisor to ensure residents had full visual privacy and no residents were found not having full visual privacy. Maintenance Supervisor, Department Heads and/or Designee will make rounds during regular business days and will report any findings in the stand up meeting. Findings will be reported to the administrator. Trending and Analysis will be done by the Maintenance Supervisor and /or designee and reports will be submitted during monthly Continuous Quality Improvement meeting for further evaluation and / or recommendations.	10/31/2016
{F 465} SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional,	{F 465}	Maintenance Supervisor on 9/20/16 replaced the said faucet for Resident 31, allowing the faucet to completely shut off with no water leaking. The Maintenance Supervisor inspected other faucets in resident rooms and no similar concerns/problems identified.	10/31/2016

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{F 465}	Continued From page 10 sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that the environment was functional for one of 15 sampled residents (Resident 31). For Resident 31, the water faucet in the restroom did not shut off completely and was leaking, which had the potential for flooding and water damage in Resident 31's restroom and room. Findings: During the initial tour on 9/20/16, it was observed in the restroom of Resident 31 that a water faucet was not completely shut off. LVN 8 was asked if the water was turned off completely. LVN 8 confirmed it was not and attempted to turn the water completely off. The water faucet continued to have water leaking. LVN 8 confirmed that the faucet should not have been leaking.	{F 465}	Maintenance Supervisor, Department Heads and/or Designee will make rounds daily and will report any findings in the stand up meeting. Findings will be reported to the administrator. Trending and Analysis will be done by the Maintenance Supervisor and /or designee and reports will be submitted during monthly Continuous Quality Improvement meeting for further evaluation and/ or recommendations.	10/31/2016