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

PRINTED: 10/22/2018
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
	555849	A. BUILDING _____ B. WING _____	10/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA DEL SOL CARE CENTER	11620 WEST WASHINGTON BLVD LOS ANGELES, CA 90066

(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 Recertification survey. Representing the Department of Public Health: Surveyor ID: 19096, RN, HFEN Surveyor ID: 36385, RN, HFEN Total population: 29 Total size: 12 Highest Severity and Scope: E	F 000	By submitting this Plan of Correction. Vista Del Sol care Center does not admit or concede the facts and contentions cited, or the existence or scope of severity of the deficiencies and conditions cited in the 2567. tThe Plan of Correction is submitted to comply with Federal and State Law. Vista del Sol care Center respects the allegations made in the 2567, has acted and will continue to act to implement this Plan of Correction.	
F 582 SS=E	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must– (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those	F 582	IMMEDIATE CORRECTIVE ACTION A copy of the SNF ABN form was given by the Administrator and Social Services Designee to the residents under Medicare Part A coverage. IDENTIFICATION OF OTHERS AT RISK Other residents in the facility under Medicare A coverage have the potential to be affected by the same practice. A list of residents under Medicare A coverage was reviewed by The Social Services Designee and the Administrator and a SNF ABN form given to the beneficiary/responsible party. there were no other residents affected by this deficient practice. PROCESS IN PLACE TO PREVENT REOCCURRENCE. The Administrator conducted an In-service Training with the Admissions Coordinator/ Social Services Designee pertaining to the following:	10/25/18 10/25/18 10/24/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator 10/31/18

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 582	Continued From page 1 services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide three (3) of three (3) randomly selected residents for Skilled Nursing Facility (SNF) Beneficiary Protection Notification Review, who received Medicare Part A services with a Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN) form. This deficient practice had the potential for the residents to not know	F 582	Continuation from Page #1 * Notification forms SNF ABN CMS 10055 and a copy of notification form and instructions.. * All services available in the facility and changes that are not covered under Medicare and Medical to be informed to the residents before or at the time of admission by the Admissions Coordinator/ Social Services Designee. MONITORING PROCESS The Admissions Coordinator/Social Services Designee and the Administrator will monitor and track residents under Medicare coverage on a weekly basis. Any findings will be discussed at the QAA Committee for follow up/resolution and continuous compliance.	10/24/18 10/24/18 11/6/18

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F 582	Continued From page 2 what items and services that were covered or not covered under Medicare / Medicaid during their facility stay. Findings: A review of the SNF Beneficiary Protection Notification form filled out by the facility for three of three discharged residents, indicated a copy of the SNF ABN-10055 was not provided to the beneficiary or the beneficiary's representative. During an interview with the Administrator in the presence of the Director of Nursing (DON) on 10/08/18 at 12:40 p.m., she stated at the present time they did not have a business office personnel for months, and had been trying to fill the position. The DON further stated she had been running all office transactions. The Administrator stated she was not aware of the form, but was going to discuss with the social services director (SSD) any paperwork was done to fulfill this requirement. During an interview with the social services director (SSD) on 10/08/18 at 1:31 p.m. , she stated she verbally informed the family of the charges and was not aware of a written form. A review of the resident's records indicated no documented evidence the residents were given verbal information regarding beneficiary information.	F 582		
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after	F 640	IMMEDIATE CORRECTIVE ACTION Resident #2 is no longer residing at Vista Del Sol care Center. On October 08, 2018, RN MDS Coordinator completed and submitted the Discharge MDS	10/08/18

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F 640	Continued From page 3 a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment.	F 640	Continuation from page # 3 Assessment for Resident # 2. IDENTIFICATION OF OTHERS AT RISK As all Residents are potentially affected by the alleged deficient practice contained herein, Vista Del Sol care Center will take corrective action in the facility. On October 27, 2018, RN MDS Coordinator did a sweep of all current Residents at the facility to ensure that all required MDS assessments are completed and submitted timely to CMS. On October 29, 2018, RN MDS Coordinator did a sweep of all the Admissions and Discharges from May 1, 2018 to October 29, 2018 to ensure that all required MDS Assessments are completed and submitted timely to CMS. No additional Residents were found to be affected by the alleged deficient practice contained herein. PROCESS OR SYSTEM IN PLACE TO PREVENT REOCCURRENCE: On October 29, 2018, the MDS Nurse Consultant conducted and completed a 1:1 In-Service/Training to the RN MDS Coordinator regarding Facility's Policy and procedure titled, "MDS Completion and Submission Time frames". On October 10, 2018, RN MDS Coordinator initiated a Monthly MDS Assessment Calendar for October 2018. RN MDS Coordinator will complete a monthly MDS Assessment Calendar that would reflect and track the needed MDS Assessments/ Entry Tracking for all the Residents.	10/08/18 11/06/18 11/06/18

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F 640	Continued From page 4 §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure one of three discharged residents (Resident 2) in a total sample of 22 residents had a discharge Minimum Data Set (MDS). This deficient practice resulted in not appropriately identifying the resident status to Centers for Medicare and Medicaid Services (CMS). Findings: A review of Resident 2's Resident Assessment facility task, a system-generated assessment tool for Resident 2, indicated an MDS that was 120 days overdue. During an interview and record review with the MDS nurse on 10/08/18 at 12:27 p.m., he stated he did not transmit Resident 2's discharge MDS to CMS after the resident was discharged on 5/10/18 (five months from when the resident was discharged). The MDS nurse stated did not have a calendar to track residents who needed their MDS reviewed. He missed transmitting the MDS for Resident 2. A review of the facility policy revised in September 2010 titled "MDS Completion and Submission Timeframes" indicated for a discharge assessment with a return to the facility not anticipated, the transmission timeframe was after 14 days calendar days from the MDS	F 640	Continuation from page # 4 The monthly MDS Assessment calendar will be updated at least 3x/week by the RN MDS Coordinator for every Resident admission, Discharge, Significant Change in Resident Status. RN MDS Coordinator will Highlight every MDS Assessment plotted in the Monthly MDS Assessment Calendar after it was successfully submitted to CMS. RN MDS Coordinator will submit completed MDS Assessments on a weekly basis and as frequent as needed. A copy of the Validation Report for every MDS Assessment submitted to CMS will be printed and filed in a Binder labeled "Validation Report" for record keeping and immediate availability for review. Administrator and DON will be given a copy of the completed Monthly MDS Assessment calendar after all the MDS Assessments are completed and submitted to CMS. Medical records Director will conduct a Weekly Audit for the Monthly MDS Assessment Calendar to ensure that all needed MDS Assessments are timely listed in the MDS assessment Calendar, completed and submitted timely to CMS. Verification of the Validation Report will be part of the Audit. Results of the Audit will be given to the RN MDS Coordinator, Administrator and DON. MONITORING PROCESS: At the direction of the QAA Committee, the Administrator and/or DON will conduct a weekly random check of 5MDS Assessments listed in the Monthly MDS Calendar and verify validation Report of the MDS Assessments. results of findings will be reported to the QA&A Committee for review and recommendation. The QA&A Committee will meet monthly and review progress x3months or until 100%	11/6/18

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F 640	Continued From page 5 completion date.	F 640	Continuation of page # 5 compliance is achieved.	11/6/18
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to	F 656	IMMEDIATE CORRECTIVE ACTION: On 10/08/18 a Care plan for Anticoagulants for Resident #16 was done by the DON. On 10/24/18 The Licensed Nurses were In serviced by the DON regarding Care Plans for residents who are on anticoagulants, including but not limited to side effects and proper handling of residents. IDENTIFICATION OF OTHERS AT RISK On 10/23/18 all residents who are on anticoagulants were audited by Medical records Designee to ensure that Care Plans for anticoagulants were in place and found no other residents affected by this deficiency. PROCESS OR SYSTEM IN PLACE TO PREVENT REOCCURRENCE. The Licensed Nurses will do a Care Plan for residents who are on anticoagulants upon receiving the order from the physician. MONITORING PROCESS: The Medical Records Designee will review the charts and medication records on a weekly basis, and will conduct monthly audits to ensure that all anticoagulants are care planned for it's use, and adverse effects. Any findings will be reported to the QAA Committee on a quarterly basis for follow up/ resolution.	

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F 656	Continued From page 6 local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to develop and implement a comprehensive care plan for two of 12 sampled residents (Residents 16 and 23). Resident 16 was placed at risk for bruising and bleeding. Resident 23 did not have a care plan for skin rashes. This deficient practice placed the residents at risk for inadequate interventions. Findings: 1. On 10/07/18 at 10:43 a.m., Resident 16 was observed in the activity room wearing sheer geriatric sleeves (used to protect the upper extremities from abrasions, bruises, snags and skin tears) to both arms. Blue-purple dark discolorations were observed on the exposed parts of the lower arms and hands. On 10/07/18 at 2:23 p.m., in the presence of the Registered Nurse (RN), dark purple discoloration were observed on Resident 16's wrists. The resident stated, "If you give me your hand, I can show you why." Resident 16 took the surveyor's right hand, and with the resident's right hand, pressed on the hand and stated "This is how I get these bruises, the staff holds me too tight." The	F 656	Continuation of page #6 IMMEDIATE CORRECTIVE ACTION: On 10/08/18 DON contacted Resident #16 responsible party regarding the use of an electric shaver vs. disposable razors in order to decrease the risk of cuts and bleeding during shaving. On 10/09/18 an electric Shaver for Resident #16 was provided by responsible party. On 10/26/18 The Licensed Nurses and Nursing Assistants were given an in-service by the DON/DSD on the use of disposable razors versus electric razors on patients that are on anticoagulants. IDENTIFICATION OF OTHERS AT RISK: All Residents on anticoagulants were identified by Licensed Nurses and checked for cuts/nicks and found no other Residents affected by this deficiency. PROCESS OR SYSTEM IN PLACE: All Residents who are on anticoagulants will use an electric razor. (family will provide). MONITORING PROCESS: The Social Services Designee will coordinate with family to ensure that the electric razor is available upon admission. Any findings will be reported to the QAA Committee on a quarterly basis for follow up/ resolution.	10/09/18 11/06/18

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F 656	Continued From page 7 resident stated that he has told the nursing staff but, "they don't listen". During the same observation with the RN, the geriatric sleeves were taken off the resident and revealed multiple dark purple discoloration along the right upper arm and wrist and the left forearm and wrist. The RN stated, "His skin is very fragile". A review of Resident 16's admission record indicated the resident was admitted on 1/26/18 with diagnoses that included cardiac arrhythmia (irregular heart rate) with the presence of a cardiac pacemaker and chronic obstructive pulmonary disease (COPD, a lung disease characterized by difficulty breathing). On 10/08/18, at 9:22 a.m. in the presence of Licensed Vocational Nurse 2 (LVN 2), Resident 16 was observed to have crusted dried blood over his right chin. LVN stated, "I would have to ask the CNA (Certified Nurse Assistant) what happened. It looks like the resident already had been given morning care because he has his clothing and is ready to get out of bed." LVN 2 stated that as far as she knew, the resident did not have an electric shaver. During an interview with Certified Nursing Assistant 3 (CNA 3) on 10/08/18 at 10:01 a.m., she stated she shaved the resident's face with a razor the day before. CNA 3 stated she cut the resident's chin because the resident was moving his head. CNA 3 stated she informed LVN 2 about the cut to the resident's chin. During a concurrent interview with LVN 2, she stated she notified the RN treatment nurse but she was not aware of any new orders for treatment for the cut	F 656	Continuation from page #7 Resident #23 was seen by the Dermatologist on 10/08/18. All other residents in the room of Resident #23 were checked for skin rashes or itching by Licensed Nurse on 10/08/18 and there were no rashes or itching identified. On 10/09/18 a care plan for skin rashes was done by the Licensed Nurse. On 10/09/18 and 10/10/18 the staff was in-serviced by DON in regards to Infection Control/ Skin Rashes. IDENTIFICATION OF OTHERS AT RISK: On 10/09/18 a skin sweep of all residents in the facility was conducted by Licensed Nurses and found no other residents with skin rashes. On 10/10/18 The Dermatologist and a Licensed Nurse conducted a skin sweep of all residents in the facility and found no other residents with rashes/itching. PROCESS OR SYSTEM IN PLACE TO PREVENT REOCCURRENCE: Residents will be monitored/evaluated on a weekly basis by treatment Nurse and confer with DON regarding any skin condition findings. MONITORING PROCESS: The Treatment Nurse will meet with the DON on a monthly basis and will report any skin related issues to ensure appropriate assessment and treatment. Any findings will be reported to QAA Committee on a quarterly basis for follow up/resolution.	11/06/18

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F 656	Continued From page 8 on the right chin. LVN 2 stated she was the treatment nurse and would need to notify the physician and the resident's family regarding the incident. ON 10/8/18 at 10:02 a.m., during an interview with Licensed Vocational Nurse 1 (LVN 1), who was responsible for administering medications to Resident 16, stated the resident was taking Plavix 75 milligram (mg) (a blood thinner) and Aspirin 81 mg. LVN stated when a resident are on those type of medications, "we monitor for bleeding and bruising." A review of Resident 16's physician's (MD) orders indicated the resident was ordered to receive Plavix 75 mg one tablet by mouth daily and Aspirin 81 mg one tablet by mouth daily, both for deep vein thrombosis (blood clot) prophylaxis. On 10/08/18 at 1:11 p.m., during an interview and record review with the Medical Records (MR) staff on the resident's care plans, indicated there were no care plans for risk for bleeding or anticoagulant therapy in the resident's medical record (chart). During an interview with the Director of Nursing (DON) on 10/08/18 at 10:08 a.m., stated Resident 16 had peripheral artery disease (circulatory problem in which narrowed arteries reduce blood flow to the extremities). The DON stated that because the resident was taking Plavix, there was a risk for spontaneous breakage of the vascular wall and bruising. The DON stated that when using a disposable razor, the nurse should be careful when it is used. The DON stated another option to decrease the risk for cuts and bleeding during shaving, was to ask the family to	F 656		

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F 656	Continued From page 9 provide an electric razor. The DON stated that "it should be care planned. There was no care plan, I will do one myself right now. 2. During an interview with Resident 23 on 10/06/18 at 2:27 p.m., she stated "I think I have fleas in my room on the bed." The resident stated she "Gets bit at night at it itches." The resident stated that she had told Certified Nurse Assistant 1 (CNA 1) and "she put some cream on my rashes." The resident stated she was unable to sleep comfortably at night because of the rashes and constant itching. The resident stated "I have to get up and walk. It's better to walk and itch rather than be lying down." A review of Resident 23's admission records indicated she was admitted to the facility on 5/16/16 and re-admitted on 3/24/18 with diagnoses that included malignant neoplasm of the lung (abnormal tumor growth) and hypertension (high blood pressure). A review of the resident's History and Physical dated 8/20/18 indicated the resident had the capacity to understand and make decisions. During an interview with Certified Nurse Assistant 2 (CNA 2) who was assigned to Resident 23 on 10/07/18 at 2:43 p.m., he stated he had only worked with the resident a few times and his regular CNA was Certified Nurse Assistant 1 (CNA 1) but she is not working today." During Resident 23's skin assessment with the Registered Nurse, treatment nurse on 10/08/18 at 2:50 p.m., raised pin point rashes were observed to the resident's lower back and bilateral arms. The resident was observed scratching her sides	F 656		

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F 656	Continued From page 10 while lying on the bed. A review of Resident 23's care plans with the medical records staff (MR), stated "there is no care plan for itching or rashes for the resident." During a interview with the Staff Developer (SD) on 10/07/18 at 4:29 p.m., she stated "body checks are done by CNAs daily and if there was a problem, the charge nurses are notified." "They are told to look out for redness, rashes, open areas, unusual swelling, skin discoloration and bruising and they are told to report immediately." The SD stated the charge nurse who was responsible for the resident had to develop a care plan and if there was a treatment, to carry out the treatment order." The SD stated for monitoring the status of rashes, it would take sometimes one week, sometimes two weeks and the treatment nurse should notify the physician (MD) or get a dermatology consult. During an interview and record review with the Director of Nursing (DON) on 10/08/18 at 11:00 a.m., the completed Center for Medicare and Medicaid Services (CMS) form 671 (resident census and conditions of residents) indicated 6 residents with rashes. However, a list of resident with rashes obtained from the RN treatment nurse only indicated 5 residents. The DON stated Resident 23 was not on the list a one of the residents identified with rashes. There was no previous dermatology consult.	F 656		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that	F 684		

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F 684	Continued From page 11 applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to accurately assess, identify and address three of 12 sampled residents (Residents 13, 30 and 86) who had generalized body rash/itching. This deficient practice caused the residents to not get adequate care for their body rash/itching and the treatment needed. Findings: 1. A review of Resident 86's face sheet indicated the resident was re-admitted to the facility on 5/7/17, with diagnosis that included urinary tract infection (An infection in any part of the urinary system, the kidneys, bladder, or urethra), dsyphagia (difficulty swallowing) pneumonia (lung infection) and muscle weakness. The minimum data set (MDS), a standardized assessment tool dated 6/18/18, indicated the resident is alert and cognitively able to make daily decision and requires total assistance in performing activities of daily living. During an observation of Resident 86 in the activity room on 10/7/18, at 9:30 a.m., Resident 86, was observed sitting in the wheelchair continuously scratching his arms, legs chest and stomach. The resident was observed with red	F 684	IMMEDIATE CORRECTIVE ACTION: On 10/08/18 Residents #86, #30 and #13 were checked by the Licensed Nurse. Residents #30 and #13 are roommates, Resident #86 has 2 roommates and no one had rashes or itching. A care plan for skin rashes for residents #86,#30 &#13 was done by Licensed Nurse on 10/08/18. On 10/11/18 Licensed Nurses were in-serviced by DON on Infection Control/Skin Rashes. IDENTIFICATION OF OTHERS AT RISK All Residents on that wing were checked for skin rashes and itching and 3 other residents were found to be having rashes and itching who are already on a regimen for rashes and itching as previously ordered by Dermatologist. Licensed Nurses will document the visits of the Dermatologist and will follow up on progress notes of MD's consultations. PROCESS IN PLACE TO PREVENT REOCURRENCE: The treatment nurse will check and follow up the skin assessments done/reported by nursing assistants every shift daily to ensure that all residents that have skin issues are properly assessed, reassessed and provided with treatment and referral to Dermatology as needed, care plan and document the response on each medication whether there is improvement or not responding to regimen ordered by the Dermatologist and what is the follow up plan on a weekly basis. MONITORING PROCESS: The treatment nurse will do skin sweeps and report findings to DON on a weekly basis to ensure all skin rashes & itching are responding well to treatment protocol and if not a referral to Dermatologist as needed.	10/08/18 10/08/18 11/06/18

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F 684	Continued From page 12 small circular marks his stomach. On 10/7/18, at 10:00 a.m., Resident 86 was observed with multiple small red circular spots on his stomach, legs, and back. Scratch marks were noted on both upper thighs and, ankles. During an interview with the treatment nurse and DON, they stated Resident 86 was being treated for itching and was given an ointment every twelve hours. A review of Resident 86's Physician's/Telephone orders Audit form indicates on 7/21/18, and 7/22/18, the physician ordered for the resident to receive Elimate (medication used to treat scabies, a condition caused by tiny insects called mites that infest and irritate skin) 5% head to toe avoid mucus membranes, and to wash off after 14 hours. On 8/4/18, at 2 p.m., Resident 86 had a physician order for the resident to been seen by a Dermatologist (a skin specialist) and for the resident to receive COAl trimcinolone ointment 1% (this medication is used to treat a variety of skin conditions (such as eczema, dermatitis, allergies, rash) to generalized body rash every day for thirty (30) days. On 8/9/18, Resident 86 had a physician order for the resident to receive Claritin 10 milligram (mg) every day for allergy and to discontinue trimcinolone ointment. Further review of the physician's order indicated to start Clotrimazole cream 1% (an anti-fungal medication used to treat yeast infection such as jock itch, body ringworm, and body rashes) everyday for thirty (30) days.	F 684	Continuation of Page #12 All findings will be reported to QAA Committee for follow up/resolution	11/06/18

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F 684	Continued From page 13 On 8/19/18, the resident had another physician order to administer Prednisone 40 mg (an medication to treat inflammation) by mouth every day for five days for itching. On 9/6/18, Resident 86 had another physician's order for the resident to be seen by a Dermatologist for skin rashes. A review of the Resident 86's Interdisciplinary Team (IDT, a coordinated group of experts from several different fields who work together toward a common goal) dated 8/9/18 indicated the IDT discussed the resident's continued itching despite prophylactic treatment. A review of the clinical record indicated no documented evidence of a Dermatology consultation as ordered by the physician on 8/4/18. 2. On 10/8/18, at 10 a.m., Resident 30 was observed lying continuously scratching her head, arms stomach, chest and legs. During an interview with Resident 30, the resident stated," I am itching all over my body and it bothers me." A review of Resident 30's clinical record indicated the resident was originally admitted to the facility on 7/1/15 and re-admitted on 8/21/18, with diagnoses that included gastritis (irritation of the stomach) and chronic kidney disease. A review of Resident 30's clinical records indicated the resident had a physician's order dated 8/21/18, to apply A & D ointment to the resident's left arm rash for 14 days, and Hydrocortisone cream 1% (a topical cream used to treat redness, swelling, itching, and discomfort of various skin conditions) twice a day for 14 days	F 684		

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F 684	Continued From page 14 to the resident's chest, right lower abdomen, and right lower back. A review of Resident 30's short term problems dated 8/21/18, for under arm rash, right lower abdomen rash, chest rash, and right lower back rash indicates to treat the resident's skin as ordered and to keep the skin clean and dry and notify physician of any changes. A review of Resident 30's IDT/Review of Diagnoses dated 8/22/18, indicated a body assessment on admission indicating the resident having skin rashes to the upper chest area left and right upper arm and lower back. A review of Resident 30's physician's order dated 9/5/18, at 1 p.m., for body rashes indicated to apply triamcinolone ointment to the resident everyday for 14 days. Further review of the resident's physician's orders dated 9/10/18 at 3:30 p.m., indicated to discontinue Claritin, and to start Benadryl (medication for allergies) 25 mg every night as needed. A physician order was also written for the resident to be seen by a Dermatologist. On 9/25/18, Resident 30 had a physician's order to apply Permethrin cream 5% for,"scabies" to the resident's neck to toe and to leave on for 8 hours before washing off. The order further indicated to clean linen in hot water. 3. On 10/8/18, at 10 a.m., Resident 13 stated she had a real bad itching problem at one point, but did not itch as much. A review of Resident 13's clinical record indicated	F 684		

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F 684	Continued From page 15 the resident was admitted to the facility on 1/12/18, with diagnosis that included muscle weakness. On 7/31/18, on the physician order was written to cleanse Resident 13's right thigh dermatitis (inflammation of the skin) with soap water, pat dry and apply skin barrier everyday for 30 days. A review of Resident 13's physician order dated 8/28/18 indicated for the resident to be seen by a Dermatologist. There was no care plan for the generalized rash/itching for the patients listed above. During an interview and review of the patients clinical records with the DON on 10/8/18, she stated the licensed staff should have developed a plan of care for the resident's rash and itching to ensure residents are treated appropriately and that skin conditions are identified and assessed properly. Review of the facility's policy and procedure revised December 2016, indicates, a comprehensive person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.	F 684		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed	F 755		

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F 755	Continued From page 16 personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. 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. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure: 1. Internal and external medications were kept separate. 2. There were no expired medications for one of 12 sampled residents (Resident 16) was stored with other residents' medications These deficient practices had the potential for medications via wrong route or receive	F 755	IMMEDIATE CORRECTIVE ACTION: On 10/08/18 all medication cabinets were checked by The Licensed Nurse for expired medications including internal and external medications. There were no other medication storage findings affected by this deficiency. IDENTIFICATION OF OTHERS AT RISK: Licensed Nurses to check the Medication room and ensure that there are no discontinued medications and that internal & external medications are stored separately. PROCESS OR SYSTEM IN PLACE TO PREVENT REOCCURRENCE On 10/26/18 an In service on Medication storage was given to Licensed Nurses by the DON. The licensed nurses will check check medication storage room and medication carts on a weekly basis to ensure that all expired medications and medical supplies are removed and disposed off accordingly. MONITORING PROCESS: The DON will conduct weekly inspections of the medication carts and medication storage cabinets to ensure the following: All expired medications are removed and disposed of according to facility Policy and standard disposal. All expired medications are re-ordered promptly from the pharmacy to replenish resident's medication and facility supply.	11/06/18

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F 755	Continued From page 17 medications that are ineffective. Findings: a. On 10/06/18 at 10:57 a.m., a medication storage room observation was conducted with Licensed Vocational Nurse. One medication cabinet was observed to have the following: 1. Two boxes of Bisacodyl suppositories containing 100 pieces of 10 milligram (mg) suppositories in each box. (house supply) 2. One box Bisacodyl suppositories containing 12 pieces of 10 mg suppositories (house supply) 3. Lactulose solution bottle 10 grams (G) per 15 milliliters (ml) 4. One bottle of Polyethylene Glycol 527 G oral powder b. During a medication storage room observation with Licensed Vocational Nurse 2 (LVN 2) on 10/06/18 at 11:00 a.m., one bottle of Nature thyroid [(a product made from animal thyroid glands to replace or supplement people with underactive thyroid (hypothyroidism)], 65 milligram (mg) tablet, one tablet by mouth everyday with instructions to discard after 8/18/18 for Resident 16 was found in the medication storage room together with other residents' medications. During a concurrent interview with LVN 2, she stated all licensed nurses were responsible for checking the expiry dates on medications. LVN 2 stated expired medications were not to be given to residents because there was a possibility it would not work and could have undue side effects. A review of an undated facility policy titled "Storage of Medications" indicated orally	F 755		

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F 755	Continued From page 18 administered medications are kept separate from externally used medications such as suppositories, liquids and lotions. Outdated, contaminated or deteriorated medications are immediately removed from stock, disposed of according to procedures for medication disposal and reordered from the pharmacy., if a current order exists.	F 755		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.	F 883		

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F 883	Continued From page 19 §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to maintain records for the pneumococcal vaccine administration for one of 12 sampled residents (Resident 86) and nine (9) of 29 total residents in the facility. This deficient practice placed the residents at increased risk for pneumonia (lung infection). Findings: During an observation on 10/07/18 at 11:00 a.m., Licensed Vocational Nurse 2 (LVN 2) and the	F 883	IMMEDIATE CORRECTIVE ACTION: All current residents, new admissions and re-admissions who did not have a record of vaccinations for Pneumonia and flu vaccine were offered both vaccinations. (To resident and responsible party. On 10/25/18 all Licensed nurses were in-serviced by DON on Influenza and Pneumoccocal vaccines . * Education of resident/responsible party regarding benefits and potential side effects of the vaccines before offering them. The vaccines are offered during the period between October 1, through March 31 every year; unless the immunization is medically contraindicated or the resident has already received the immunization during this period. The resident/responsible party have the opportunity to refuse immunization. * The Licensed nurses will document in the residents chart that the resident/responsible party have been provided education regarding the benefits and potential side effects of influenza or Pneumonia vaccine. * That the resident received or did not receive the influenza or Pneumonia vaccines due to refusal or medical contraindication. IDENTIFICATION OF OTHERS AT RISK: All residents who had refused the influenza or Pneumonia vaccine at the facility or the Acute Hospital were re offered the both vaccines and Risk and benefits explained Licensed Nurses to document in the chart whether the resident receive or refused the vaccinations or it was medically contraindicated.	10/25/18 10/25/18

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F 883	Continued From page 20 Director of Nursing was seen entering Resident 86's room. The resident was lying on his bed and complained of shortness of breath. The pulse oximeter (digital device used to measure percentage of hemoglobin [a protein molecule in red blood cells, which carries oxygen from the lungs to the body tissues]) reading was observed to be 94%. A review of Resident 86's admission records indicated he had diagnoses that included history of pneumonia (lung infection). A review of Resident 86's medical records (chart) indicated no influenza or pneumococcal vaccinations forms in the chart. During a review and interview of the influenza/pneumonia vaccine log for 2018 with the Director of Nursing (DON) on 10/08/18 at 11:45 a.m., indicated 10 (including Resident 86) out of 29 residents did not have a pneumococcal vaccine date recorded. The Centers for Disease Control and Prevention (CDC) recommended vaccination with the pneumococcal conjugate vaccine (PCV13 or Prevnar 13®) for all adults 65 years or older and people 2 through 64 years old with certain medical conditions (including those with chronic illnesses such as chronic heart, liver, kidney, or lung [including chronic obstructive lung disease (COPD), emphysema, and asthma] disease, diabetes, or those with conditions that weaken the immune system (HIV/AIDS, cancer, or damaged/absent spleen) or those who smokes cigarettes. The CDC recommends vaccination with the pneumococcal polysaccharide vaccine (PPSV23 or Pneumovax23®) for all adults 65	F 883	Continuation from Page #20 PROCESS IN PLACE TO PREVENT REOCCURRENCE. The admissions Coordinator will screen all possible admissions and obtain information regarding the residents immunization records for influenza and Pneumonia vaccine. If there is no record of resident having received the vaccines, the facility will offer them , explain risks and benefits and obtain consent from resident or responsible party. If the vaccinations are refused or are medically contraindicated this will be documented in the residents chart by the Licensed Nurses. MONITORING PROCESS: The Medical Records Designee will audit the charts on a weekly basis during the FLU season to check residents who have not received vaccinations for Flu and Pneumonia. All findings will be discussed at the quarterly QAA Meeting for review/resolution.	11/6/18

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

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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
	555849	A. BUILDING _____ B. WING _____	10/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA DEL SOL CARE CENTER	11620 WEST WASHINGTON BLVD LOS ANGELES, CA 90066

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F 883	Continued From page 21 years or older and people 2 through 64 years old with certain medical conditions. [https://www.cdc.gov/vaccines/vpd/pneumo/public/index.html] A review of the facility's undated policy and procedure titled "Pneumococcal Vaccine" indicated prior to admission, residents will be assessed for eligibility to receive the pneumococcal vaccine series and when indicated will be offered the vaccine series within thirty (30) days of admission to the facility unless medically contraindicated or the resident has already been vaccinated. Assessments of pneumococcal vaccine status will be conducted within five (5) working days of the resident's admission if not conducted prior to admission.	F 883		
F 912 SS=B	Bedrooms Measure at Least 80 Sq Ft/Resident CFR(s): 483.90(e)(1)(ii) §483.90(e)(1)(ii) Measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms; This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide at least 80 square feet (sq. ft) per resident in multiple resident bedrooms for ten out of 20 resident rooms. Findings: The facility submitted a written request for a continued waiver. The Request for Waiver letter dated October 6, 2018, signed by the Administrator for ten rooms	F 912	IMMEDIATE CORRECTIVE ACTION Administrator and Department Heads to conduct daily rounds to identify issues that may affect the residents daily routine in regards to mobility and over all comfort as a result of smaller rooms. IDENTIFICATION OF OTHERS AT RISK During facility rounds no room space related issues were identified that may affect or jeopardize the residents quality of life. PROCESS IN PLACE TO PREVENT REOCCURRENCE. The Administrator, Department Heads and Licensed Staff to conduct daily rounds to identify any potential adverse effects due to room space. Any other issues will also be discussed at the rResidents Council Meeting.	10/23/18 10/23/18 10/23/18

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F 912	Continued From page 22	F 912	MONITORING PROCESS The Activity Director and Social services Designee will report any findings to the QAA Committee for follow up/resolution.	10/23/18

was reviewed. The room waiver letter indicated these rooms did not meet the 80 square foot requirement per federal regulation. The letter indicated there is enough space to provide for each resident's care dignity and privacy and that the rooms are in accordance with the special needs of the residents, and would not have an adverse effect on the resident's health and safety.

The following rooms provided less than 80 square feet (sq. ft.) per resident.

Rm.	Beds	Sq/Feet	Sq.Ft/Res.
104	3	230	76.6
105	3	230	76.6
106	3	230	76.6
107	3	230	76.6
108	3	230	76.6
109	3	230	76.6
116	3	230	76.6
117	3	230	76.6
119	3	230	76.6
120	3	230	76.6

The minimum required square footage for a three bed room is 240 sq. ft.

During the general observation of the resident's rooms on October 6, 7 and 8, 2018, the residents had ample space to move freely inside the rooms, and there was sufficient space to provide freedom of movement for the residents and for nursing staff to provide care to the residents and space for beds, side tables and resident care equipment.