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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
i	555268	A. BUILDING _____ B. WING	02/12/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING LAKE VILLAGE	5555 MONTGOMERY DRIVE SANTA ROSA, CA 95409

(X4) ID PREFJX 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)	(XS) COMPLETION DATE
F DOD	INITIAL COMMENTS The following represents the findings of the California Department of Public Health during an annual Recertification Survey. Representing the California Department of Public Health: Health Facilities Evaluator Nurses 29797 and 32524. The facility census on 2/9/15, the day of entry, was 60 with no bed holds. There were 15 sampled residents and no random residents. There were no ERIs or complaints investigated during the survey.	F DOD	Spring lake Village Nursing Center (Facility) makes its best effort to operate in substantial compliance with both Federal and State Law. Nothing in this Plan of Correction is an admission otherwise. The facility has submitted this plan of correction in order to comply with its regulatory obligation and does not waive any obligations to the merits or form any allegations contained herein. Please note	3/12/15 LP
F 356 SS=D	483.3D(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request,	F 356	that the facility may contest the merit and or form of any of the deficiency findings alleged below and may take reasonable steps to appeal them. The facility is submitting this plan of correction as required by law as its written credible allegation of compliance for the alleged deficiencies noted. **Corrective action for residents affected by alleged deficient practice:** No residents were affected by the alleged deficient practice	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE Administrator | (X6) DATE 3/11/15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which tile 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 suivey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosabfe 14 days following the date these documents are.made available to the facilfty. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

POC Accepted. Administrator notified. 3/23/15
Linda Retuban HFE

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F 356	Continued From page 1 make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to post updated nurse staff information that included the hours worked by Registered Nurses (RNs) and Licensed Vocational Nurses (LVNs). This failure had the potential for residents, families and/or legal representatives to receive incomplete information about available staff hours per resident. Findings: During observation of the daily staffing numbers, on 2/9/15, at 11:55 a.m., the staffing document posted in the facility was dated 2/6/15. During an interview with Administrative Staff A, on 2/9/15, at 12:00 p.m., she stated that the staff responsible for the staff posting was thrown off by the arrival of the survey team. The facility policy and procedure titled " Posting of Daily Staffing Numbers", dated 10/07/11. "The facility will post, on a daily basis for each shift, the number of nursing personnel responsible for providing direct care to residents".	F 356	**How facility will identify residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents have the potential to be affected by the alleged deficient practice; therefore the facility has implemented a new process effective March 6, 2015, to verify that posting of the Daily Census sheet is done timely. **Measures or systemic changes made to ensure alleged deficient practice does not recur:** The Nursing Supervisor has the responsibility for posting the daily NHPPD. The Unit Secretary will verify the process has been done by the Nursing Supervisor and documented on the Daily Census Sheet. **How facility plans to monitor its performance to make sure the solutions are sustained, evaluation of the plans effectiveness and the integration of the POC into our quality assurance program:** The Unit Secretary will verify each day, when updating the daily census, that the Nursing Supervisor has posted the daily NHPPD. If the posting has not occurred, the Unit Secretary will notify the DON or Nursing	3/12/15 LP
F 441 SSF	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS			

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F441	Continued From page 2 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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 356 Con't	Supervisor. The Unit Secretary will keep daily documentation of this verification for review by the Administrator and Director of Nursing. This process will be reviewed quarterly at the Quality Assurance Performance Improvement Committee for compliance review and recommendation. **Completion Date**: March 12, 2015 **Corrective action for residents affected by alleged deficient practice:** No residents were affected by this alleged deficient practice. **How facility will identify residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** Since all residents have the capacity to be affected, the facility has implemented the following process. A check list has been developed and the housekeeping staff educated staring February 18, 2015, to test the efficacy of the Action D and also to document the expiration date of the test strips to ensure they are effective.	3/12/15
		F-441		

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F 441	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility housekeeping staff used expired test strips to check the concentration of cleaning solution. This had the potential to result in staff using ineffective cleaning solution, increasing the possibility of exposing staff, residents, and visitors to infectious diseases. Findings: During an observation and interview with Housekeeping Staff C, on 2/10/15, at 10:00 a.m., Housekeeping Staff C demonstrated testing of the strength of cleaning solution dispensed in the janitor closet. The Hydrion (brand of test strip used) test strips had an expiration date of 6/15/14. The facility policy and procedure titled, "Cleaning and Disinfecting of Equipment, dated 5/25/10, indicated "Manufacturers' instructions will be followed for proper use of disinfecting (or detergent) products including: a. Recommended use-dilution.	F 441	**Measures or systemic changes made to ensure alleged deficient practice does not recur:** The Housekeeping staff were educated on February 18 and 19th, 2015, to the Action D consistency check list, as well as documentation of the Test strips expiration date. The Housekeeping Supervisor; or designee, will monitor the check list as part of monthly facility rounds to ensure compliance with the check list and its accuracy. **How facility plans to monitor its performance to make sure the solutions are sustained, evaluation of the plans effectiveness and the integration of the POC into our quality assurance program** The Housekeeping Supervisor, or designee will submit a report to the Quality Assurance Performance Improvement Committee for review for at least the next three months to ensure the process is effective and then quarterly thereafter as needed for review and recommendation. **Completion Date:** March 12, 2015	3.12.15
F 518 SS= F	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. This REQUIREMENT is not met as evidenced by:	F518	**Corrective action for residents affected by alleged deficient practice:** No residents were affected by the alleged deficient practice.	

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F 518	Continued From page 4 Based on observation, interview and record review, the facility failed to ensure all employees were familiar with emergency procedures when, **1) 1** of 5 staff could not answer emergency questions correctly. 2) The emergency cart had not been checked one evening. Findings: 1) During a concurrent interview and observation with Laundry Staff D on 2/10/15, at 9:30 a.m., Laundry Staff D was unable to locate the water shut-off valve for the Laundry service. The facility policy and procedure titled "Orientation Program", dated 1/2004, indicated "The orientation program includes, but is not limited to:..... b. 3. Disaster Preparedness." The facility document titled "Spring Lake Village Emergency Prep for all Staff", undated, indicated "Water Shutoff for the Administration Building is located inside the Northwest corner Mechanical room, at the rear of boiler #2." 2) During a concurrent interview and observation, with Licensed Staff B on 2/10/15, at 11:10 a.m., the emergency cart checklist, titled "Modified Crash Cart Check", was not initialed on 2/9/15, to indicate that it had been checked. The facility policy titled, Modified Crash Cart, dated 05/14/14. indicated "Licensed Nurse will check the modified crash cart every PM shift."	F 518	**How facility will identify residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** Since all residents have the potential to be affected by both of these alleged deficient practices, the facility has implemented the following processes. 1. A sign was placed on the correct shut off valve for the laundry water. Laundry staff were reeducated to this shut off starting on February 13, 2015 2. The Nursing Supervisor will now check the crash cart log daily to ensure compliance. **Measures or systemic changes made to ensure alleged deficient practice does not recur:** 1. The Laundry staff was educated to the water shut off starting February 13, 2015 and a sign was posted next to the shut off valve. The Housekeeping Supervisor; or designee, will ensure compliance through semi-annual review follow up education.	3/12/15 LP

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F 518	Continued From page 4 Based on observation, interview and record review, the facility failed to ensure all employees were familiar with emergency procedures when, **1) 1** of 5 staff could not answer emergency questions correctly. 2) The emergency cart had not been checked one evening. Findings: 1) During a concurrent interview and observation with Laundry Staff D on 2/10/15, at 9:30 a.m., Laundry Staff D was unable to locate the water shut-off valve for the Laundry service. The facility policy and procedure titled "Orientation Program", dated 1/2004, indicated "The orientation program includes, but is not limited to:..... b. 3. Disaster Preparedness." The facility document titled "Spring Lake Village Emergency Prep for all Staff", undated, indicated "Water Shutoff for the Administration Building is located inside the Northwest corner Mechanical room, at the rear of boiler #2." 2) During a concurrent interview and observation, with Licensed Staff B on 2/10/15, at 11:1O a.m., the emergency cart checklist, titled "Modified Crash Cart Check", was not initialed on 2/9/15, to indicate that it had been checked. The facility policy titled, Modified Crash Cart, dated 05/14/14, indicated "Licensed Nurse will check the modified crash cart every PM shift."	F 518	2. The PM shift nurse on the 100 hall is assigned to check the contents of the modified Crash Cart and sign off on the log. Weekly, the Nursing Supervisor checks the log to ensure compliance. Nursing Supervisors will increase surveillance to daily for a minimum of three months to ensure compliance with the process. **How facility plans to monitor its performance to make sure the solutions are sustained, evaluation of the plans effectiveness and the integration of the POC into our quality assurance program:** 1 The Housekeeping Supervisor, or Designee will monitor Laundry staff monthly for three months to ensure compliance and semi-annually thereafter with reports to the Quality Assurance Committee for review and recommendation. 2 Nursing Supervisors will monitor the Modified Crash Cart Log for compliance daily. Results of the monitors will be reported to the Quality Assurance committee for review and recommendation for the next three months and then at least quarterly thereafter. **Completion Date:** March 12, 2015	3/12/15