[redacted] Accepted 1/07/13

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

PRINTED: 12/20/2012
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
Annie Woods (Digitally signed by Annie Woods DN: cn=Annie Woods, o=West District Office, ou=HFID, email=awoods@cdph.ca.gov, c=US Date: 2013.02.26 15:55:36 -08'00')	555004	A. BUILDING _____ B. WING _____	11/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAYA DEL REY CARE AND REHABILITATION CENTER	7716 MANCHESTER AVENUE PLAYA DEL REY, CA 90293

(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 and complaint(s) investigation. Complaint Intake #: CA00331290 - Substantiated Entity Reported Incident (ERI) Intake #: CA00332397 - Substantiated with no regulatory violations. Representing the Department of Public Health: 09697, RN, HFEN 22303, RN, HFEN 14065, RN, HFEN Total Population: 94 Sample Size: 19	F 000	THIS PLAN OF CORRECTION IS PREPARED AND SUBMITTED AS REQUIRED BY LAW. BY SUBMITTING THIS PLAN OF CORRECTION, PLAYA DEL REY CARE & REHABILITATION CENTER DOES NOT ADMIT THAT THE DEFICIENCIES LISTED ON THIS FORM EXIST, NOR DOES THE CENTER ADMIT TO ANY STATEMENTS, FINDINGS, FACTS, OR CONCLUSIONS THAT FORM THE BASIS FOR THE ALLEGED DEFICIENCY. THE CENTER RESERVES THE RIGHT TO CHALLENGE IN LEGAL AND/OR REGULATORY OR ADMINISTRATIVE PROCEEDINGS THE DEFICIENCIES, STATEMENTS, FACTS, AND CONCLUSIONS THAT FORM THE BASIS FOR THE DEFICIENCIES.	
F 166 SS=E	Highest Severity and Scope: E 483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure prompt efforts to resolve grievances a resident may have for five of seven residents that attended the Group Meeting. The residents express concerns over staff speaking	F 166	**Re: F 166 – 483.10(f)(2) Rights to Prompt Efforts to Resolve grievances** It is the policy of this facility that each resident has the right to prompt efforts by the facility to resolve grievances that a resident may have, including those with respect to the behavior of other residents. **Immediate Corrective Action:** The nursing staff was re-educated 11/12/12 by Director of Nursing Services/Designee on noise level in the facility to keep at a minimum. **Residents Potentially At Risk:** Residents by the nursing stations were identified as being at risk for being disturbed by a high noise levels in the facility by the Director of Nursing Services/Designee on 11/12/12	12/28/12

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

[signature] ADMINISTRATOR 1/3/13

deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that r safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days ving 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 following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued am participation.

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F 166	Continued From page 1 loudly among themselves. As a result, they had restless nights. Findings: During the Group Meeting on November 9, 2012, at 3 p.m., five of seven alert and oriented residents stated staff while providing care in their rooms or in the hallways, would speak loudly among themselves. They stated it made them feel useless when staff would talk among themselves while in their rooms. They further stated that staff would shout out to each other in the hallways. The residents stated it was worse during the evening shift and at nights when management was gone for the day. They stated they complained about this on many occasions and that management told them they were addressing the situation. During an interview with the director of nursing on November 10, 2012, at 10 a.m., he stated he was aware of the complaints and that staff has been working on resolving the above concern. He further stated they frequently give in-services to staff regarding noise level. However, he could not provide any documentation of in-services given to staff nor could he provide any documentation to support that the grievance was addressed. A review of the facility undated policy and procedure regarding Grievances indicates all resident grievances would be promptly addressed. The facility staff would make prompt efforts to resolve the problems a resident may have. The facility staff failed to implement the above policies for its residents.	F 166	**Actions Taken to Prevent Recurrence:** Staff on all shifts will be re-educated quarterly by Director of Nursing Services/Designee on noise levels to keep at a minimum in facility. Director of Nursing Services/Designee will do monthly rounds on all shifts for 3 months to monitor for noise level in facility. **Monitoring for Corrective Action:** Director of Nursing Services/Designee will report findings to the Performance Improvement Committee Meeting for three months or until substantial compliance is determined by the facility. The center staff will be responsible. Director of Nursing Services/Designee will monitor for compliance.	
F 176	483.10(n) RESIDENT SELF-ADMINISTER	F 176	**Re: F 176 – 483.10(n) Resident self-administer drugs if deemed safe** An individual resident may self administer drugs if interdisciplinary team, has determined that this is a safe practice **Immediate Corrective Action:** The medication was removed from Resident #2's bedside by Director of Nursing	12/28/12

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F 176 SS=D	Continued From page 2 DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the resident who was found with medication at bedside was assessed for self-administration of drugs for one of 19 sampled residents (2). This deficient practice had the potential to result in medication self-administration errors. Findings: Resident 2 was admitted to the facility on August 2, 2012, with admitting diagnoses of dysphagia (swallowing difficulty) and hypertension. A review of Minimum Data Set (MDS) assessment and care screening tool, dated August 30, 2012, revealed the resident's short and long-term memory was intact and required extensive assistance with his activities of daily living. On November 6, 2012, at 5 p.m., Resident 2 was observed holding a small tube labeled Neosporin ointment. When interviewed, he stated he brought it with him to treat his skin spot on his forehead. The registered nurse 1 (RN 1) who was with the evaluator during the tour helped Resident 1 applied the medication on his forehead.	F 176	Services/Designee 11/08/12. Resident was assessed for self administration by Interdisciplinary Team and was deemed unsafe for self- administration 11/0912. **Residents Potentially At Risk:** An audit of residents' residing at the facility was conducted by the nursing staff on 11/12/12 to determine whether any other residents with medications in their room have been assessed for self administration. There were no additional residents identified. **Actions Taken to Prevent Recurrence:** Interdisciplinary Team will assess residents on admission and those residing in center who wish to self administer medications. Residents that wish to have self administration for medication will be assessed quarterly for any changes by Interdisciplinary Team. The director of Nurses will conduct a monthly audit to ensure that residents who have medications in their room have been assessed for self administration. **Monitoring for Corrective Action:** Director of Nursing Services/Designee will report on residents that have self administration in place to the monthly Performance Improvement Committee Meeting for 3 months for substantial compliance or until compliant. The licensed Nursing staff will be responsible. Director of Nursing Services /Designee will monitor for compliance.	

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F 176	Continued From page 3 Further review of the resident's clinical record revealed no documented evidence Resident 2 was assessed for self-administration of medication. There was no physician's order for the Neosporin ointment medication. On November 10, 2012, at 1 p.m., the Director of Nursing (DON) stated he would assess the resident for self-administration of medication.	F 176		
F 246 SS=E	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, interview and record review, the facility failed to ensure resident's needs was provided in a timely manner, call lights were within reach and answered in a timely manner for one of 19 sampled residents (3) and six of seven alert and oriented residents that attended the Group Meeting. As a result, the residents expressed stress and anxiety and had potential. Findings: a. Resident 3 was admitted to the facility on	F 246	**Re: F 246 – 483.15(e)(1) Reasonable Accommodation of needs/Preferences** It is the policy of this facility that each resident has 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 **Immediate Corrective Action:** Resident #3 call light was placed within reach by nursing staff on 11/10/12. **Residents Potentially At Risk:** Director of Nursing Services/Designee completed check on other residents in center and found call lights were within reach for each resident on 11/10/12. **Action taken to prevent recurrence:** The Director of Nursing Services/Designee re-educated nursing staff on 11/10/12 to keep call light within reach for each resident and to answer call lights promptly according to centers policy and procedures. The Director of Nursing Services/Designee Staff will conduct weekly rounds to ensure that call lights are within reach for each resident and that each resident call light is answered promptly. **Monitoring for Corrective Action:** The Director of Nursing Services/Designee will report findings from these audits to the	12/28/12

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F 246	Continued From page 4 October 26, 2012, with admitting diagnoses that included chronic obstructive pulmonary disease (COPD). A review of Minimum Data Set (MDS) assessment and care screening tool, dated November 2, 2012, revealed that his short term and long term memory was intact and he required extensive assistance from staff with his activities of daily living. During the initial tour of the facility on November 8, 2012, Resident 3 was observed in bed receiving oxygen at 2 liters per minutes by a nasal cannula through an oxygen concentrator at bedside. Resident 3 verbalized that he had been calling for help at 12 noon. He indicated that he talk to one of the staff and that staff did not came back. Registered nurse 1 (RN 1) asked him if he used his call light to call for help and stated he did. Resident stated that he needed his breathing treatment. Further review of the Resident 3's clinical record revealed that on October 26, 2012, there was a physician's order for Ipratropium-Albuterol 0.5-2.5-3 (mg)/3ml solution inhalation every three hours every day and every 4 hours as needed for shortness of breath. Resident 3 was revisited at 6 p.m., and claimed that his treatment was already given by the license nurse. b. During the Group Meeting on November 9, 2012, at 2:45 p.m., six of seven alert and oriented	F 246	Performance Improvement committee monthly for 3 months or until substantial compliance is determined by the committee. The center staff will be responsible. The Director of Nursing Services/Designee will monitor for compliance.	

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F 246	Continued From page 5 residents stated that sometimes staff would take over 45 minutes to answer their call lights. Two of the residents stated staff would leave the call lights far from them and they would have to scream for help. One of the residents stated the staff would forget to put the call lights back where they can reach it. Four of the residents stated that it would take staff up to 45 minutes to answer the call lights, especially on the 3 p.m. to 11 p.m. shift. They stated it was stressful when staff would tell them to be patient because they did not have enough staff for the day. One of the residents stated his anxiety level would increase when he needed to use the restroom and staff would not answer his call lights in a timely manner. During an interview with the licensed vocational nurse 5 (LVN 5) on November 9, 2012, at 5 p.m., she stated she was aware of this and told management about it. During an interview with the director of nursing (DON) on November 10, 2012, at 9 a.m., he stated he would continue to in-service his staff to answer the call lights within 5 to 7 minutes. A review of the resident council meeting minutes for the month of August, September and October 2012, revealed the residents continued to complain about staff not answering the call lights in a timely manner. During an interview with the administrator on November 10, 2012, at 11:55 a.m., he stated the facility would immediately in-service all staff to keep the call lights within reach. The administrator stated staffs have been in-serviced many times to answer the lights within 5 minutes.	F 246	THIS PAGE LEFT BLANK INTENTIONALLY	

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F 246	Continued From page 6 A review of the facility policy and procedure dated April 2012, on Call Light Use indicates all call lights should be positioned in an area convenient for the resident to use and must be answered promptly. Staffs are to meet resident's needs and never make the resident feel you are too busy to give assistance. The facility staff failed to implement this policy for the residents that attended the group meeting.	F 246		
F 248 SS=E	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, the facility failed to provide an ongoing program of activities to meet the interests and psychosocial well-being of each resident for six of seven alert residents present at the group meeting. The residents stated they felt bad they have not been out of the facility for over a year. Findings: During the group meeting on November 9, 2012, at 2:45 p.m., six of seven residents stated they have not had activities away from the facility for over a year. They stated they were disappointed and sad when staff told them they did not have enough staff, transportation or money to take	F 248	**Re: F 248 – 483.15(f) (1) Activities Meet Interests/Needs of each Resident** It is the policy of this facility to provide an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and physical, mental, and psychosocial well-being of each resident **Immediate Corrective Action:** The Activity Director has been Re-educated by administrator to coordinate and provide an ongoing program to include regular resident outings with staff members on 11/09/12. **Residents Potentially At Risk:** Residents who wish to go on facility outings were identified by Activity Director on 11/09/12. **Actions Taken to Prevent Recurrence:** The Activity Director was re-educated by Administrator on scheduling regular ongoing resident outings with staff members 11/10/12. Regular resident outings will be placed on the monthly activity calendar. The Activity Director will coordinate these outings with other staff members. **Monitoring for Corrective Action:** The Administrator will audit the monthly activities calendar to ensure that resident outings have been scheduled.	12/28/12

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F 248	Continued From page 7 them out of the facility. They stated they use to go to the park but that has stopped because staff was not available to go with them. A review of the facility policy and procedure dated April 2010, titled "Community Outings/ Transport " , indicates the facility would coordinate regular resident outings with staff members. The Activity/Recreation Department in would make arrangements for transportation in advance of an outing. The facility will provide the resident population with regular opportunities to have interaction with the general community by providing outings on a regular basis. However, the facility staff failed to implement the above policy for the residents. During an interview and record review with the activity director on November 10, 2012 at 11 a.m., she provided the evaluator with a calendar of activities. There were no outings listed on the calendar for the month of August, September, and October 2012. The activity director stated they are in the process of making arrangements to provide the residents with an outing/field trip.	F 248	The Activity Director will report on monthly resident outings to the Performance Improvement Committee Meeting monthly for 3 months or until substantial compliance is determined by the committee. The Activities Director will be responsible. The Administrator will monitor for compliance.	
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record	F 250	**Re: F 250 – 483.15(g)(1) Provision of Medically related Social Services** It is the policy of this facility to provide medically related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for each resident **Immediate Corrective Action:** Resident #8 was scheduled to be seen by a podiatrist. Resident #6 was assessed by the Social Service Director for discharge to a lower level of care on 11/12/12.	12/28/12

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F 250	Continued From page 8 review, the facility failed to ensure the resident had podiatry consult/care and to have a discharge plan for resident who was independent with care for two of 19 sampled residents (6, 8). These deficient practices had potential for resident not receiving the necessary care/services they needed. Findings: a. Resident 8 was admitted to the facility on May 9, 2012, with diagnoses that included diabetes and dementia. A review of the resident's MDS dated June 12, 2012, indicated the resident was assessed as totally dependent on staff. The resident had a physician's order dated August 27, 2012, for podiatry consult/care. However, the facility's staff failed to follow the physician's orders. There was no documented evidenced that Resident 8 received podiatry consult/care. During an observation on November 8, 2012, at 6:50 p.m., Resident 8 was observed in bed with long and sharp toe nails. During an interview with the licensed vocational nurse 5 (LVN 5) at the same time, she stated it is the responsibility of social services to follow up on the podiatry care. During an interview with the social service designee on November 10, 2012, at 1 p.m. she stated she missed the physician's order. A record review of the facility's policy dated June 2010, titled "Social Services " indicates it is the responsibility of the social worker to ensure the	F 250	**Residents Potentially At Risk:** Other residents that reside in the center were evaluated for podiatry care needs by Director Nursing Services/Designee on 11/12/12. Social Services completed an audit on discharge planning for other residents that reside in the center on 11/14/12. **Actions Taken to Prevent Recurrence:** Social Services was re-educated by Administrator on providing Podiatry care services on regular basis for those residents that reside in the center. Social Services was re-educated by Administrator on 11/13/12 re: completing discharge planning on admission and quarterly for those residents that reside in the center. Residents will be assessed by the Licensed Nurse upon admission for need to have podiatric consultation. The Director of Staff Development/Designee will complete a monthly list of residents who need for podiatric care. The Social Services will complete discharge plan for each resident on admission and on a quarterly basis to include individualized care plan to be updated as the need requires and quarterly. **Monitoring for Corrective Action:** The Director of Staff Development/Designee will report monthly on residents that need podiatry services to the Performance Improvement Committee Meeting for 3 months or until substantial compliance is achieved. The Social Services will provide a monthly audit on status of resident with discharge planning needs to Performance Improvement Committee Meeting x 3 months or until substantial compliance is achieved. The Nursing staff and Social Worker will be responsible. The Director of Nursing Services/Designee will monitor for compliance.	

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F 250	Continued From page 9 physician's orders for medically-related social services, such as podiatry consults are completed in a timely manner. Medically-related social services are provided to maintain or improve each resident's mental and psychosocial needs. The social service worker failed to implement the above policy. She failed to refer Resident 8 for a podiatry consult/care. b. On November 8, 2012, a review of the clinical record for Resident 6 indicated that the resident was admitted to the facility on April 4, 2011, with diagnoses that include hypertension, diabetes mellitus and hyperlipidemia. A review of the MDS dated October 18, 2012, revealed that Resident 6 was independent with decision making and activities of daily living. The resident's vital signs were in normal ranges. The resident was taking all oral medications. On November 8, 2012, at 6:30 p.m., during an initial tour of the facility, the resident was observed sitting on her bed reading book. At 7 p.m., the resident was seen walking on the hallway with steady gait without using any assistive device. The resident looked well groomed and neat looking. During an interview with Resident 6 on November 8, 2012, at 7:30 p.m., she stated that she does everything by herself and loves to spend most of her time in her room. A review of the social work progress notes revealed that there was no documented evidence that the social worker had attempted to refer the resident to a lower level care facility as a part of	F 250	THIS PAGE LEFT BLANK INTENTIONALLY	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555004	A. BUILDING _____ B. WING _____	11/10/2012

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PLAYA DEL REY CARE AND REHABILITATION CENTER	7716 MANCHESTER AVENUE PLAYA DEL REY, CA 90293

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F 250	Continued From page 10 his discharge planning. During an interview with the social service staff on November 9, 2012, at 6:20 p.m., she stated that she did not do a discharge planning and she missed it. She also stated that she did not attempt to refer the resident for a lower level of care facility.	F 250		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a resident who was totally dependent on staff with activities of daily had clean fingernails for one of 19 sampled residents (8). The deficient practice place the resident at risk for low self-worth and embarrassment. Findings: During an observation on November 8, 2012, at 6:50 p.m., Resident 8 was observed with long dirty fingernails. The charge nurse stated it was very long and she would get a staff member to take care of it. A review of Resident 8's clinical record indicated the resident was admitted to the facility on May 9,	F 312	**Re: F 312 – 483.25(a) (3) ADL Care provided for Dependent Residents** It is the policy of this facility that a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. **Immediate Corrective Action:** Resident #8 fingernails were cleaned and trimmed by the nursing staff on 11/08/12. **Residents Potentially At Risk:** The Director of Staff Development /Designee examined fingernails on other residents that reside in the center. No other residents were identified from the audit completed on 11/12/12. **Actions Taken to Prevent Recurrence:** The Nursing staff was re-educated on ADL care and Dignity and Respect specifically related to fingernails and resident cleanliness on 11/09/12 by Director of Nursing Services/Designee. The Director of Nursing Services/Designee will complete weekly audits on resident cleanliness including fingernail care for monthly for three months or until substantial compliance is achieved. **Monitoring for Corrective Action:** The Director of Nursing Services/Designee will submit the results of these audits to the Performance Improvement Committee monthly for 3 months or until substantial compliance is	12/28/12

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F 312	Continued From page 11 2012, with diagnoses that included diabetes and dementia. A review of the resident's MDS dated June 12, 2012 indicated the resident was assessed as totally dependent with personal hygiene such as nail care. A review of the facility's policy undated for Routine Resident Care indicates it is the policy of the facility that basic nursing care tasks will be provided for each resident based on resident needs. These tasks are associated with a resident's personal cleanliness such as providing nail care to each resident. On November 9, 2012, at 5 p.m., an interview was conducted with licensed vocational nurse 6 who stated she was not aware who is responsible for providing nail care. She stated they did not have a policy/procedure in place regarding nail care and who would cut the resident's nails.	F 312	determined by the committee. The Nursing staff will be responsible. The Director of Nursing Services or designee will monitor for compliance.	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER 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	F 315	**Re:. F 315- 483.25(d) No catheter, prevent UTI, restore bladder** It is the policy of this facility that, based on each resident's comprehensive assessment , the facility must ensure that a resident who enters the facility without catheter is not catheterized unless the residents clinical condition demonstrates that catheterization was necessary ; and a resident that is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infection and to restore as much normal bladder function as possible. **Immediate Corrective Action:** Resident #2 had bladder assessment completed by Director of Nursing Services/Designee 11/10/12.	11/28/12

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F 315	Continued From page 12 review, the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to restore as much normal bladder function as possible for one of 19 sampled residents (2). This deficient practice place the resident at risk for low self-esteem and loss of dignity. Findings: Resident 2 was admitted to the facility on August 2, 2012, with admitting diagnoses of dysphagia (swallowing difficulty) and hypertension. A review of Minimum Data Set (MDS) assessment and care screening tool, dated August 30, 2012, revealed that his short and long term memory was intact and required extensive assistance on staff with his activities of daily living. The resident was also assessed as frequently incontinent of bowel and bladder (unable to control urine and/or feces). On November 8, 2012, at 5 p.m., during the initial tour, Resident 2 was observed with incontinent pad. This was again observed on November 9, 2012 at 2 p.m. to 6 p.m. On November 10, 2012, at 10 a.m., he stated that he can use the bathroom if somebody assisted him. The resident stated sometimes he cannot control to urinate and defecate when nobody helped him to go to the bathroom. On November 10, 2012, at 11 a.m., an interview with Certified Nursing Assistant 2 (CNA 2) confirmed that the resident can use the bathroom if being assisted.	F 315	Resident was placed on a toileting plan on 12/11/12 to restore as much normal bladder function as possible. **Residents Potentially At Risk:** The Interdisciplinary Team reassessed the residents who have episodes of bladder incontinence or changes in continence level. Residents identified were placed on scheduled toileting plan or bladder retraining program. **Actions Taken to Prevent Recurrence:** The Director of Nursing Services/Designee re-educated nursing staff on completion of the Bladder assessment and placing residents on a toileting program or bladder retraining program for those residents identified to have bladder incontinence or changes in continence level on 11/12/12. **Monitoring for Corrective Action:** The Director of Nursing Services/Designee will conduct assessments upon admission and quarterly or as needed for residents with incontinence to ensure toileting plans are developed according to bladder assessments and individualized needs. The results of these audits will be submitted to the Performance Improvement Committee meeting monthly for 3 months or substantial compliance has been determined by the committee. The Nursing staff will be responsible. The Director of Nursing Services/Designee will monitor for compliance.	

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F 315	Continued From page 13 The nursing assessment dated August 22, 2012, revealed Resident 2 bowel and bladder appliance was pads/briefs. There was no documented evidence a toileting plan was provided to restore as much normal bladder/bowel function as possible. On November 10, at 12 noon, the Director of Nursing (DON) was requested to provide the policy and procedure on bowel and bladder training program. However, it was not provided to the survey team.	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 the resident who had gastric tube (GT [a surgical opening into the stomach, may be used for feeding or medication administration]) feeding would have the formula bottle labeled for one of 19 sampled residents (4). This deficient practice place the resident at risk of not receiving the correct amount of feeding formula.	F 322	**Re: F 322 – 483.25(g) (2)** **NG Treatment/Services Restore Eating Skills** It is the policy of this facility that based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, naso-pharyngeal ulcers and to restore, if possible, normal eating skills **Immediate Corrective Action:** Resident #4's container of enteral tube formula was immediately labeled with residents name, room, date, start time and rate by Director of Nursing Services/Designee on 11/08/12. **Residents Potentially At Risk:** Other residents with gastric tube formula were re-assessed for proper labeling on 11/08/12 by the Director of Nursing Services/Designee. All other bottles were found to be properly labeled. **Actions Taken To Prevent Recurrence:** The Licensed nursing staff was re-educated on facility policy and procedures regarding labeling enteral feeding containers and to identify	12/28/12

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F 322	Continued From page 14. Findings: The clinical record indicated Resident 4 was admitted to the facility on May 9, 2012, with diagnoses that included diabetes mellitus and hypertension. A review of Resident 4's Minimum Data Set (MDS) assessment dated November 2, 2012, indicated the resident was moderately impaired with cognitive skills for daily decision-making and requiring extensive assistance on staff with activities of daily living, and had a gastric tube for feeding. There was a physician's order dated September 27, 2012, to administer Glucerna 1.2 at 75 cubic centimeters per hour (cc/hr.) for 20 hours via GT pump. Turn the pump on at 2 p.m. and off at 10 a.m. or until the dose limit was met. On November 8, 2012, at 6 p.m., during an initial tour of the facility, Resident 4 was observed sitting on his wheelchair with his gastric tube attached to GT pump running at 75cc/hour. There was a Glucerna 1.2 1000 cc feeding bottle hanging on a pole connected to the resident's G-tube pump. There was no label found on the feeding bottle that showed who and when the feeding was started, and the rate of infusion. During an interview with the registered nurse supervisor on November 8, 2012, at 7 p.m., she agreed the resident's feeding bottle should be labeled by the licensed nurse prior to administering the formula via feeding pump. According to the facility's policy and procedure	F 322	residents name, date, room, start time and rate 11/09/12 by Director of Nursing Services/Designee. **Monitoring for Corrective Action:** The Director of Nursing Services/Designee will daily examine enteral feeding bottles to ensure that enteral feeding container are labeled with identified resident name, room, date, start time and rate. Results from audit will be submitted to the Performance Improvement Committee Meeting monthly for 3 months or until substantial compliance is determined by the committee. The Licensed staff will be responsible. The Director of Nursing services will monitor for compliance.	

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F 322	Continued From page 15 entitled "Enteral Pump Protocol, the staff should label formula container with resident's name, room number, date, and delivery rate.	F 322		
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the resident was receiving the correct amount of intravenous (IV) fluids as ordered by the physician for one of 19 sampled residents (5). The deficient practice resulted to resident not receiving the amount of fluid as prescribed by the physician and placing the resident at risk for hydration. Findings: A review of Resident 5's Minimum Data Set dated October 24, 2012, indicated the resident cognitive skills for daily decision-making was severely impaired and was totally dependent on staff with activities of daily living, and had a gastric tube for feeding. There was a physician's order dated November 7, 2012, at 11 p.m., to hold GT feeding due to leaking through GT site and to administer D5-0.45 normal saline to give intravenously (IV) at 50 cc per hour times one bag, then follow-up with the physician.	F 327	**Re: F 327 – 483.25(j) Sufficient Fluid to Maintain Hydration** It is the policy of this facility to provide each resident with sufficient fluid intake to maintain proper hydration and health **Immediate Corrective Action:** Resident #5 no longer resides at the facility. All IV Regulators being used for hydration were replaced by IV Infusion pumps to ensure the correct infusion of fluids within the time ordered. **Residents Potentially At Risk:** The Director of Nursing Services conducted an audit of residents receiving hydration using IV Regulators that needed to be replaced by IV Infusion pumps 11/08/12. **Actions Taken to Prevent Recurrence:** IV Infusion pumps will be solely used in the future for residents requiring IV hydration. The Director of Nursing Services will re-educate licensed nursing staff on the use of IV Infusion pumps for hydration. The Director of Nursing Services/Designee will audit the use of IV pumps during daily rounds for residents receiving IV hydration. **Monitoring for Corrective Action:** The Director of Nursing Services will submit the results from these audits to Performance Improvement Committee Meeting monthly for 3 months or until substantial compliance is determined by the committee. The Licensed Nursing staff will be responsible. The Director of Nursing Services will monitor for compliance.	12/18/12

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F 327	Continued From page 16 On November 8, 2012, at 6 p.m., during the initial tour of the facility, Resident 6 was observed lying in bed with an IV heplock on her right arm. There was a D5/.46 normal saline IV bag (1 liter) infusing at 50 cc per hour using a IV regulator via gravity. The label on the IV bag showed a hanging date of November 7, 2012, at 11 p.m. and there was 300 cc's of fluid left in the bag. From the start time of infusion on November 7, 2012, at 11 p.m., to November 8, 2012, at 6 p.m., the resident should have received 950 cc's of IV fluid and there should only be 50 cc left in the IV bag. During an interview with licensed vocational nurse 3 (LVN 3) on November 8, 2012, at 6:30 p.m., she stated that she was not aware that the resident was on IV infusion and the day shift nurse did not mention the IV order during the change of shift report. During an interview with the registered nurse supervisor on November 8, 2012, at 7 p.m., she had no explanation why the resident did not received the correct amount of fluid as ordered by the physician. She also agreed the resident would be high risk for dehydration.	F 327		
F 328 ~~SS=B~~	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;	F 328	**F 328 – 483.25(k)** **Treatment/Care for Special Needs** It is the policy of this facility to 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 and suctioning, Respiratory care, Foot care and Prosthesis **Immediate Corrective Action:** The oxygen flow rate for Resident #7 was readjusted to 3 liters/min as ordered by MD	12/28/12

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F 328	Continued From page 17 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 the resident received prescribe amount of oxygen (considered as medication) for one of 19 sampled residents (7). This deficient practice resulted to resident receiving extra amount of oxygen and potential to cause medical complication. Findings: Resident 7 was admitted to the facility on October 28, 2012, with diagnoses that included pneumonia, dementia and hypertension. The Minimum Data Set (a standardized assessment tool) dated October 12, 2012, indicated the resident had short and long-term memory problems and that his cognitive skills for daily decision-making were moderately impaired. On November 8, 2012, at 5:45 p.m., the resident was observed in bed receiving oxygen via nasal cannula at 4 Liters per minute (L/min). However, a review of the clinical records with the registered nurse 2 (RN 2) revealed the physician's order for oxygen was 3 liters per minute (L/min). A review of the facility policy and procedure dated May 2009, titled "Oxygen Therapy /Nasal Cannula" revealed it is the responsibility of the facility staff to follow procedures to ensure the physician's order for oxygen rate is carried out in	F 328	11/08/12 by the Director of Nursing Services/Designee. **Residents Potentially At Risk:** An audit was conducted by the Director of Staff Development on 11/08/12, on the other residents receiving oxygen to ensure correct liter flow was being delivered as ordered by MD. There were no other residents with inaccurate liter flow. **Actions Taken to Prevent Recurrence:** The licensed nursing staff were re-educated by the Director of Nursing Services/Designee 11/09/12, on the necessity of following physicians' order regarding the flow rate for oxygen delivery. The Director of Nursing Services/Designee will review liter flow for residents receiving oxygen therapy to ensure they are receiving the correct liter flow according to their physician's orders. **Monitoring for Corrective Action:** The Director of Nursing Services/Designee will submit the results of his findings re: the oxygen flow of concentrators to the Performance Improvement Committee monthly for 3 months or until compliance is determined by the committee. The Licensed Nursing staff will be responsible. The Director Nursing services will monitor for compliance.	

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F 328	Continued From page 18 a correct manner. The oxygen must be set according to the orders.	F 328	**Re: F 458 – 483.70(d) (1) (ii) Bedrooms Measure at least 80 SQ FT/Resident**	12/28/12
F 458 SS=B	483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must 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's resident rooms did not meet the minimum size requirement of 80 square feet per resident in multiple-bed rooms. Findings: The following rooms did not meet the minimum requirement of 80 square feet for multiple-bed rooms: Room 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 15, 20, 21, 22, 23, 24, 28, 29, 30, and 31. The square feet per room of all the above rooms is 228. During the course of the survey conducted on November 8 to November 10, 2012, there were no problems observed with residents getting in and out of their rooms, nor were there any difficulties observed with staff delivering care to residents in the form of administering medications or assisting with personal hygiene. There was reasonable space and storage in each room. During the group meeting on November 9, 2012, at 3 p.m., none of the residents expressed	F 458	It is the policy of this facility that resident bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. **Immediate Corrective Action:** An application for a waiver of the room square footage requirement was respectfully requested on 11/10/12 by administrator. **Residents Potentially At Risk:** The rooms in question were inspected for negative living conditions or any conditions that may affect the physical or emotional health and safety of the residents, such as cleanliness, signs of clutter, personal space suitability, over-crowding, over-furnishing (too many personal items), ease of access for medical personnel, space availability for visitors, homelike environment, suitability for habitation, etc. due to room size. There were no negative conditions discovered. **Actions Taken to Prevent Recurrence:** No negative living conditions or any conditions that negatively affect the physical or emotional health and safety of the residents in the affected rooms due to room size were found. The facility will continue to monitor the condition of the rooms and the health and safety of the residents of these rooms for any indication of negative conditions. In addition, the Resident Council will be consulted on a regular basis to assist in determining whether negative conditions due to room size are arising. Concerns or problems in these rooms due to room size will be documented as a part of the facility's Concern/Grievance process and will be given directly to the Administrator. Following the facility's grievance process, the results of these concerns will be	

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F 458	Continued From page 19 problems with the size of their rooms.	F 458	reviewed by the Administrator and submitted to the Performance Improvement Committee monthly.	
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the laundry personnel failed to wash the soiled linen at a 160 degree Fahrenheit and above temperature according to the facility's washing temperature policy and procedure to disinfect the soiled linens. Findings: On November 10, 2012, at 12 p.m., during an inspection in the laundry area, two of the washing machines were observed on their wash cycle with water temperature of 100 degrees Fahrenheit. During an interview with the Maintenance Supervisor on November 10, 2012, at 12:30 p.m., he stated when washing isolation soiled linens, the water temperature should be on 160 degrees Fahrenheit. According to the facility's policy and procedure entitled "Laundry", indicated that wash water temperature must reach 160 degrees F for 25 minutes.	F 465	**Monitoring for Corrective Action:** As a part of the facility's Performance Improvement Committee Meeting, the Administrator will report on grievance trends regarding room accommodations. The Administrator will monitor for compliance **Re: F 465 – 483.70(h) Safe / Functional / Sanitary/ Comfortable Environment** It is the policy of this facility to provide a safe functional, sanitary, and comfortable environment for residents, staff and the public. **Immediate Corrective Action:** All linen that was washed after the last time the water temperature was known to be at or above 160°F had not yet been delivered to the floor. It was removed from service. A plumber was called immediately by the Administrator and the boiler supplying the hot water to the laundry was restored to proper functioning on 11/10/12. All improperly washed linen was re-laundered under proper conditions before being sent to the floor for use. **Residents Potentially At Risk:** An examination of all linen available for use determined that no improperly washed linen had been sent to the floor from the laundry yet. **Actions Taken to Prevent Recurrence:** Hot water temperatures will be checked daily to ensure proper cleaning operation. A log of water temperatures for the laundry operations will be kept daily to ensure normal operation of the water heaters by Maintenance Director.	12/28/12

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
	555004	A. BUILDING _____ B. WING _____	C 11/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAYA DEL REY CARE AND REHABILITATION CENTER	7716 MANCHESTER AVENUE PLAYA DEL REY, CA 90293

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			Regular preventive maintenance will be performed on the water heaters to maintain them in good mechanical condition. **Monitoring for Corrective Action:** As a part of the facility's Quality Assurance program, the Maintenance Supervisor will submit a monthly report to the Performance Improvement committee Meeting, on the status of any of the water heaters supplying the laundry and any adverse issues with the heaters will be brought up to the committee for possible solutions to the problems for 3 months or until substantial compliance is determined by the committee. The Maintenance Director will be responsible. The Administrator will monitor for compliance.	