Plan of Correction reviewed and approved 6-7-2012 by 07598

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A137	A. BUILDING _____ B. WING _____	03/31/2012

HEALTH FACILITIES INSPECTION DIVISION ADMINISTRATION
2012 AUG 23 AM 10:09
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL PARK A CENTER OF EFFECTIVE LIVING	1425 LA[illegible] POMONA, CA 91767

(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 represents the findings of the Department of Public Health during a Recertification survey. Representing the Department of Public Health: 07598 09697 10115 Total Resident Sample: 11 Total Resident Population: 43 Highest Scope and Severity = F	F 000	**"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Laurel Park does not admit that the deficiency listed on this form exist, nor does Laurel Park admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. Laurel Park reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."** **Michael A. Gassis**	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on interview, the facility staff failed to promote care to enhance each resident's dignity by providing privacy during intimate relationship for two of three special needs residents. Findings: On March 31, 2011 at 2:30 p.m., a group meeting with special needs residents (deaf and mute) was	F 241 SS D 483.15 (a) pages: 01-02	**F 241; SS=D; 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY** **A. What and how corrective action(s) will be accomplished, both temporarily and permanently, for those patients, employees, and/or facility operations identified/found to have been affected by the deficient practice:** **Starting 03.29.12: Staff Development Coordinator and Assistant Program Director coordinated and completed an in-service with facility personnel on the policies and procedures regarding dignity and respect including, but not limited to, confidentiality, visual privacy, staff announcement prior to entering resident private areas (appropriately announcing self via knocking and verbal announcement with hearing residents and turning the light on and off numerous times with deaf residents), respect, and dignity. This inservice provided personnel with education on assuring the deficient practice is corrected and does not reoccur.** **B. How the facility will identify other patients, employees, and/or facility**	**E. Dates when corrective action will be completed:**

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X5) DATE
	MICHAEL A. GASSIS, ADMINISTRATOR	05.04.12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 241	Continued From page 1 conducted with the facility ' s sign language interpreter. The facility had a total population of 8 deaf and mute residents. There were 5 residents who attended the group meeting and expressed that they were left out during the regular group meeting earlier. Two of five residents expressed that the facility staff should be more attentive to their needs by providing privacy especially if they are having intimate relationships. The residents further stated that some of the staff just open the privacy curtain while they are having intimate relationships, and before the staff flip the lights on and off several times as warning signs that the staff are approaching. The two residents further stated that they have to hurry up and get dressed up. On March 30, 2012 at 4 p.m., the Administrator was informed of the concern and stated that additional training regarding communication with the special needs residents (deaf and mute) will be provided to all staff.	F 241	**operations having the potential to be affected by the same deficient practice and what corrective action(s), both temporarily and permanently, will be taken:** **Starting 03.29.12: Staff Development Coordinator and Assistant Program Director coordinated and completed an in-service with facility personnel on the policies and procedures regarding dignity and respect including, but not limited to, confidentiality, visual privacy, staff announcement prior to entering resident private areas (appropriately announcing self via knocking and verbal announcement with hearing residents and turning the light on and off numerous times with deaf residents), respect, and dignity. This inservice provided personnel with education on assuring the deficient practice is corrected and does not reoccur.** **C. What immediate measures will be put into place and/or what systematic changes the facility will make to ensure the deficient practice does not recur:** **Starting 03.29.12 and weekly: Administrative and supervisory staff randomly observe staff for appropriately announcing self prior to entering resident private areas. Staff encourage residents to communicate to administrative and supervisory personnel their issues with staff appropriately announcing self prior to entering resident private areas. Upon identification of issues, administrative and supervisory staff counsel and educate personnel. As needed, Staff Development Coordinator and Assistant Program Director coordinate and complete in-services with facility personnel on the policies and procedures regarding dignity and respect including, but not limited to, confidentiality,**	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility staff failed to practice accepted professional standard of practice by pre-pouring the residents medications.	F 281		

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F 281	Continued From page 2 Findings: On March 30, 2012 at 4 p.m., during medication pass observation at the nursing station, the licensed vocational nurse prepared several patients medications in the medication room and placed the medications in the medication cup on the tray. On the same day, at 4:30 p.m., the residents were observed lined up outside of the nursing station. The LVN stated the residents were waiting to take their medications before they go for dinner. The LVN then identified the residents and gave the pre-poured medication with the residents choice of water or juice. After giving each of the residents their medication, the LVN asked each resident to open their mouth so she could check to see if the residents swallowed their medication completely. On the same day, at 5 p.m., the Director of Nursing (DON) was asked about pre-pouring medications. The DON stated that it has been the practice of the facility to pre-pour the medications due to the residents having psychological diagnoses. The evaluator requested the facility policy or waiver regarding pre-pouring the medications. The DON did not provide the facility policy or waiver to the survey team, and stated that the facility had no policy regarding pre-pouring the residents medications.	F 281	**visual privacy, staff announcement prior to entering resident private areas (appropriately announcing self via knocking and verbal announcement with hearing residents and turning the light on and off numerous times with deaf residents), respect, and dignity. This inservice provides personnel with education on assuring the deficient practice is corrected and does not reoccur.** **D. How the facility plans to monitor its performance to make sure that solutions are sustained (description of the monitoring process and positions responsible for monitoring). The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system:** **Starting 03.29.12 and weekly: During the weekday Clinical At Risk Evaluation/Facility Rounds and Stand-Up Meetings and during monthly facility resident council meetings, Social Services Designee, as a member of the Performance Improvement Committee, continues to address facility resident concerns with facility residents and facility personnel related to facility resident dignity and respect including, but not limited to, staff announcement prior to entering resident private areas. Performance Improvement Committee continues with necessary follow through to address identified issues. All above stated weekly Performance Improvement actions are reviewed, at least quarterly, by the Performance Improvement Committee for success, areas of improvement, and necessary future action.**	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain	F 309		

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F 309	Continued From page 3 or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility's nursing staff failed to follow the physician's orders and failed to update Resident 7's treatment plan to reflect the resident's current status, for one of 11 sample residents (Resident 7). Resident 7 had a physician order to have blood drawn for laboratory (lab) tests, but the facility failed to follow the physician's orders for drawing blood. Resident 7 also had a physician's order to receive medication for a rash to her extremities. The nursing staff failed to update the treatment plan, and continued to administer the medication after the resident's rash to the extremities had healed. Resident 7 had an incomplete physician's order for eye drops to be administered, but the facility did not clarify the order. Findings: a. 1. On 3/31/12, a review of the clinical record for Resident 7 revealed the resident was admitted to the facility on 9/2/11, with diagnoses that included impulse control disorder, and personality disorder. A review of the Minimum Data Set (MDS), a standardized assessment and care planning tool, dated 3/10/12 revealed that Resident 7 initially had no observable problems with her cognitive (mental) level. The resident was also	F 309 F 281 SS D 483.20 (k) (3) (i) pages: 02-03	**As needed, Staff Development Coordinator and Assistant Program Director coordinate and complete in-services with facility personnel on the policies and procedures regarding dignity and respect including, but not limited to, confidentiality, visual privacy, staff announcement prior to entering resident private areas (appropriately announcing self via knocking and verbal announcement with hearing residents and turning the light on and off numerous times with deaf residents), respect, and dignity. This inservice provides personnel with education on assuring the deficient practice is corrected and does not reoccur.** **F 281; SS=D; 483.20(k)(3)(i)** **SERVICES PROVIDED MEET PROFESSIONAL STANDARDS** **A. What and how corrective action(s) will be accomplished, both temporarily and permanently, for those patients, employees, and/or facility operations identified/found to have been affected by the deficient practice:** **As the Laurel Park has maintained this practice for more than 30 years in order to maintain the security of the medications, improve mediation compliance of the resident population, and mitigate resident physical aggression during medication pass, Laurel Park respectfully submits a program flexibility approval request to the Department (SEE ATTACHED). Facility personnel continue to assure that the services provided meet the professional standards required by regulation, policy and procedure, and resident population behavioral, psychiatric, and emotional presentations.** **B. How the facility will identify other patients, employees, and/or facility**	5.04.12 E. Dates when corrective action will be completed:

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F 309	Continued From page 4 independent in activities of daily living. A review of the physician's orders dated 9/19/11, revealed the following for Resident 7: Nystatin-triamcinolone 100000-0.1 unit/GM-(gram) % (percent) cream topical (external), twice a day, every day, and apply to affected areas (Minor rashes on lower extremities) until healed. On 3/29/12, a review of the medication administration record (MAR) revealed Resident 7 was currently receiving treatment according to the physician's order for rashes to the lower extremities. A review of the quarterly nursing assessment dated 12/4/11 and 3/4/12 indicated that Resident 7 had no skin condition, although the resident was still being treated for the rash. On 3/31/12, during a review of Resident 7's short term skin treatment care plan entitled, " Lower extremities, eczema, rashes, and discoloration revealed documentation in the form of a nursing note dated 3/7/12, indicating that Resident 7's lower extremities had no redness, eczema, or discoloration. Documentation also indicated that the rashes were healing well. As of 3/31/12, there were no entries by the licensed nurse after 3/7/12. On 3/31/12, a joint review of the clinical record with the Director of Nursing confirmed that the short term skin treatment care plan was not updated to reflect the resident's current status. On 3/31/12, during an interview with the DON she stated that Resident 7's legs were assessed, and the Resident did not have rashes on her lower extremities, although the resident was still receiving the Nystatin-triamcinolone cream to the lower extremities. A review of a form entitled,"Change of Condition Documentation", dated 3/31/12, revealed	F 309	**operations having the potential to be affected by the same deficient practice and what corrective action(s), both temporarily and permanently, will be taken:** **As the Laurel Park has maintained this practice for more than 30 years in order to maintain the security of the medications, improve mediation compliance of the resident population, and mitigate resident physical aggression during medication pass, Laurel Park respectfully submits a program flexibility approval request to the Department (SEE ATTACHED). Facility personnel continue to assure that the services provided meet the professional standards required by regulation, policy and procedure, and resident population behavioral, psychiatric, and emotional presentations.** **C. What immediate measures will be put into place and/or what systematic changes the facility will make to ensure the deficient practice does not recur:** **As the Laurel Park has maintained this practice for more than 30 years in order to maintain the security of the medications, improve mediation compliance of the resident population, and mitigate resident physical aggression during medication pass, Laurel Park respectfully submits a program flexibility approval request to the Department (SEE ATTACHED). Facility personnel continue to assure that the services provided meet the professional standards required by regulation, policy and procedure, and resident population behavioral, psychiatric, and emotional presentations.** **D. How the facility plans to monitor its performance to make sure that solutions are sustained (description of the monitoring**	

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F 309	Continued From page 5 Resident 7 was still being given the Nystatin-triamcinolone after the skin problem had been resolved. On 3/31/12, a review of the facilities policy for weekly reviews indicated that the purpose of the clinical weekly report was to identify and document actions planned or taken to affect, positive clinical outcomes. The policy also specified that the quarterly review, reviews the resident's overall plan of care, to validate that the plan is effective as well as ongoing systematic compliance. 2. On 3/31/12, a review of the clinical record for Resident 7 revealed the resident was admitted to the facility on 9/2/11, with diagnoses that include impulse control disorder, and personality disorder. A review of the Minimum Data Set (MDS), a standardized assessment and care planning tool, dated 3/10/12 revealed that Resident 7 initially had no observable problems with her cognitive (mental) level. The resident was also independent in activities of daily living. Further review of the clinical record revealed Resident 7 had a physician's order dated, 9/2/11, for the following Laboratory (lab) blood tests to be completed: CMP (complete metabolic panel) level, HGB A1c (glycohemoglobin) level, and Lipid (fats) Panel, lab tests to be drawn every 3 months on the third Thursday (Sept. Dec. March, June). A review of the clinical record revealed Resident 7 had blood drawn for the test on Wednesday, 3/7/12, and Wednesday 3/21/12. The blood tests were not completed as the physician ordered, but instead were drawn twice within one month. On 3/31/12, the DON and the charge nurse were apprised of the blood tests being drawn twice	F 309	**process and positions responsible for monitoring). The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system:** **During the weekday Clinical At Risk Evaluation/Facility Rounds and Stand-Up Meetings, Director of Nursing, as a member of the Performance Improvement Committee, reviews that corrective actions are and achieved and sustained for providing services that meet professional standards. Performance Improvement Committee continues with necessary follow through to address identified issues. All above stated weekly Performance Improvement actions are reviewed, at least quarterly, by the Performance Improvement Committee for success, areas of improvement, and necessary future action.** **F 309; SS=D; 483.25** **PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING** **A. What and how corrective action(s) will be accomplished, both temporarily and permanently, for those patients, employees, and/or facility operations identified/found to have been affected by the deficient practice:** **a.1) Starting 03.31.12: Director of Nurses reviewed Resident 7's chart, weekly summaries, identified physician order (treatment), and identified care plan. Director of Nurses assessed Resident 7's skin condition. Determined licensed nursing personnel did not carry out identified physician order by discontinuing medication upon resolution of Resident 7's skin**	**5.04.12** **E. Dates when corrective action will be completed:**

F 309
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483.25
pages: 03-08

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F 309	Continued From page 6 within one month and not as the physician ordered. The DON and the charge nurse acknowledged the error and there was no additional information presented to the surveyor. 3. On 3/31/12, a review of the clinical record for Resident 7 revealed the resident was admitted to the facility on 9/2/11, with diagnoses that include impulse control disorder, and personality disorder. A review of the minimum data set (MDS), a standardized assessment and care planning tool, dated 3/10/12 revealed that Resident 7 initially had no observable problems with her cognitive (mental) level. The resident was also independent in activities of daily living. A review of the physician's order for Resident 7 revealed an order dated 2/29/12, for Gentamicin ophthalmic (ophthalmic Gentamicin is used to treat certain eye infections. Gentamicin is in a class of medications called antibiotics. It works by killing the bacteria that cause infection) (eye) solution, 1 to 2 drops four times a day to both eyes. A review of the interdisciplinary team (IDT) notes dated 2/29/12, indicated that Resident 7 should receive Gentamicin eye drops, two drops, to both eyes four times a day. This order differed from the physician's order in the clinical record. A review of the medication administration record (MAR) for the month of March revealed a physician's order indicating for the licensed nurse to administer Gentamicin Sulfate ophthalmic dose 0.3 % to start 2/29/12, daily. The number of drops to be administered to the resident was not indicated on the MAR. The nursing staff failed to clarify the physician ' s order so as to determine the number of Gentamicin eye drops that were	F 309	**condition. Director of Nurses assessed Resident 7 - no adverse effects. Director of Nursing contacted ordering physician and received orders to discontinue identified treatment. Director of Nurses resolved identified short term care plan.** **a.2) Starting 03.31.12: Director of Nurses reviewed Resident 7's chart, identified physician order (laboratory test), and laboratory results. Determined licensed nursing and laboratory did not collect and complete identified laboratory test as ordered. Director of Nurses assessed Resident 7 - no adverse effects. Director of Nurses contacted ordering physician and received orders to proceed with current physician ordered laboratory tests.** **a.3) Starting 03.31.12: Director of Nurses reviewed Resident 7's chart, identified physician order (treatment), and identified care plan. Determined licensed nursing personnel did not include the number of drops to be administered as part of the order; however, they did administer the number of drops as directed by the medication's manufacturer instructions. Director of Nurses assessed Resident 7 - no adverse effects. Director of Nursing contacted ordering physician and received orders to discontinue identified treatment.** **a.1-3) Starting 03.31.12: Staff Development Coordinator coordinated and completed an in-service with licensed nursing personnel on the initiation/updating/resolution of care plans, the accurate completion of weekly summaries, the accurate receiving and carrying out of physician orders including, but not limited to, treatments, medications, and laboratory tests in order to provide care and services for residents' highest well being. This inservice provided personnel**	

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F 309	Continued From page 7 prescribed. There was also no documentation by the licensed nurses administering the medication of how many Gentamicin drops the resident actually received to both eyes. On 3/31/12, at 9:20 a.m., this was brought to the attention of the DON who acknowledged the error and stated that the amount of drops administered to the resident should have been on the MAR. The DON further stated that the physician's order should have been clarified. When asked what elements should be contained in a physician's order, the DON gave the surveyor a policy entitled, "New orders of Schedule 3-5 controlled substances". The policy indicated that a new order should include the following: Date of order; Resident name; Medication name, strength, dosage, time or frequency, and route of administration; Physician's/prescriber's name; Pertinent ancillary instructions; and resident location. The policy indicated that all resident information is complete and verified by physician/prescriber's.	F 309	**with education on assuring the deficient practice is corrected and does not reoccur.** **B. How the facility will identify other patients, employees, and/or facility operations having the potential to be affected by the same deficient practice and what corrective action(s), both temporarily and permanently, will be taken:** **A.1-3) Starting 03.31.12: Director of Nurses randomly reviewed 5 resident charts for necessary and current nursing care plans, necessary physician orders, completed laboratory tests, necessary and accurate weekly summaries – no physician order or laboratory issues identified and identified care plan and weekly summary issues corrected. Staff Development Coordinator coordinated and completed an in-service with licensed nursing personnel on the initiation/updating/resolution of care plans, the accurate completion of weekly summaries, the accurate receiving and carrying out of physician orders including, but not limited to, treatments, medications, and laboratory tests in order to provide care and services for residents' highest well being. This inservice provided personnel with education on assuring the deficient practice is corrected and does not reoccur.**	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	**C. What immediate measures will be put into place and/or what systematic changes the facility will make to ensure the deficient practice does not recur:** **a.1-3) Starting 03.31.12 and weekly/monthly: During monthly reviews of nursing related care plans, Director of Nurses assures necessary and current nursing care plans with appropriate interventions. During weekday reviews of physician orders, Director of Nurses assures that physician orders are necessary, complete, and being**	

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F 371	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility kitchen staff failed to ensure that the low temperature dishwashing machine was adequately sanitizing the dishes and silverware. Findings: On March 31, 2012 at 1:15 p.m., the evaluator observed the kitchen dietary supervisor applying a test strip to a holding tray after it had gone through a full wash cycle in the low temperature dishwasher machine. The test strip read a sanitizing solution concentration of nearly 10 parts per million (ppm). Upon further observation of the dishwasher machine, it was observed by both the evaluator and the dietary supervisor, that the hose line carrying the sanitizing solution leading to the machine had some air bubbles in the hose. During an interview with the dietary supervisor, she stated the air bubbles prevented the proper concentration of sanitizer solution from being dispersed on the dishes and silverware. The dietary supervisor further stated this was a common problem that had occurred before and that she would call the service company to come and repair the hose. The dietary supervisor also stated she would direct the staff to use disposable plates and utensils until the dish washer was dispensing the sanitizing solution properly.	F 371	**appropriately carried out. During weekday reviews of laboratory tests, Director of Nurses assures that physician ordered laboratory tests are completed. During monthly reviews of weekly summaries, Director of Nurses assures accurate documentation of residents' current status. Identified issues are promptly corrected with necessary counseling and education of licensed nursing personnel. As needed, Staff Development Coordinator coordinates and completes in-services with licensed nursing personnel on the initiation/updating/resolution of care plans, the accurate completion of weekly summaries, the accurate receiving and carrying out of physician orders including, but not limited to, treatments, medications, and laboratory tests in order to provide care and services for residents' highest well being. This inservice provides personnel with education on assuring the deficient practice is corrected and does not reoccur.** **D. How the facility plans to monitor its performance to make sure that solutions are sustained (description of the monitoring process and positions responsible for monitoring). The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system:** **a. 1-3) Starting 03.31.12 and weekly: During the weekday Clinical At Risk Evaluation/Facility Rounds and Stand-Up Meeting, Director of Nursing and Health Information Manager, as members of the Performance Improvement Committee, bring forward identified issues (through**	

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	05A137	A. BUILDING _____ B. WING _____	03/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL PARK A CENTER OF EFFECTIVE LIVING	1425 LAUREL AVENUE POMONA, CA 91767

(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 371	Continued From page 9 A review of the sanitizing log sheet indicated the required sanitizing concentration should be 50 ppm and that prior to the lunch meal preparation on March 31, 2012, dishwasher machine had been dispensing the correct required concentration all month for all three meals previously.	F 371	**their completed audits and reviews of resident health records) related to the provision of care and services to meet residents' highest well being including, but not limited to, care planning and interventions, physician orders, and weekly summaries. Performance Improvement Committee continues with necessary follow through to address identified issues. During monthly facility visits, Regional Director of Clinical Operation, as a member of the Performance Improvement Committee, completes monthly reviews of the facility's clinical practices including, but not limited to, resident care planning and interventions, the carrying out of physician orders, and accurate completion of weekly summaries. This includes providing the nursing department operation recommendations and assuring the nursing department follows up on such recommendations. All above stated weekly and monthly Performance Improvement actions are reviewed, at least quarterly, by the Performance Improvement Committee for success, areas of improvement, and necessary future action. As needed, Staff Development Coordinator coordinates and completes in-services with licensed nursing personnel on the initiation/updating/resolution of care plans, the accurate completion of weekly summaries, the accurate receiving and carrying out of physician orders including, but not limited to, treatments, medications, and laboratory tests in order to provide care and services for residents' highest well being. This inservice provides personnel with education on assuring the deficient practice is corrected and does not reoccur.**	**5.04.12**
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 failed to maintain a square footage of 80 square feet per bed in 15 out of 19 resident bedrooms. Findings: During observations on March 29, 30, and 31, during the course of the survey, no difficulties were observed with residents or staff getting in or out the rooms. A review of a room waiver request dated March 14, 2012, indicated the following rooms did not meet the 80 square foot space requirement: Room # / # of beds / square footage 3 / 2 / 156 4 / 2 / 156 5 / 2 / 156 6 / 2 / 156 7 / 3 / 221 8 / 3 / 234 9 / 2 / 143 10 / 3 / 221	F 458		
		F371	**F 371; SS=D; 483.35(i)**	**Dates**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A137	A. BUILDING _____ B. WING _____	03/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL PARK A CENTER OF EFFECTIVE LIVING	1425 LAUREL AVENUE POMONA, CA 91767

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F 458	Continued From page 10 12 3 228 14 3 228 16 3 228 20 2 150 21 2 150 22 2 150 23 2 150 During interviews with residents both individually and collectively, they stated they had no complaints regarding the size of the rooms. A review of the facility's room waiver request indicated the health and safety of the residents were not adversely affected in any way.	F 458 SS D 483.35 (j) pages: 08-10	**FOOD PROCURE, STORE/PREPARE/SERVE – SANITARY** **A. What and how corrective action(s) will be accomplished, both temporarily and permanently, for those patients, employees, and/or facility operations identified/found to have been affected by the deficient practice:** **Starting 03.31.12: Nutritional Service Director initiated the use of disposable plates and utensils. Nutritional Service Director contacted facility's contracted vendor to service and repair identified hose line. Facility's contracted vendor serviced and repaired identified hose line. Nutritional Service Director coordinated and completed an in-service with dietary personnel on the policies and procedures regarding sanitary conditions – food preparation and service including, but not limited to, maintaining sanitary food preparation and service equipment. This inservice provided personnel with education on assuring the deficient practice is corrected and does not reoccur.** **B. How the facility will identify other patients, employees, and/or facility operations having the potential to be affected by the same deficient practice and what corrective action(s), both temporarily and permanently, will be taken:** **Starting 03.31.12: Nutritional Services Director assessed the sanitation of the dietary department's food preparation and service equipment – equipment clean, free of debris and functioning properly. Nutritional Service Director completed an in-service with dietary personnel on the policies and procedures regarding sanitary conditions – food preparation and service including, but not limited to, maintaining sanitary food preparation and service equipment. This**	**when corrective action will be completed:**
F 504 SS=D	483.75(j)(2)(i) LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN The facility must provide or obtain laboratory services only when ordered by the attending physician. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to obtain laboratory services as ordered by the attending physician for one of 11 residents (8). Findings: On March 31, 2012, a review of Resident 8's clinical record disclosed that the resident was admitted to the facility on March 14, 2011, with diagnoses of schizoaffective disorder subtonic with acute exacerbation (a mental illness). On March 15, 2011, there was a physician ' s order for a laboratory (lab) test to be done as	F 504		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A137	A. BUILDING _____ B. WING _____	03/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL PARK A CENTER OF EFFECTIVE LIVING	1425 LAUREL AVENUE POMONA, CA 91767

(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 504	Continued From page 11 follows: complete blood count (CBC) every two weeks specifically on Wednesday. A review of the clinical record revealed there were CBC results dated February 22, 2012 and March 22, 2012. There were no laboratory test results that indicated the CBC was done every two weeks as the physician ordered. The CBC test results indicted the lab tests were done only once a month, instead of every two weeks as the physician ordered. On March 31, 2012 at 4:50 p.m., the licensed vocational nurse and the Director of Nursing explained that when the resident is being administered Fazaclo [(Clozapine) (a medication used to treat the symptoms of schizophrenia)], the physician ordered for CBC to be done every two weeks for standard lab monitoring of the CBC for period of time until the pharmacy notifies the facility. However, the CBC monitoring was done on monthly basis instead of every two weeks. The facility missed one CBC. On March 31, 2012, at 4:55 p.m., the licensed nurse and the Director of Nursing further stated that the CBC is done every two weeks for the first few months then the CBC will be done on monthly basis. However, there was no documented evidence the physician ' s ordered the CBC to be done on a monthly basis and there was no documented evidence of a communication with the pharmacy regarding a change of when the CBC was to be done.	F 504	**inservice provided personnel with education on assuring the deficient practice is corrected and does not reoccur.** **C. What immediate measures will be put into place and/or what systematic changes the facility will make to ensure the deficient practice does not recur:** **Starting 03.31.12 and daily: During daily observation of food preparation and service equipment, cooks and Nutritional Services Supervisor assess equipment for sanitation and proper operation. Identified issues corrected and necessary steps taken to maintain sanitation when identified issues may take a period of time to correct. As needed, Nutritional Service Director coordinates and completes necessary in-services with dietary personnel on the policies and procedures regarding sanitary conditions – food preparation and service including, but not limited to, maintaining sanitary food preparation and service equipment. This inservice provides personnel with education on assuring the deficient practice is corrected and does not reoccur.** **D. How the facility plans to monitor its performance to make sure that solutions are sustained (description of the monitoring process and positions responsible for monitoring). The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system:** **Starting 03.31.12 and weekly: During weekday Clinical At Risk Evaluation/Facility Rounds and Stand-Up Meetings, Nutritional Services Supervisor, as**	

a member of the Performance Improvement Committee, reviews the sanitation of the dietary department including, but not limited to, food preparation and service equipment. Performance Improvement Committee continues with necessary follow through to address identified issues. During weekly facility visits, Regional Registered Dietician, as a member of the Performance Improvement Committee, completes monthly sanitation checklists. This includes providing dietary department operation recommendations and assuring the dietary department follows up on such recommendations. All above stated weekly Performance Improvement actions are reviewed, at least quarterly, by the Performance Improvement Committee for success, areas of improvement, and necessary future action. As needed, Nutritional Service Director coordinates and completes necessary in-services with dietary personnel on the policies and procedures regarding sanitary conditions – food preparation and service including, but not limited to, maintaining sanitary food preparation and service equipment. This inservice provides personnel with education on assuring the deficient practice is corrected and does not reoccur. 5.04.12

F	F 458; SS=B; 483.70(d)(1)(ii)	E.
458	RESIDENT ROOMS	Dates
	A. What and how corrective action(s) will	when
SS	be accomplished, both temporarily and	correc-
B	permanently, for those patients, employees,	tive
	and/or facility operations identified/found to	action
483.70	have been affected by the deficient practice:	will be
(d)	Administrator submitted and the	com-
(1)	Department accepted the annual "Program	pleted:
(ii)	Flexibility Waiver regarding F 458 –	

pages: 10-11	483.70(d)(1)(ii) Resident Rooms" letter to the Department for rooms #3, #4, #5, #6, #7, #8, #9, #10, #12, #14, #16, #20, #21, #22, and #23. Starting 12/26/10 and daily: Facility personnel assure that the needs of residents in rooms #3, #4, #5, #6, #7, #8, #9, #10, #12, #14, #16, #20, #21, #22, and #23 are fully met and that no adverse effects to health, safety, or welfare exist for the residents occupying the rooms. B. How the facility will identify other patients, employees, and/or facility operations having the potential to be affected by the same deficient practice and what corrective action(s), both temporarily and permanently, will be taken: Rooms #15, #17, #18, and #19 met the minimum square footage requirement. Facility personnel assure that the needs of residents in rooms are fully met and that no adverse effects to health, safety, or welfare exist for the residents occupying the identified rooms. C. What immediate measures will be put into place and/or what systematic changes the facility will make to ensure the deficient practice does not recur: Per the request of the Department, Administrator submits the annual "Program Flexibility Waiver regarding F 458 – 483.70(d)(1)(ii) Resident Rooms" letter to the Department for rooms #3, #4, #5, #6, #7, #8, #9, #10, #12, #14, #16, #20, #21, #22, and #23. Facility personnel assure that the needs of residents in rooms are fully met and that no adverse effects to health, safety, or welfare exist for the residents occupying the identified rooms. D. How the facility plans to monitor its performance to make sure that solutions are sustained (description of the monitoring

	process and positions responsible for monitoring). The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system: During weekday Clinical at Risk Evaluation/Facility Rounds and Stand-Up Meetings, Assistant Administrator, as a member of the Performance Improvement Committee, reviews that corrective actions are and achieved and sustained for resident rooms. Performance Improvement Committee develops and implements necessary corrections for identified issues related to the meeting of residents' needs. All above stated weekly Performance Improvement actions are reviewed, at least quarterly, by the Performance Improvement Committee for success, areas of improvement, and necessary future action.	5.04.12
F 504 SS D 483.75 (j) (2) (i) pages: 11-12	F 504; SS=D; 483.75(j)(2)(i) LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN A. What and how corrective action(s) will be accomplished, both temporarily and permanently, for those patients, employees, and/or facility operations identified/found to have been affected by the deficient practice: Starting 03.31.12: Director of Nurses reviewed Resident 8's chart, identified physician order (laboratory test), and laboratory results. Determined licensed nursing and laboratory did not collect and complete identified laboratory test as ordered. Director of Nurses assessed Resident 8 - no adverse effects. Director of Nurses contacted ordering physician and received orders to proceed with current	E. Dates when corrective action will be completed:

physician ordered laboratory tests. Resident 8's ensuing laboratory orders completed as ordered. Staff Development Coordinator coordinated and completed an in-service with licensed nursing personnel on the accurate receiving and carrying out of physician orders including, but not limited to, laboratory tests in order to assure that laboratory services are only completed when ordered by the physician. This inservice provided personnel with education on assuring the deficient practice is corrected and does not reoccur.

B. How the facility will identify other patients, employees, and/or facility operations having the potential to be affected by the same deficient practice and what corrective action(s), both temporarily and permanently, will be taken:

Starting 03.31.12: Director of Nurses randomly reviewed 5 resident charts for physician ordered and completed laboratory tests - no issues identified. Staff Development Coordinator coordinated and completed an in-service with licensed nursing personnel on the accurate receiving and carrying out of physician orders including, but not limited to, laboratory tests in order to assure that laboratory services are only completed when ordered by the physician. This inservice provided personnel with education on assuring the deficient practice is corrected and does not reoccur.

C. What immediate measures will be put into place and/or what systematic changes the facility will make to ensure the deficient practice does not recur:

Starting 03.31.12 and weekly: During weekday reviews of physician orders, Director of Nurses assures that physician

orders are necessary, complete, and being appropriately carried out. During weekday reviews of laboratory tests, Director of Nurses assures that physician ordered laboratory tests are completed. Identified issues are promptly corrected with necessary counseling and education of licensed nursing personnel. As needed, Staff Development Coordinator coordinates and completes in-services with licensed nursing personnel on the accurate receiving and carrying out of physician orders including, but not limited to, laboratory tests in order to assure that laboratory services are only completed when ordered by the physician. This inservice provides personnel with education on assuring the deficient practice is corrected and does not reoccur.

D. How the facility plans to monitor its performance to make sure that solutions are sustained (description of the monitoring process and positions responsible for monitoring). The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system:

Starting 03.31.12 and weekly: During the weekday Clinical At Risk Evaluation/Facility Rounds and Stand-Up Meeting, Director of Nursing and Health Information Manager, as members of the Performance Improvement Committee, bring forward identified issues (through their completed audits and reviews of resident health records) related to the physician orders and laboratory tests including, but not limited to, completing laboratories only when and according to

physician orders. Performance Improvement Committee continues with necessary follow through to address identified issues. During monthly facility visits, Regional Director of Clinical Operation, as a member of the Performance Improvement Committee, completes monthly reviews of the facility's clinical practices including, but not limited to, the carrying out of physician orders. This includes providing the nursing department operation recommendations and assuring the nursing department follows up on such recommendations. All above stated weekly and monthly Performance Improvement actions are reviewed, at least quarterly, by the Performance Improvement Committee for success, areas of improvement, and necessary future action. As needed, Staff Development Coordinator coordinates and completes in-services with licensed nursing personnel on the accurate receiving and carrying out of physician orders including, but not limited to, laboratory tests in order to assure that laboratory services are only completed when ordered by the physician. This inservice provides personnel with education on assuring the deficient practice is corrected and does not reoccur.

5.04.12

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
05A137	A. Building B. Wing	6/7/2012

Name of Facility	Street Address, City, State, Zip Code
LAUREL PARK A CENTER OF EFFECTIVE LIVING	1425 LAUREL AVENUE POMONA, CA 91767

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix F0241 Reg. # 483.15(a) LSC	Correction Completed 06/07/2012	ID Prefix F0281 Reg. # 483.20(k)(3)(i) LSC	Correction Completed 06/07/2012	ID Prefix F0309 Reg. # 483.25 LSC	Correction Completed 06/07/2012
ID Prefix F0371 Reg. # 483.35(i) LSC	Correction Completed 06/07/2012	ID Prefix F0458 Reg. # 483.70(d)(1)(ii) LSC	Correction Completed 06/07/2012	ID Prefix F0504 Reg. # 483.75(i)(2)(i) LSC	Correction Completed 06/07/2012
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor: R Richard for Mike Almaraz	Date:
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
3/31/2012			