POC Accepted 9-15-2017

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FORM APPROVED
OMB NO. 0938-0391

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555719 | A. BUILDING _____ B. WING _____ | 08/07/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| IMPERIAL CREST HEALTH CARE CENTER | 11834 INGLEWOOD AVENUE HAWTHORNE, CA 90250 |

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| F 000 | INITIAL COMMENTS<br><br>The following represents the Department of Public Health during a Recertification Survey and complaint visits.<br><br>Complaint #: CA00546020 - Unsubstantiated<br>Complaint #: CA00547064 - Unsubstantiated<br><br>Representing the Department of Public Health:<br><br>Surveyor ID: 36356 RN, HFEN<br>Surveyor ID: 36385 RN, HFEN<br><br>Resident Population: 92<br>Resident Sample Size: 19<br>Randomly Selected Resident: 1 | F 000 | Imperial Crest Healthcare Center submits this Plan of Correction as the part of the requirements under state and federal law.<br>The plan of correction is submitted in accordance with specific regulatory requirements. It shall not be construed as admission of any alleged deficiency cited or any liability. The provider submits this plan of correction with the intention that it is inadmissible by any third party in any civil, criminal action or proceedings against the provider or its employee, agents, officers, directors, or shareholders. The provider reserves the right to challenge the cited findings if at any time the provider determines that the disputed findings are relied upon in a manner adverse to the interests of the provider either by the governmental agencies or their party. | |
| F 155 SS=E | Highest Severity & Scope - E<br>483.10(c)(6)(8)(g)(12), 483.24(a)(3) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES<br><br>483.10<br>(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.<br><br>(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).<br><br>(i) These requirements include provisions to | F 155 | **F-155**<br><br>**Corrective Action for Affected Residents**<br>The POLST forms for Residents 3, 6, 13 and 16 were completed and placed in their respective chart.<br><br>**Procedure for Identifying Potentially Affected Residents**<br>Social Services audited all the charts on 8/07/17. No other residents were missing POLST forms. | 8/25/17 |

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

KL Administrator 8/25/17

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 155 | Continued From page 1<br>inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.<br><br>(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.<br><br>(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.<br><br>(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law.<br><br>(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.<br><br>483.24<br>(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and record | F 155 | **Corrective Action for Potentially Affected Residents**<br>**Measures Adopted for Systemic Change**<br>Under the supervision of the DON, facility staff including Licensed Nurses, IDT members and Social Services were in-serviced on 8/08/17 ensuring the POLST forms are completed on admission or during initial IDT.<br><br>**Monitoring of Corrective Action and Quality Assurance**<br>On a quarterly the DON or designee will do random chart audits to ensure the POLST forms are signed and dated. Medical Records will resident POLSTs on a monthly basis.<br>All findings will be brought to the Administrator who will review the results and bring to the QA committee. | |

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review, the facility failed to ensure three of 19 sampled residents (3, 13, 16) had specific choices and treatments communicated through a Physician Orders for Life-Sustaining Treatment (POLST [a physician order that outlines the plan of care regarding a residents's life sustaining choices]). This deficient practice had the potential for the residents not be given the right to accept or refuse specific medical treatments and have those options honored.

Findings:

a. A review of the clinical records indicated Resident 6 was admitted on February 23, 2017, with diagnoses but not limited to dementia (chronic or persistent mental disorder processes marked by memory disorders, personality changes, and impaired reasoning).

The Minimum Data Set (MDS), a standardized assessment and care screening tool), dated March 1, 2017 indicated Resident 6 had severe cognitive (mental process of knowing, awareness, perception, reasoning, and judgment) impairment.

During interview and record review in the presence of Social Service Assistant (SSA) on August 2, 2017, there was no POLST document found with the rest of Resident 6 clinical records. The SSA stated the resident's family had already filled the POLST document but she did not know what had happened to the POLST.

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During interview and record review on August 4, 2017, at 8 a.m., SSA provided an unsigned POLST document for Resident 6. The SSA was not able to explain why the POLST document was not signed but that it was her responsibility to make sure the residents POLST document was signed and dated on admission.

b. A review of Resident 3's admission records indicated she was admitted to the facility on April 22, 2016 and re-admitted on July 16, 2017 with diagnoses that included multiple sclerosis (a nervous system disease that affects the brain and spinal cord), Parkinson's disease (disease affecting nerve cells in the brain that affects movement), dysphagia (difficulty swallowing) and adult failure to thrive (describes a state of decline that may be caused by chronic concurrent diseases and functional impairments which can result in weight loss, decreased appetite, poor nutrition and inactivity).

A review of Resident 3's History and Physical examination record, dated July 16, 2017 indicated the resident did not have the capacity to understand and make decisions.

A review of Resident 3's Minimum Data Set (MDS), a standardizes assessment and care screening tool, dated July 2, 2017 indicated the resident had severe cognitive (mental process of knowing, awareness, perception, reasoning, and judgment) impairment.

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| F 155 | Continued From page 4 | F 155 | | |

During an interview and record review with the Social Services Assistant (SSA) on August 4, 2017 at 3:40 p.m., she verified Resident 3's POLST was not in the chart (medical record). SSA stated social services was responsible for completing the form and was done usually upon admission of the resident to the facility. The SSA stated she forgot to complete the form.

During an interview with the director of nursing (DON) on August 4, 2017 at 3: 55 p.m., she stated the POLST was important for the staff to know the resident's code status (the level of medical interventions a patient wishes to have started if their heart or breathing stops). The DON confirmed it was social services responsibillty to complete the form.

c. A review of Resident 13's admission records indicated he was admitted on November 22, 2016 and re-admitted on January 3, 2017 with diagnoses that included pneumonia (infection of the lungs), dysphagia (difficulty swallowing), paraplegia (impairment in movement or sensation of the lower extremities) and chronic (over a length of time) pain syndrome.

A review of Resident 13's History and Physical examination record, dated January 29, 2017 indicated the resident had the capacity to understand and make decisions.

A review of Resident 13's Minimum Data Set (MDS), a standardized assessment and care

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| F 155 | Continued From page 5<br>screening tool, dated June 2, 2017 indicated the resident had no cognitive impairment.<br><br>During an interview and record review with the Medical Records Director on August 7, 2017 at 5:30 p.m., confirmed there was no POLST form in Resident 13's chart. | F 155 | | |
| F 156 SS=E | 483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES<br><br>(d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care.<br><br>§483.10(g) Information and Communication.<br>(1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility.<br><br>(g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including:<br><br>(i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes -<br><br>(A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section;<br><br>(B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of | F 156 | F-156<br><br>**Corrective Action for Affected Residents**<br>All residents have the potential to be affected. The vases which were in front of the Ombudsman poster were taken down immediately by Activity Director.<br><br>**Procedure for Identifying Potentially Affected Residents**<br>All residents had the potential to be affected.<br><br>**Corrective Action for Potentially Affected Residents**<br>Facility staff were in-serviced about the facility policy regarding posting the Ombudsman poster in a manner accessible and visible to the residents, staff and visitors. Ombudsman poster posted in the Employee break room. | 8/25/17 |

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| F 156 | Continued From page 6<br>resources under section 1924(c) of the Social Security Act.<br><br>(C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and<br><br>(D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.<br><br>(ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.)<br>[§483.10(g)(4)(ii) will be implemented beginning | F 156 | **Measures Adopted for Systemic Change**<br>Under the supervision of the DON, facility staff were in-serviced on 8/08/17 regarding facility policy of Ombudsman posting, including their contact information which should be posted in an area that is visible to the residents.<br><br>**Monitoring of Corrective Action and Quality Assurance**<br>On a quarterly basis the Social Services and Activity Director, during rounds will monitor that the Ombudsman posters are all accessible and visible to the residents, staff and visitors in all designated areas.<br>All findings will be brought to the Administrator who will review and bring to the QA committee. | |

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| F 156 | Continued From page 7<br>November 28, 2017 (Phase 2)]<br><br>(iii) Information regarding Medicare and Medicaid eligibility and coverage;<br>[§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)]<br><br>(iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program;<br>[§483.10(g)(4)(iv) will be implemented beginning November 28, 2017 (Phase 2)]<br><br>(v) Contact information for the Medicaid Fraud Control Unit; and<br>[§483.10(g)(4)(v) will be implemented beginning November 28, 2017 (Phase 2)]<br><br>(vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.<br><br>(g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives:<br><br>(i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for | F 156 | | |

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jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and

(ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community.

(g)(13) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

(g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay.

(i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility.

(ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any.

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(iii) Receipt of such information, and any amendments to it, must be acknowledged in writing;

(g)(17) The facility must--

(i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of-

(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;

(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and

(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in paragraphs (g)(17)(i)(A) and (B) of this section.

(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.

(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is

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reasonably possible.

(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.

(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.

(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.

v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to ensure the Ombudsman (advocate for the residents) postings including their contact information were posted and visible in all designated areas. This deficient practice had the potential for the residents, staff and visitors to not have accessibility to the Ombudsman contact information.

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| F 156 | Continued From page 11<br>Finding:<br><br>a. During a tour of the facility on August 2, 2017 at 11:25 a.m. with Registered Nurse (RN 1), it was noted the Ombudsman poster in the dining room was covered by vases containing artificial flowers and obscured from view. RN 1 stated the Dmbudsman poster should be "clear of sight" for residents.<br><br>During an interview with the Activity Director on August 2, 2017 at 11: 27 a.m., stated she was only able to see the top part of the Ombudsman poster because it was blocked by the flowers but would take down the flower vases immediately.<br><br>b. During a tour of the facility on August 2, 2017 with Registered Nurse 1 (RN 1), it was noted and verified the Ombudsman posting was absent in the employee break room. The staff did not have information available to them if they wanted to contact the Ombudsman.<br><br>A review of the facility's undated policy's policy and procedures titled "Ombudsman Posting" indicated the facility will post information pertinent to the State Ombudsman Program and the name, address and phone number will be posted in at least four areas of the facility including a location that is used for employee breaks and in one location used for communal functions for residents that includes the resident dining area. | F 156 | | |
| F 167 SS=E | 483.10(g)(10)(i)(11) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE | F 167 | F-167 | 8/25/17 |

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| F 167 | Continued From page 12<br><br>(g)(10) The resident has the right to-<br><br>(i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and<br><br>(g)(11) The facility must--<br><br>(i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility.<br><br>(ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and<br><br>(iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public.<br><br>(iv) The facility shall not make available identifying information about complainants or residents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and record review, the facility failed to ensure the most recent standard recertification survey, all subsequent extended complaint surveys and their plan of corrections was available and accessible to residents and visitors at all times in a visible location without having to ask staff. This deficient practice placed residents and family members or visitors at risk of not knowing the status of the | F 167 | **Corrective Action for Affected Residents**<br>The location of the survey results were immediately moved by the Maintenance Director to a visible location in the front lobby on 8/02/17.<br><br>**Procedure for Identifying Potentially Affected Residents**<br><br>All residents had the potential to be affected.<br><br>**Corrective Action for Potentially Affected Residents**<br><br>All residents had the potential to be Affected.<br><br>**Measures Adopted for Systemic Change**<br>Under the supervision of the DON, facility staff were in-serviced on 8/08/17 regarding having the most recent standard survey, all complaint surveys and their plan of corrections available to accessible to the residents and visitors in a visible location, without having to ask any staff of its location. | |

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| F 167 | Continued From page 13<br>facility noncompliance outcome results.<br><br>Findings:<br><br>a. During the initial tour of the facility on August 2, 2017 at 11:15 a.m., the most recent standard survey, all subsequent extended extended complaint surveys and their plan of corrections could not be found. During an interview with Registered Nurse (RN 1), stated it was in a binder in nursing Station 1. However, there was a unmarked binder, behind a clear plastic water dispenser located on top of the nursing station counter. During a consequent interview with RN 1, stated that given the height of the nursing counter the residents on wheelchairs will have difficulty reaching for the survey results binder and verified that there was no notice posted in regards to their availability.<br><br>b. During a group meeting with alert and oriented residents (awake and responsive, and oriented to person, place and time) on August 4, 2017 at 10:30 a.m., four out of nine residents stated they were not aware where the most recent standard survey was located.<br><br>A review of the facility's admission packet included a form titled "Resident Rights" dated May 2011, indicated the resident had the right to examine the most recent survey of the facility conducted by the Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination in a place readily | F 167 | **Monitoring of Corrective Action and Quality Assurance**<br>On a quarterly basis the Administrator or designee, during rounds will monitor for proper location of survey/complaint visits binder and ensure that it is in a visible location. All findings will be brought to the Administrator who will review and bring to the QA committee. | |

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| F 167 | Continued From page 14<br>accessible to the residents and must post a notice of their availability. | F 167 | | |
| F 252 SS=E | 483.10(e)(2)(i)(1)(i)(ii)<br>SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT<br><br>(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.<br><br>§483.10(i) Safe environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide-<br><br>(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.<br><br>(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.<br><br>(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview, the facility failed to ensure the residents room window frame was free of spider webs, accumulated dust, window blinds were not missing and a broken window latch was fixed. The deficient practices denied the resident a comfortable homelike | F 252 | F-252<br><br>**Corrective Action for Affected Residents**<br>The spider webs and accumulated dust were thoroughly cleaned on 8/02/17.<br>The missing blinds in room 125 were replaced on 8/03/17 by the Maintenance Supervisor.<br>The window latch in room 125 was repaired on 8/03/17 by the Maintenance Supervisor.<br><br>**Procedure for Identifying Potentially Affected Residents**<br><br>Maintenance Supervisor checked the blinds and window latches in all the resident rooms. All were found to be in compliance. | 8/25/17 |

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| F 252 | Continued From page 15<br>environment and had the potential for harboring insects.<br><br>Findings:<br><br>a. During the intial residents tour accompanied by Minimum Data Set Director (MDSD) and interview on August 2, 2017 at 9:10 a.m., spider webs were observed on room 128's window frame next to a resident's bed. The MDSD stated there should be no spider webs on the resident's window frame.<br><br>b. On August 2, 2017 at 3 p.m., a family member (FM 1) stated there missing blinds and the window latch was broken in room 125. During an environmental observation of Room 125, it was noted the resident's window had missing four white plastic vertical blinds. During a consequent observation, the window latch did not lock into position where it could easily be opened. The window was facing west onto a major busy street.<br><br>During interview with family member (FM 2) on August 3, 2017 at 12:35 p.m., stated she had told the facility about the missing blinds a week ago but nothing was done. FM 2 also stated the latch to the window in Room 125 had been broken for three months and not been fixed.<br><br>During an interview with RSR 21 on August 3, 2017 at 3 p.m., resident was observed to be aphasic (partial or total loss of the ability to articulate ideas or comprehend spoken or written | F 252 | **Corrective Action for Potentially Affected Residents**<br>**Measures Adopted for Systemic Change**<br>Under the supervision of the DON, facility staff including were in-serviced on 8/08/17 regarding on the importance of a homelike environment and having a safe, clean and comfortable living environment.<br><br>**Monitoring of Corrective Action and Quality Assurance**<br>On a quarterly basis the Maintenance Supervisor, during rounds will monitor for a safe, clean and homelike environment. Any repairs will be promptly repaired. All findings will be brought to the Administrator who will review and bring to the QA committee. | |

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| F 252 | Continued From page 16 | F 252 | | |

language, resulting from damage to the brain) but she indicated that she was aware of the broken window latch by nodding, when asked by surveyor. The resident gestured by putting her left index finger (located between the thumb and the middle finger) and thumb slightly apart. Upon asking the resident to verify if the gesture meant a little, the resident confirmed by nodding her head.

During an interview with the maintenance supervisor (MS) on August 3, 2017 at 4:17 p.m., he stated that FM 2 had told him two weeks ago about the broken window latch. MS stated that he needed to put a lock at the end of the sliding track to prevent the window from opening but had not ordered the part. MS stated that the delay was due to other repairs and painting he was busy with at the facility. MS stated that he was aware that the window faced a busy street and that "people can come in".

During the same interview, MS stated that he was told about the missing blinds "this morning by the housekeeper". He stated that everyday there were missing blinds around the facility. He stated he had not gotten to replace the ones in the room.

A review of the maintenance supervisor job description dated February 5, 2013 indicated that the essential duties and responsibilities include to ensure that major equipment and furnishings are maintained in a safe, operable condition and/ or arranges for replacement and investigates complaints about service and equipment and

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| F 252 | Continued From page 17<br>takes corrective action. | F 252 | | |
| F 257 SS=E | 483.10(i)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS<br><br>(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81 degrees F.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and record review, the facility failed to provide comfortable room temperatures that did not exceed 81 degrees Fahrenheit (F) in four resident's rooms and for one of 19 sampled residents (4). The deficient practice resulted in residents and family members complaining of feeling hot and having difficulty breathing.<br><br>Findings:<br><br>a. During a general tour and interview of the facility on August 2, 2017 at 2:20 p.m., three resident rooms on Station 2 was hot. During further investigation, one of the resident's stated the room temperature was too hot despite the portable air conditioner in the room along with an electric blow fan in the hallways. The resident also stated it was difficult for her to breath because the room temperature was too hot. In a separate room, a family member visiting a resident was observed removing bed linen off the resident. The family member was also observed with sweat on her face down to her neck. The family member stated it's too hot. Another resident was observed mopping her face with a | F 257 | F-257<br><br>**Corrective Action for Affected Residents**<br><br>Cooling measures and room changes were made immediately in the 4 residents rooms and for Resident 4 on 8/03/17 by Maintenance Supervisor.<br><br>**Procedure for Identifying Potentially Affected Residents**<br>All residents had the potential to be affected. The room temps in all the rooms were checked and were all within compliance. | 8/25/17 |

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| F 257 | Continued From page 18<br>cold and wet wash cloth. The resident stated the room was too hot.<br><br>During room temperature checks conducted by the Maintenance Supervisor on August 3, 2017 at 2017 indicated temperatures ranged between 85 degrees Fahrenheit (F) to 88 degrees F for three rooms on Station 2.<br><br>b. During an observation and interview of Resident 4 on August 3, 2017 at 3:40 p.m., the resident was sitting on her wheelchair in front of a stand up fan in her room. The resident stated she was "hot, don't feel well. I'm dizzy and can't breathe too well." She further stated had almost fallen over twice because of the heat in her room. The resident was observed to have a tracheostomy collar (a device used to keep a tracheotomy [a surgical opening through the neck to allow access to a breathing tube] tube in position) that was not connected to an oxygen machine. When asked why she was not on the oxygen machine, stated she felt better sitting in front of the stand up fan rather than "dying of heat". The resident stated the elevated temperatures in her room had been ongoing "for weeks" and the facility staff were aware of the issue.<br><br>A review of Resident 4's admission records indicated she was admitted to the facility on September 23, 2014 with diagnoses that included chronic respiratory failure (a long-term condition that happens when the lungs can not get enough | F 257 | **Measures Adopted for Systemic Change**<br>Under the supervision of the DON, facility staff including the Maintenance Supervisor were in-serviced on 8/08/17 regarding comfortable and safe temperature levels which should be in the range of 71 – 81 degrees F.<br><br>**Monitoring of Corrective Action and Quality Assurance**<br>On a quarterly basis the Maintenance Supervisor, during rounds will monitor will monitor for comfortable and safe temperature levels in the resident rooms. All findings will be brought to the Administrator who will review the results and bring to the QA committee. | |

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| F 257 | Continued From page 19<br>oxygen into the blood with symptoms including shortness of breath), type 2 diabetes mellitus (abnormal blood sugar) and dysphagia (difficulty swallowing).<br><br>A review of Resident 4's Minimum Data Set (MDS), a standardized assessment and care screening tool), dated July 5, 2017 indicated she was cognitively intact (mental process of knowing, awareness, perception, reasoning, and judgment).<br><br>During an observation with the Maintenance Supervisor (MS) on August 3, 2017 at 4:05 p.m. inside Resident 4's room, the MS checked the room temperature using a hand held laser thermometer. While pointing the thermometer towards Resident 4's area, the thermometer read 89 degrees Fahrenheit. During consequent interview the MS stated the room temperature ranges should had been between 72 to 82 degrees F. | F 257 | F-281 | |
| F 281 SS=D | 483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS<br><br>(b)(3) Comprehensive Care Plans<br><br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br><br>(i) Meet professional standards of quality.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview, the facility failed to handle the residents (10) gently during a | F 281 | **Corrective Action for Affected Residents**<br><br>On 8/03/17 Resident 8's G-tube placement was assessed by RN Supervisor and the G-tube is intact and patent.<br>LVN #11 checked the physician order and applied the abdominal binder immediately to keep the G-tube in place.<br>LVN #11 was in-serviced on 8/03/17 by DON. | 8/25/17 |

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| F 281 | Continued From page 20<br>shower preparation and apply abdominal binder for one of 19 sampled residents (8) to avoid pulling out gastrostomy tube (G-Tube, a tube inserted through the abdomen that delivers nutrition directly to the stomach). These deficient practices had the potential of causing discomfort to the resident, unnecessary and repeated transfer to General Acute Care Hospital (GACH) along with x-rays to ensure G-Tube replacements.<br><br>Findings:<br><br>a. A review of Resident 8's clinical records indicated a readmission to the facility on April 9, 2017, with diagnoses not limited to contractures (condition of shortening and hardening of muscles, tendons, or other tissue, and often leading to deformity and joint rigidity) of bilateral (both) hands and knees.<br><br>The Minimum Data Set (MDS), a standardized assessment and care screening tool, dated July 16, 2017, indicated Resident 8 had severe cognitive (mental process of knowing, awareness, perception, reasoning, and judgment) impairment. The MDS assessment indicated the resident had impairment on bilateral upper and lower extremities. The document also indicated the resident was totally dependent on nurses for activities of daily living such as transfer, movement within the facility, feeding, dressing, toilet use and personal hygiene.<br><br>During an observation and interview in the | F 281 | **Procedure for Identifying Potentially Affected Residents**<br>All residents who have a physicians order for an abdominal binder were reassessed by RN Supervisor on 8/08/17 and all were in place and the G-tube was intact and patent.<br><br>**Corrective Action for Potentially Affected Residents**<br>On 8/08/17 – 8/11/17, under the supervision of the DON, Nursing staff were in-serviced regarding the importance of the abdominal binder when ordered by physician for the resident to prevent the pulling out of the G-tube and to avoid causing resident discomfort and unnecessary transfer to the hospital.<br><br>**Measures Adopted for Systemic Change**<br><br>Licensed nurses will monitor residents with an abdominal binder during daily rounds.<br>**Monitoring of Corrective Action and Quality Assurance**<br>On a quarterly basis the DON or designee, during rounds will monitor for residents with abdominal binder and its placement .All findings will be brought to the Administrator who will review and bring to the QA committee. | |

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| F 281 | Continued From page 21<br>presence of Licensed Vocational Nurse (LVN 11), on August 3, 2017 at 10 a.m., Resident 8 was observed with no abdominal binder on. LVN 11 stated on several occasions the resident's feeding tube had fallen out. LVN 11 stated she was not aware the resident had an order for an abdominal binder to keep the G-Tube in place.<br><br>A review physician orders, dated July 29, 2017 at 6 p.m., indicated Resident 8 had an abdominal binder applied to prevent pulling out of G-Tube.<br><br>A review of Nurses Progress Notes indicated Resident 8 was transferred to GACH for dislodged G-Tube on the following days;<br><br>April 9, 2017.<br><br>July 5, 2017.<br><br>July 22, 2017.<br><br>July 24, 2017.<br><br>July 31, 2017.<br><br>b. Resident 10 was admitted to the facility on June 30, 2017 with diagnoses not limited to cerebral vascular accident (stroke), tracheostomy (incision in the windpipe made to relieve an obstruction to breathing) dependence, oxygen dependence, and encephalopathy (brain damage).<br><br>The Minimum Data Set (MDS), a standardized | F 281 | | |

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| F 281 | Continued From page 22<br>assessment and care screening tool, dated July 13, 2017, indicated Resident 10 had severe cognitive (mental process of knowing, awareness, perception, reasoning, and judgment) impairment. The document also indicated the resident was totally dependent on nurses for activities of daily living such as transfer, movement within the facility, feeding, dressing, toilet use, and personal hygiene).<br><br>During a shower preparation on August 4, 2017 at 1:25 p.m., Certified Nurse Assistant (CNA 3) was observed grabbing, roughly and quickly dropping Resident 10's right leg on top of the left leg. CNA 3 turned and undressed the resident without explaining the task. CNA 3 with the help of Respiratory Therapist (RT 1), a Licensed Vocational Nurse (LVN 3) and CNA 10, wheeled the resident to the shower room. CNA 3 also failed to prepare the shower room in advance as evidenced by the presence of several shower chairs inside the shower room. CNA 3 and RT 1 wheeled the resident out from the shower room and waited in the hallway as LVN 3 and CNA 10 removed the shower chairs from the shower room.<br><br>An interview on August 4, 2017 at 2:50 p.m., was conducted with the Director of Staff Development (DSD) about the observation of grabbing, roughly and quickly dropping Resident 10's right leg on top of the left leg and CNA 3 turning and undressing the resident without explaining the task. The DSD stated nurses must prepare ahead of time for bedbath or shower and ask for help as necessary. The DSD also stated the | F 281 | | |

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| F 281 | Continued From page 23<br>shower room must be free of shower chairs and shower gurneys before a resident is wheeled in to shower. The DSD also stated the resident's must be handled gently at all times and they must always explain every task they are about to perform. | F 281 | | |
| F 309 SS=E | 483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>483.24 Quality of life<br>Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care.<br><br>483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following:<br><br>(k) Pain Management.<br>The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.<br><br>(l) Dialysis. The facility must ensure that | F 309 | F-309<br><br>**Corrective Action for Affected Residents**<br>Resident 8 was assessed on 8/04/17 by Charge nurse after RNA reported it to her. Resident 8 was given Tyelenol 650 mg as ordered by his physician on 8/04/17 who also ordered a pain management consult. Resident was evaluated by Pain Management MD on 8/04/17 with new orders which were carried out. Baclofen 10mg TID for muscle spasticity, Norco 5/325mg 1 tablet every 6 hours PRN for moderate to severe pain, Norco 5/325 1 tablet an hour before wound care routine and Lidocaine 5% ointment applied to affected joints BID PRN.<br>The RNA was given a 1:1 counseling regarding facility policy on 8/04/17 by DON on facility policy of pain management.<br><br>Resident 12's dialysis transportation schedule was verified and reconfirmed by Social Services on 8/04/17. Logistic Care will pick up resident every Monday, Wednesday and Friday at 4:45 am.<br><br>Dietary Supervisor was counseled on 8/08/17regarding ensuring dialysis residents leave with a snack. | 8/25/17 |

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| F 309 | Continued From page 24<br>residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and record review, a Restorative Nurse Assistant (RNA) failed to identify symptoms of pain and stop range of motion ([ROM] full joint movement potential) exercises (8) and provide dialysis treatment (12) in a timely manner for two of 19 sampled residents. These deficient practices resulted in Resident 8's exhibiting signs of pain as evidenced by facial grimace, resisting, pulling the right arm away and covering the face with both hands during RNA exercise and Resident 12 experiencing anxiety about the missed dialysis treatment.<br><br>Findings:<br><br>A review of Resident 8's clinical records revealed the resident was readmitted to the facility on April 9, 2017, with diagnoses not limited to contractures (condition of shortening and hardening of muscles, tendons, or other tissue, and often leading to deformity and joint rigidity) of bilateral (both) hands and knees.<br><br>The Minimum Data Set (MDS, a comprehensive assessment tool and care-screening tool) document dated July 16, 2017, indicated the resident had severe cognitive (mental process of knowing, awareness, perception, reasoning, and | F 309 | **Procedure for Identifying Potentially Affected Residents**<br><br>All other dialysis residents were reviewed regarding transportation and snacks. No other residents were affected.<br><br>**Corrective Action for Potentially Affected Residents**<br>**Measures Adopted for Systemic Change**<br>Dietary Supervisor reviewed all residents On dialysis to ensure they will have lunch/snack bag before going to dialysis. Charge Nurse will check resident's lunch/snack bag prior to leaving for dialysis.<br>Under the supervision of the DON, facility staff including Dietary Supervisor and Social Services were in-serviced on 8/04/17 – 8/08/17 regarding facility policy of dialysis transportation, snacks for dialysis residents and pain management. | |

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| F 309 | Continued From page 25<br>judgment) impairment. The document also indicated the resident had impairment on bilateral upper and lower extremities. The resident was totally dependent on nurses for activities of daily living for transfer, movement within the facility, feeding, dressing, toilet use, and personal hygiene.<br><br>During an observation and interview on August 4, 2017 at 1:05 p.m., RNA 1 was observed Resident 6 was observed performing ROM therapy to the right arm. RNA 1 explained to observe the resident for pain which would be evidenced by facial grimacing. The resident was observed to have facial grimacing, resisted and pulled away his right arm and covered his face with his both arms from RNA 1. However, RNA 1 continued to perform ROM three times to the resident. The resident was also observed to repeatedly exhibiting pain as evidenced by facial grimacing, resisting, pulling right arm and covering the face with both hands. RNA 1 stated she should have stopped therapy when the resident had facial grimacing and resisting care. RNA 1 further stated she should have informed the licensed nurse that resident had facial grimacing and was resisting ROM exercises.<br><br>A review of the facility's undated policy and procedures titled "Pain Management" indicated to provide guidelines for the consistent assessment, management, and documentation of pain of resident, in order to provide maximum comfort and quality of life. | F 309 | **Monitoring of Corrective Action and Quality Assurance**<br>On a quarterly basis the DON or designee, will check that all residents will have snacks provided before leaving for dialysis, appropriate time for pick up for dialysis residents and ensuring RNAs on facility policy on pain management.<br>All findings will be brought to the Administrator who will review and bring to the QA committee. | |

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b. During an interview with Resident 12 on August 4, 2017 at 9:25 a.m., stated he did not go to his regularly scheduled dialysis appointment today because he was told there was no transportation. The resident stated he was told his dialysis was re-scheduled for the following day, did not want to go today but did not have a choice. The resident stated he was afraid he would begin to have respiratory problems, stating "maybe can't breathe" by missing his dialysis treatment. During the same interview the resident stated he had been having getting picked up after his dialysis appointments late a few times in the past month due to a change on the transportation company. The resident stated he would go to dialysis at 4:15 a.m. every Monday, Wednesday and Friday and be "hooked up to dialysis at 4:45 a.m. and the session would end at 8:45 a.m., but would not even get a snack in the morning prior to leaving the facility, only drinks coffee and would return to the facility to have breakfast. He stated the new transportation company would sometimes pick him up at around 10 a.m. which was too late which made him get very hungry. He stated the previous transportation company picked him up between 9 a.m., or 9:15 a.m.

A review of Resident 12's admission records indicated he was admitted on July 22, 2014 and re-admitted on March 19, 2016 with diagnoses that included end stage renal disease [ESRD] loss of kidney function which filters waste and excess fluid from the blood and renal dialysis (uses a machine to filter waste and excess water from the blood and then replaces it back into the body).

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A review of the Minimum Data Set (MDS), a standardized assessment and care screening too) dated July 15, 2017 indicated Resident 12 was cognitively (mental process of knowing, awareness, perception, reasoning, and judgment) intact.

During an interview with the social services director (SSD) on August 4, 2017 at 2:30 p.m., stated she started employment at the facility on August 1, 2017. The SSD stated social services was not responsible for transportation of dialysis residents but utilized a third party transportation service. SSD stated she would call the third party transportation service as to "what happened this morning". SSD stated Resident 12 was re-scheduled for dialysis the following day at 2:30 p.m.

During an interview and record review with the director of nursing (DON) on August 4, 2017 at 3 p.m., stated the transportation came to pick up Resident 12 at 4:45 p.m. The DON stated the transportation usually picked up the resident between 4 - 4:15 a.m. and because the transportation was late the resident did not want to go because "he was afraid if he got to the dialysis center late, he will not get the full dialysis session".

A review of Resident 12's dialysis communication records indicated the resident arrived back at the facility at 10 a.m., on the following days; July 7, July 10 and July 17. The record indicated all other days the resident would arrive at 9:30 a.m.

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| F 314 SS=D | 483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES<br><br>(b) Skin Integrity -<br><br>(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-<br><br>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and<br><br>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and record review, the facility failed to ensure one of 19 sampled residents (8) was turned and repositioned every two hours. The deficient practice had the potential for worsening of pressure ulcers (localized damage to the skin and/or underlying tissue that usually occur over a bony prominence as a result of pressure and or friction) and contractures (condition of shortening and hardening of muscles, tendons, or other tissue, and often leading to deformity and joint rigidity) of bilateral (both) hands and knees.<br><br>Findings:<br><br>A review of Resident 8's clinical records was | F 314 | F-314<br><br>**Corrective Action for Affected Residents**<br><br>Resident 8 was repositioned by CNA on 8/03/17 and was already on an Alternating Dermafloat mattress since 7/29/17.<br><br>**Procedure for Identifying Potentially Affected Residents**<br>DON and or designee will identify potentially affected residents through observation of residents at risk for pressure ulcers and determine if they have been repositioned every 2 hours or per physician orders. If any resident has not been repositioned, the CNA will be immediately counseled.<br><br>**Corrective Action for Potentially Affected Residents**<br>**Measures Adopted for Systemic Change**<br>On 8/03/17 – 8/09/17, under the supervision of the DON, nursing staff will have been in-serviced on facility policy regarding positioning and repositioning of residents to prevent development of pressure ulcers. | 8/25/17 |

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| F 314 | Continued From page 29<br>readmitted to the facility on April 9, 2017, with diagnoses not limited to contractures and pressure ulcers to the left hip including an unstageable pressure ulcer of the left heel.<br><br>The Minimum Data Set (MDS), a standardized assessment and care screening tool, dated July 16, 2017, indicated Resident 8 had severe cognitive (mental process of knowing, awareness, perception, reasoning, and judgment) impairment. The document also indicated the resident had impairment on bilateral upper and lower extremities and was totally dependent on nurses for activities of daily living such as; transfer, movement within the facility, feeding, dressing, toilet use, and personal hygiene).<br><br>During an observation on August 3, 2017, from 10 a.m. to 1:50 p.m., Resident 8 was observed in his bed laying on his right side.<br><br>During an interview on August 7, 2017 at 3:50 p.m., Certified Nurse Assistant (CNA 1) stated Residents 8 must be turned and repositioned every two hours to prevent onset or worsening of pressure ulcers. | F 314 | **Monitoring of Corrective Action and Quality Assurance**<br><br>On 8/08/17 - 8/18/17, and quarterly there after DON or their designee will observe 5 residents and determine if they have been repositioned. Observations and monitoring will unannounced and a report of the findings will be submitted to the Administrator, who will review the results and bring the report to Quarterly Quality Assurance Committee, which will also review the results and recommend changes as necessary for compliance. | |
| F 322 SS=E | 483.25(g)(4)(5) NG TREATMENT/SERVICES - RESTORE EATING SKILLS<br><br>(g) Assisted nutrition and hydration.<br>(Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must | F 322 | F-322<br><br>**Corrective Action for Affected Residents**<br>Resident 1 and 2 were assessed on 8/04/17 by the RN Supervisor. There was no negative outcome observed No weight loss noted, their physicians were notified and no new orders made. | 8/25/17 |

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| F 322 | Continued From page 30<br>ensure that a resident-<br><br>(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and<br><br>(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and record review, the facility failed to ensure gastrostomy formula was provided per the physician ordered for a resident who were receiving nutrition via gastrostomy tube (GT, tube inserted through the abdomen that delivers nutrition directly to the stomach) for two of 19 sampled residents (1, 2 ). This deficient practice placed the residents at risk not to receive the necessary nutrition and potential weight loss.<br><br>Findings:<br><br>a. A review of Resident 1's admission records indicated she was admitted on October 18, 2005 and readmitted October 16, 2016 with diagnoses that included dysphagia (difficulty swallowing) and gastrostomy (an artificial opening into the stomach used for nutritional support). | F 322 | **Procedure for Identifying Potentially Affected Residents**<br><br>All residents on G-tube feeding were reviewed by the DON on 8/04/17. All were found to be in compliance.<br><br>**Corrective Action for Potentially Affected Residents**<br><br>Under the supervision of the DON, Nursing staff were in-serviced regarding Facility policy of Enteral Feeding Maintenance and regarding carrying out Physicians Orders on 8/04/17 – 8/10/17.<br><br>**Measures Adopted for Systemic Change**<br>All Licensed Nurses will check residents with G-tube feeding every shift to ensure that residents receive the nutrition according to the physicians orders.<br><br>**Monitoring of Corrective Action and Quality Assurance**<br>On a quarterly basis the DON or designee, during rounds will monitor for facility process of Enteral Feeding Maintenance and ensuring carrying out Physicians orders appropriately. All findings will be brought to the Administrator who will review and bring to the QA committee. | |

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A review of Resident 1's Minimum Data Set (MDS, a comprehensive assessment and care-screening tool of health status ) assessment dated May 10, 2017 indicated the resident was cognitively intact (mental process of knowing, awareness, perception, reasoning, and judgment). The resident needed extensive from the staff with eating. The resident had a enteral feeding (the delivery of a nutritionally complete fluid containing protein, carbohydrate, fat, water, minerals and vitamins, directly into the stomach) for nutrition with mechanical soft diet (finely chopped) oral gratification for lunch.

A review of Resident 1's physician's order dated January 16, 2017, indicated to provide Jevity 1.5 at 60 cubic centimeters (cc) per hour for 16 hours to provide 960 cc/1440 Kcal per day.

A review of a plan of care initiated on September 1, 2014 revealed for the Resident 1 to receive GT feedings. The intervention was to administer enteral feedings as ordered.

On August 4, 2017 at 7:55 a.m., during environmental tour Resident 1 was observed lying in her bed. The resident's GT formula bottle (Jevity 1.5) was hung on the enteral pump (a pump used to deliver liquid nutrients and medications to a resident's digestive tract) which was turned on. The label on the bottle indicated it had been started on August 3, 2017 at 6:30 p.m. The enteral pump indicated that 657 milliliters (ml) was infused.

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During an interview with licensed vocational nurse (LVN 1) on August 4, 2017 at 8:32 a.m., stated Resident 1's GT comes on at 6 p.m., and was turned off at 8 a.m., 14 hours for a total of 840 ml. LVN 1 stated the enteral machine indicated 665 ml infused, which was 175 ml less than required per the physician order. LVN 1 stated the staff would stop the feeding for an hour to change the resident, which would still be 115 ml less than the required nutrition amount.

b. A review of Resident 2's admission record indicated he was admitted on June 15, 2017 with diagnoses which included pneumonia (lung infection), chronic respiratory failure (a long-term condition that happens when the lungs cannot get enough oxygen into the blood causing symptoms including shortness of breath), dysphagia and gastrostomy.

A review of resident 2' a Minimum Data Set indicated that the resident had severe cognitive impairment with decisions of daily living. The resident was on a GT feeding.

A review of a physician's order dated July 9, 2017 indicated the resident was on Jevity 1.2 at 70 cc/hour for 20 hours to provide 1440 cc/ 1680 kcal of nutrition per day. The enteral pump was to be turned on at 12 noon and off at 8 a.m. or until total volume was infused.

During an observation on August 4, 2017 at 8:20 a.m., Resident 2 was lying on his bed. The

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| IMPERIAL CREST HEALTH CARE CENTER | 11834 INGLEWOOD AVENUE HAWTHORNE, CA 90250 |

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| F 322 | Continued From page 33<br>resident had a GT formula bottle (Jevity 1.2) that was hung on the enteral pump which was turned on. The label on the bottle indicated it had been started on August 4, 2017 at 3 a.m. The enteral pump indicated 100 milliliters (ml) was infused.<br><br>During an interview with registered nurse 3 (RN 3) on August 4, 2017 at 8:25 a.m., while looking at the enteral pump and GT feeding, verified the amount infused was 100 ml and stated it should be 350 ml. The feeding was 250 ml less than required nutrition amount was infused per the physician order. RN 3 stated the staff would stop the pump when they had to provide care but "shouldn't take that long". | F 322 | | |
| F 323 SS=E | 483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>(d) Accidents.<br>The facility must ensure that -<br><br>(1) The resident environment remains as free from accident hazards as is possible; and<br><br>(2) Each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>(n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.<br><br>(1) Assess the resident for risk of entrapment from bed rails prior to installation. | F 323 | F-323<br><br>**Corrective Action for Affected Residents**<br><br>The hot water tap in room 119 was Immediately closed by the Maintenance Supervisor on 8/02/17<br>The metal weighing scale blocking the outside sliding door to the patio for Room 248 was moved immediately by the Maintenance Supervisor on 8/02/17.<br>The stand up fan on top of the over-bed Table facing Resident 4's bed was Immediately placed on the floor by the Maintenance Supervisor on 8/02/17 | 8/25/17 |

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| F 323 | Continued From page 34<br>(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.<br><br>(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and record review, the facility failed to ensure hot water faucets were properly functioning, a stand up fan was secured and no equipment were blocking the exits. The deficient practices had the potential for altering medication effectiveness and potential for thermal (heat) injury.<br><br>Findings:<br><br>a. During the initial tour accompanied by Minimum Data Set Director (MDSD) and interview on August 2, 2017 at 8:55 a.m., Room 119 restroom was observed with hot water continuously flowing. The MDSD stated the hot water should not be flowing continuously because of potential for hot water burns.<br><br>b. During an environmental tour of the facility on August 2, 2017 at 3:50 p.m., observed a metal stand-up weighing scale blocking the outside sliding door to the patio for Room 248.<br><br>During an interview with Resident 4 on August 2, 2017 at 3:55 p.m., observed resident sitting on a | F 323 | **Procedure for Identifying Potentially Affected Residents**<br><br>Maintenance Supervisor checked the facility for any other hazards including running taps, objects blocking patio doors and fans or TVs sitting on bedside tables which are not strapped down as per facility policy. There were no other findings.<br><br>**Corrective Action for Potentially Affected Residents**<br>**Measures Adopted for Systemic Change**<br>Under the supervision of the DON, facility staff including the Maintenance Supervisor were in-serviced on 8/08/17 – 8/10/17 regarding resident environment free from accident hazards.<br><br>**Monitoring of Corrective Action and Quality Assurance**<br>On a quarterly basis the Maintenance Supervisor, during rounds will monitor for facility process of maintaining an environment for the residents which is free from accident hazards. All findings will be brought to the Administrator who will review and bring to the QA committee. | |

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| F 323 | Continued From page 35<br>wheelchair in her room. The resident stated she did go out into the patio sometimes.<br><br>A review of Residen 4's admission record indicated she was admitted to the facility on September 23, 2014 with diagnoses that included chronic respiratory failure (a long-term condition that happens when the lungs cannot get enough oxygen into the blood with symptoms including shortness of breath), type 2 diabetes mellitus (high blood sugar) and dysphagia (difficulty swallowing).<br><br>A review of Resident 4's Minimum Data Set (MDS), a standardized assessment and care screening tool), dated July 5, 2017 indicated she was cognitively intact (mental process of knowing, awareness, perception, reasoning, and judgment).<br><br>During an interview with the Administrator on August 2, 2017 at 4:05 p.m., stated an exit door was any form of eggress (a way of getting out) and should not be blocked.<br><br>During an interview with the Maintenance Supervisor (MS) on august 4, 2017 at 4:10 p.m., he verified the weighing scale was outside the patio sliding door of Room 248. The MS stated weighing scale will need to be moved against a wall and not block the exit for the resident.<br><br>c. During an environmental tour of the facility on August 3, 2017 at 12:30 p.m., observed a black | F 323 | | |

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| F 323 | Continued From page 36<br>stand up fan on top of an overbed table facing Resident 4's bed. The fan was not strapped or secured to the over bed table.<br><br>During an observation and interview with Resident 4 on August 3, 2017 at 3:40 p.m., when asked about the fan standing on the over bed table the resident stated it had been on the table for four days.<br><br>During an interview with the maintenance supervisor (MS) on August 3, 2017 at 4:05 p.m. inside resident 4's room, he verified that the stand up fan was on top of the table. He stated that the fan should be on the floor otherwise it would fall down on the resident. | F 323 | | |
| F 425 SS=D | 483.45(a)(b)(1) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH<br><br>(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.<br><br>(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who–<br><br>(1) Provides consultation on all aspects of the provision of pharmacy services in the facility;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, the facility failed to ensure medications was not left unattended at the bedside for two of | F 425 | F-425<br><br>**Corrective Action for Affected Residents**<br><br>The medications left at the bedside of Residents 6 and 10 were immediately removed by MDS nurse and charge nurse on 8/02/17.<br>The emergency kit was replaced Immediately on 8/02/17 by the Pharmacy. | 8/25/17 |

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| F 425 | Continued From page 37<br>20 sampled residents (Resident 6, 10). The facility also failed to ensure the emergency kit (Ekit) was replaced within 72 hours. The deficient practice had the potential of residents with cognitive impairment consuming the medications.<br><br>Findings:<br><br>a) Resident 6 was admitted on February 23, 2017, with diagnoses not limited to Dementia ( chronic or persistent mental disorder processes marked by memory disorders, personality changes, and impaired reasoning).<br><br>The Minimum Data Set (MDS, a comprehensive assessment tool and care-screening tool) dated March 1, 2017, indicated Resident 6 had severe cognitive (mental process of knowing, awareness, perception, reasoning, and judgment) impairment.<br><br>During an accompanied initial tour with Minimum Data Set Director (MDSD) on August 2, 2017, at 8:30 a.m., a small clear plastic cup with 30 milliliters of light blue liquid with white granules at the bottom of the cup, was observed on Resident 6's bedside table. MDSD stated the light blue liquid with white granules were crushed medications. MDSD director stated the light blue liquid with white granules was not supposed to be left on the residents bedside table.<br><br>A review of the Medication Administration Record (MAR) dated August 2, 2017, indicated Resident 6 had received Protonix 40 (medication to prevent acid reflex) 40 milligrams )mg) was administered at 6:00 a.m. The MAR also indicated the resident also received Oxybutrin (medication for | F 425 | **Procedure for Identifying Potentially Affected Residents**<br><br>All other residents' bedside was checked for medications and all emergency kits were checked on 8/02/17. There were no other findings.<br><br>**Corrective Action for Potentially Affected Residents**<br>**Measures Adopted for Systemic Change**<br>Under the supervision of the DON, Licensed staff were in-serviced on 8/08/17 – 8/11/17 regarding facility policy on Medication Administration and Replacement of Emergency Kit.<br><br>**Monitoring of Corrective Action and Quality Assurance**<br>On a quarterly basis the DON or designee, during rounds will monitor during daily rounds the residents bedsides. RN Supervisor will check the Emergency Kits daily.<br>All findings will be brought to the Administrator who will review and bring to the QA committee. | |

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| F 425 | Continued From page 38<br>overactive bladder) 2.5 mg at 6:30 a.m.<br><br>During a telephone interview on August 3, 207, at 9:15 a.m., Licensed Vocational Nurse (LVN 4) stated she has never left residents medication at the bedside. LVN 4 was not able explain why crushed medications were found on Resident 6's bedside table.<br><br>b) Resident 10 was admitted to the facility on June 30, 2017, with diagnoses not limited to encephalopathy (brain damage).<br><br>The MDS dated July 13, 2017, indicated Resident 10 had severe cognitive impairment.<br><br>During a shower preparation observation and interview on August 4, 2017, at 11:20 a.m., a small clear plastic cup with oily liquid with thick white substance at the bottom of the clear cup, was observed at Resident 10's bedside table. LVN 3 stated the oily liquid inside the small clear plastic cup was coconut oil. LVN 3 also stated she had placed the plastic cup with coconut at the resident's bedside table to be applied on the resident's face after shaving the resident. LVN 3 further stated leaving the oily liquid at the bedside could result in a resident drinking it.<br><br>A review of the facility undated policy titled Medication Administration indicated drugs were to be administered as soon as possible after preparation but no more than two (2) hours after preparation. The document also indicated prepared drugs are not left with the resident.<br><br>c) During an accompanied medication area | F 425 | | |

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| F 425 | Continued From page 39<br>inspection and audit observation, and interview on August 2, 2017, at 10:20 a.m., the following were observed;<br><br>Vitamin K was removed from Station 2 intramuscular (IM, into muscle) and intravenous (IV, inside vein) Ekit on July 17, 2017, at 6:30 p.m.<br><br>Liquid oral (PO, mouth) multivitamin medication was stored next to liquid rectal (PR) enema medication.<br><br>Registered Nurse (RN 3) stated the facility must notify pharmacy as soon as the Ekit is opened. LVN 6 stated he had contacted pharmacy to replace the Ekit on August 2, 2017, at 8:00 a.m. RN 3 also stated PO and PR medications were to be stored separately to prevent medication mistakes. | F 425 | | |
| F 431 SS=E | 483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS<br><br>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.<br><br>(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.<br><br>(b) Service Consultation. The facility must | F 431 | **F-431**<br><br>**Corrective Action for Affected Residents**<br>A-The vial of Influenza, 2 vial of Tuberculin Purified protein, Vitamin E 200 IU and the 2 bottles of Sodium Chloride were All immediately discarded by the RN Supervisor on 8/02/17.<br><br>B-The bubble pack belonging to Resident 15 with Gabapentin 300 mg was removed immediately on 8/02/07 by Registered Nurse and placed together with medications for disposal. | 8/25/17 |

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| F 431 | Continued From page 40<br>employ or obtain the services of a licensed pharmacist who--<br><br>(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and<br><br>(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br><br>(g) Labeling of Drugs and Biologicals.<br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>(h) Storage of Drugs and Biologicals.<br>(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and record reviews, the facility failed to: | F 431 | C-A new refrigerator was placed in Station 2 medication room along with a new temperature log and thermometer for the refrigerator on Refrigerator on 8/02/17. All the medication which was in the old refrigerator was returned to the pharmacy and replaced on 8/02/17.<br><br>**Procedure for Identifying Potentially Affected Residents**<br>All residents have the potential to be affected.<br>House supply medications and medication refrigerators were checked by the RN Supervisor and there were no other findings. Under the supervision of the DON, all discontinued and outdated medications were discarded on 8/02/17.<br><br>**Corrective Action for Potentially Affected Residents**<br>**Measures Adopted for Systemic Change**<br>Under the supervision of the DON, Licensed nurses were in-serviced on 8/02/17 – 8/11/17 regarding facility policy on Discontinued and outdated medications,Drug and storage labeling and Refrigeration/Temperature of medication which should be at 36-46 degrees Fahrenheit. | |

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| F 431 | Continued From page 41<br><br>a. Identify multiple expired (a date beyond the indicated time for use by the medication manufacturer) medications and remove them from medication storage with house supply (medications that can be bought without a physician's prescription, kept in stock at the facility to be be used routinely or as needed for all residents).<br><br>b. Ensure Resident 15's medication was not stored with house supply medications after the resident was discharged from the facility.<br><br>c. Ensure medication refrigerator temperature was maintained between 36 degrees to 46 degrees for one of two medication refrigerator (Station 2). The facility licensed nurses also did not know the recommended temperature the medication refrigerators.<br><br>This deficient practice did not follow facility protocol, placed other residents at risk for being administered expired medications and had the potential for altering medication effectiveness.<br><br>Findings:<br><br>a. During a tour of Nursing Station One medicatoin room on august 2, 2017 at 10:30 a.m. with registered nurse 1 (RN 1), observed the following expired medications inside the medication room refrigerator:<br><br>1. One vial of influenza (a viral infection affecting the nose, throat and lungs) vaccine with expiry date June 3, 2017. | F 431 | Under the supervision of the Sub Acute RN, Licensed nurses were in-serviced regarding facility policy on drug storage and labeling and refrigerator/temperature at 36-46 degrees as well as a facility temperature log.<br><br>**Monitoring of Corrective Action and Quality Assurance**<br>Daily during rounds the RN Supervisor or Designee will check medication room, medication refrigerator and the refrigerator temperature with log; they will check house supply medications on a monthly basis.<br>On a quarterly basis the DON or designee will check the medications rooms.<br>All findings will be brought to the Administrator who will review and bring to the QA committee. | |

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| F 431 | Continued From page 42<br><br>2. Two vials of tuberculin purified protein derivative [a combination of proteins that are used in the diagnosis of tuberculosis (lung disease)] vaccine opened (no stopper or cap) and with no open date indicated on the vial.<br><br>During the same tour, observed the following inside the house supply medication storage cabinets:<br><br>1. Vitamin E 200 International Units (IU) with expiry date of May 2017.<br><br>2. Two bottles of Sodium Chloride one (1) gram (G) with expiry date of June 2017.<br><br>During a subsequent interview with RN 1, he stated that expired vaccines should be discarded after 28 days of being opened. RN 1 stated he could not tell when the vaccines were opened because there was no date opened on the vial and that there should have been a blue sticker on the vial with an open date indicated. RN 1 stated that al the licensed staff were responsible for checking the medications for expiry date.<br><br>A review of the manufacturer's storage and handling instructions for the influenza vaccine (afluria), indicated not to use the vaccine beyond the expiration date printed on the label.<br><br>A review of the manufacturer's stroage and handling instructions for the tuberculin vaccine (aplisol) indicatedthat vials in use more than 30 days should be discarded due to possible exidation and degeneration which may affect potency. | F 431 | | |

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| F 431 | Continued From page 43 | F 431 | | |

A review of the undated facility's policy titled Drug Disposition indicated that drugs discontinued and outdated drugs that cannot be returned to the pharmacy for credit are properly marked and disposed of.

b. During a tour of Nursing Station One medication room on August 2, 2017 at 10:30 a.m. with registered nurse 1 (RN 1), observed one bubble pack (a pre-filled medication plastic packaging) belonging to Resident 15 with Gabapentin 300 milligram (mg) capsules, not labelled for disposal and stored together with the house supply medications.

A review of resident 15's admission records indicated she was admitted on March 17, 2017 with diagnoses which included acute pancreatitis [a serious condition where the pancreas (a small organ located behind the stomach and below the ribcage) becomes inflamed over a short period of time] and neuropathy (result of damage to nervous system, often causing weakness, numbness and pain, usually in the hands and feet). The resident was discharged on April 8, 2017.

A review of a physician's order dated march 24, 2017 indicated an order for Neurontin (Gabapentin) 900 mg by mouth (PO) three times a day (TID) for neuropathy.

During a subsequent interview with RN 1, he stated he did not know why the bubble pack was stored with the house supply and not labelled for disposal. RN 1 showed the surveyor the other medications for residents who were discharged

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| F 431 | Continued From page 44<br>was stored in the bottom cabinets in a box labelled for discontinued or for disposal.<br><br>A review of the undated facility's policy titled Drug Disposition indicated that drugs discontinued and outdated drugs that cannot be returned to the pharmacy for credit are properly marked and disposed of.<br><br>c. During an accompanied inspection and record review of Station 2 medication room on July 2, 2017, at 10:20 a.m. by Registered Nurse (RN 3), the medication refrigerator was observed to have a temperature recording between 30 degrees Fahrenheit (F) and 32 degrees F. A review of the facility's document titled Refrigerator Temperature Log To Be Done Q Shift, had no refrigerator temperature range. The thermometer inside the medication refrigerator recorded a temperature of 32 degrees.<br><br>During an interview on August 2, 2017, at 10:20 a.m., RN 3 stated in the past she had a refrigerator temperature check log with recommended temperatures but she had removed it and replaced it with the one without recommended temperature ranges. RN 3 also stated with the current refrigerator temperature log document, the licensed nurses could not know if the medication refrigerator was not in range. RN 3 stated the recommended medication refrigerator temperature range was between 31 degrees to 32 degrees. RN 3 further stated she usually checks the medication refrigerator temperature.<br><br>During an interview on August 2, 2017, at 10:40 a.m., Licensed Vocational Nurse (LVN 7) stated "I think the medication refrigerator temperature was | F 431 | | |

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| F 431 | Continued From page 45<br>between 32 degrees F and 35 degrees F." LVN 7 stated it was important to ensure safe medication refrigerator temperature ranges to ensure the medications remained effective.<br><br>A review of the facility policy document titled Medication Storage In The Facility dated April 2008, indicated medications that required refrigeration or temperatures between 36 degrees F and 46 degrees F were kept with the thermometer to allow temperature monitoring. | F 431 | | |
| F 441 SS=E | 483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>(a) Infection prevention and control program.<br><br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);<br><br>(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br><br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; | F 441 | F-441<br>**Corrective Action for Affected Residents**<br>The IV access for Resident 11 was discontinued and removed on 8/02/17 by the RN Supervisor as per physicians order.<br><br>Resident 2,9 and 10 were assessed on 8/02/17 following the deficient practice. There was no negative outcome as a result.<br><br>LVN 8 was counseled 1:1 by the DON regarding facility policy on Finger Nails/Dress Code and Infection Control on 8/03/17. | 8/25/17 |

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| F 441 | Continued From page 46<br><br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br><br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br><br>(iv) When and how isolation should be used for a resident; including but not limited to:<br><br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br><br>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and<br><br>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. | F 441 | **Procedure for Identifying Potentially Affected Residents**<br>DON/RN Supervisor reviewed all residents with IV Therapy and with IV access and no other residents have IV access.<br>Facility staff were in-in-serviced on 8/08/17 – 8/11/17 regarding facility Policy on infection control, IV access, Hand hygiene/hand washing and dress Code particularly finger nails.<br><br>**Corrective Action for Potentially Affected Residents**<br><br>For Resident 9, the feeding tube attached to a feeding bottle was replaced immediately by Charge Nurse on 8/02/17.<br>All residents with G-Tube feeding were checked by RN Supervisor that all the feeding tubes tips are covered. There were no other findings. | |

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| F 441 | Continued From page 47<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, the facility employees failed to change intravenous or remove (IV) access for one of 19 sampled residents (11) and perform hand hygiene in between residents care for two of 19 sampled residents (2, 10). The facility also to failed to ensure nurses followed its policy on finger nails. The deficient practices had the potential for infection among residents.<br><br>Findings:<br><br>a) Resident 9 was admitted on January 23, 2017, with diagnoses not limited to gastrostomy (surgical procedure for inserting a tube through the abdomen wall and into the stomach used for feeding or drainage).<br><br>The Minimum Data Set (MDS, a comprehensive assessment tool and care-screening tool) dated May 2, 2017, indicated the resident had severe cognitive (mental process of knowing, awareness, perception, reasoning, and judgment) impairment.<br><br>During the initial tour observation accompanied by Minimum Data Set Director (MDSD) and interview on August 2, 2017, at 10:00 a.m., Resident 9's feeding tube attached to a feeding bottle was observed hanging on a silver pole. The feeding tube tip was also observed with no cover on. MDSD stated "You know it's supposed to be covered." MDSD also stated covering the feeding tube tip would prevent contamination (not clean)and possible resident infection.<br><br>b) During lunch observation in the dining room on | F 441 | **Measures Adopted for Systemic Change**<br>Under the supervision of the DON, nursing staff were in-serviced on facility policy regarding infection control and hand hygiene/hand washing on 8/08/17 – 8/11/17, LVN 8 was given a 1:1 in-service on Facility policy of Dress Code/Finger Nails by DON.<br><br>**Monitoring of Corrective Action and Quality Assurance**<br>On a quarterly basis the DON or designee, during rounds will monitor for facility process of facility policy of infection control, hand hygiene and staff's Dress code/finger nails. All findings will be brought to the Administrator who will review and bring to the QA committee. | |

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| F 441 | Continued From page 48<br>August 2, 2017, at 12:05 p.m., the following were observed ;<br><br>Certified Nurse Assistant (CNA 7) was observed pass two lunch trays, set up lunch trays, and touch two residents without performing hand hygiene.<br><br>CNA 2 was observed pass breakfast trays, scratch her head, and fed a resident without performing hand hygiene.<br><br>Restorative Nurse Assist (RNA 1) was observed feed a resident, then proceeded to cut up another resident's food, and returned to feed the first resident without performing hand hygiene.<br><br>CNA 5 was observed pull up her pants, touch a resident, and then prepared and served coffee to another resident without performing hand hygiene.<br><br>CNA 6 was observed remove a bib (a piece of cloth or plastic placed around a person's neck to keep their clothes clean while eating) from a resident after lunch, touch the cover for dirty linen bin and place the bib inside it, touch another resident's shoulder, and prepare coffee for another resident without performing hand hygiene.<br><br>During an interview on August 7, 2017, at 10:55 a.m., CNA 2 stated she should have washed hands in between resident care to prevent possible spread of infection.<br><br>During an interview on August 7, 2017, at 11:00 a.m., RNA 1 stated it was important to wash hands in between resident care to observe | F 441 | | |

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infection control.

During record review of the facility's policy document titled Handwashing Notes and Considerations dated June 18, 2012, indicated hands must be washed before and after contact with each resident, resident's environment, and things that come in contact with the resident.

c) Resident 11 was admitted to the facility on April 14, 2017, with diagnoses not limited to sepsis, tracheostomy (surgical opening to the neck for breathing) and ventilator (breathing machine) dependence.

The Minimum Data Set (MDS, a comprehensive assessment tool and care-screening tool) dated July 18, 2017, indicated the resident had severe cognitive (mental process of knowing, awareness, perception, reasoning, and judgment) impairment.

During an accompanied observation, interview, and record review on August 2, 2017, at 4:20 p.m., Resident 11 was observed with an intravenous (IV, inside the vein) to her left forearm. The IV was also observed with a clear dressing sticky tape dated July 15, 2017. Registered Nurse (RN 4) stated since the resident had bad veins, the IV had been left in place for 19 days. RN 4 also stated a physician's order was necessary to keep IV in for longer than 72 hours. RN 4 was not able to locate a physician's order for resident's IV to be left in place for more than 72 hours.

A review of the facility's policy document titled General Policies For IV Therapy dated March, 2014, indicated IV sites would be rotated at least

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72 hours and as necessary (PRN). A physician's order was required to extend the use of an IV site beyond 72 hours, if warranted due to poor venous (vein) access.

d) Resident 17 was admitted to the facility on July 12, 2017, with diagnoses not limited to stage four (4, full thickness tissue loss with exposed bone, tendon or muscle) sacral (low back) pressure ulcer (pressure injury with localized skin damage and underlying soft tissue usually over a bony prominence).

The Minimum Data Set (MDS, a comprehensive assessment tool and care-screening tool) dated July 15, 2017, indicated the resident was cognitively (mental process of knowing, awareness, perception, reasoning, and judgment) intact.

During pressure ulcer treatment for Resident 17 on August 3, 2017, at 8:35 a.m., Licensed Vocational Nurse (LVN 8) was observed with approximately one and half inches long off white colored finger nails to both hands.

During interview on August 3, 2017, at 8:50 a.m., LVN 8 voluntarily stated "I know better than to have long acrylic finger nails." LVN 8 also stated acrylic long nails were source of infection.

A record review of the facility's policy document titled Handwashing Notes and Considerations dated June 18, 2012, indicated nails must be kept short.

A record review of the facility's policy document titled Dress Code, indicated fingernails must be clean and well manicured. The clinical staff

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fingernails must be short and in no event longer than 1/16 of an inch.

e) Resident 10 was admitted to the facility on June 30, 2017, with diagnoses not limited to encephalopathy (brain damage).

The MDS dated July 13, 2017, indicated Resident 10 had severe cognitive impairment.

During a shower preparation observation on August 4, 2017, at 1:25 p.m., CNA 3 was observed with gloves on, touch Resident 10, pick up dropped linen off the floor, remove the gloves, walk to a dirty linen bin, lifted and opened the dirty linen cover bin, place the contaminated linen in a dirty linen container, and touched and removed clean linen from two clean linen carts without performing hand hygiene.

During an interview on August 4, 2017, at 2:50 p.m., the Director of Staff Development (DSD) stated to prevent infection among residents, all employees must perform hand hygiene with resident and or environment contact.

f) During medication administration observation on August 3, 2017, at 6:10 a.m., LVN 9 was observed remove gloves after checking a resident's blood glucose. LVN 9 was also observed administer blood pressure medication to another resident without performing hand hygiene.

During an interview on August , 2017, at 7:30 a.m., LVN 9 stated "I remember not washing my hands after checking the blood sugar." LVN 9 also stated it was important to observe hand hygiene to prevent spread of infection.

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g) During a bed bath observation of Resident 2 on August 7, 2017 at 8:38 a.m., observed certified nursing assistant 13 (CNA 13), after applying lotion to the resident's upper body, drop the lotion cap on the floor, proceeded to re-cap the lotion bottle and using the same gloves pick up an anti perspirant bottle and continue applying anti-perspirant onto the resident. After applying the anti-perspirant, the CNA adjusted the resident's pillow and placed a clean gown on the resident using the same gloves. At 8:42 a.m., the CNA comes into the room, using gloves takes all the dirty linen and feces soiled incontinent pad and puts them in a clear plastic bag. The CNA then leaves the room, takes off his gloves, does not perform hand hygiene and proceeded to the clean linen cart to take a clean sheet from the cart and then go back into the resident's room and applied the sheet to the resident.

During further observation at 8:50 a.m., CNA 13 was observed leaving Resident 2's room, not wash his hands and enter Resident 10's room to adjust the blanket over the resident's foot cradle.

During an interview with CNA 13 on August 7, 2017 at 9: 15 a.m., he stated that he should have not picked up the lotion cap or changed his gloves. The CNA stated that he should have put on new gloves and wasked his hands after care because the residents are susceptible to germs.

During record review of the facility's policy document titled Handwashing Notes and Considerations dated June 18, 2012, indicated

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| F 441 | Continued From page 53<br>hands must be washed before and after contact with each resident, resident's environment, and things that come in contact with the resident. | F 441 | | |
| F 458 SS=B | 483.90(e)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT<br><br>(e)(1)(ii) Measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms; This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review, the facility failed to provide a minimum of 240 square feet of living space for 5 rooms with 3 residents living in each room. This deficient practice placed the residents at risk of not having enough room to receive care.<br><br>Findings:<br><br>During an interview with the administrator, on August 2, 2017 at 7 p.m., he stated the facility will be requesting a room waiver due to 5 rooms with less than the required square footage per resident.<br><br>A review of the "Client Accommodations Analysis," dated August 2, 2017 indicated the following measurements for rooms with 3 beds:<br><br>Rooms 109, 129, and 131 were 237.1 square feet<br>Room 111 was 236.1 square feet<br>Room 117 was 232.1 square feet<br><br>During observations from August 2, 3, 4 and 7, | F 458 | F-458<br><br>**Corrective Action for Affected Residents**<br>Maintenance Supervisor measured the Facility Square footage in the residents rooms. A Waiver letter was submitted on 8/02/17.<br><br>**Procedure for Identifying Potentially Affected Residents**<br>**Corrective Action for Potentially Affected Residents**<br>All residents may be potentially affected, So the facility will take corrective action in Relation to all residents. Therefore no Procedure for identifying potentially Affected residents is necessary.<br>The residents currently in those rooms were assessed that their special needs are being considered and taken care of and that the Residents are not adversely affected by the Square footage.<br>Room Waiver letter was submitted on 8/02/17 to the survey team and we are Waiting approval.<br><br>**Measures Adopted for Systemic Change**<br><br>Room Waiver letter was submitted on 8/02/17 to the survey team. | 8/25/17 |

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| F 458 | Continued From page 54<br>2017 the resident's care needs, safety and health were not affected by room size. | F 458 | **Monitoring of Corrective Action and Quality Assurance**<br>Room Waiver was submitted on 8/02/17 to the survey team as well as a letter sent to CDPH and we are waiting approval.<br>**F-469**<br><br>**Corrective Action for Affected Residents**<br>Pest control was contacted and they treated the facility on 8/24/17.<br>Resident 8 and 12 were assessed and there Was no negative outcome as a result of the deficient practice.<br><br>**Procedure for Identifying Potentially Affected Residents**<br><br>All residents have the potential to be affected.<br>**Corrective Action for Potentially Affected Residents**<br>**Measures Adopted for Systemic Change**<br>Pest Control was contacted and they treated the facility and installed aerosol fly mist machines on exit doors on 8/24/17.<br>Pest Control will continue to come on a monthly basis or as needed.<br>Under the supervision of the DON, staff was in-serviced regarding pest control and about keeping all windows and doors closed to prevent flies from entering the facility on 8/08/17 – 8/11/17. | |
| F 469 SS=E | 483.90(i)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM<br><br>(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by:<br>Based on observations and interviews, the facility failed to maintain a pest free environment for two of 19 sampled residents (8, 12) and one of nine residents during group interview. This deficient practice had the potential for an uncomfortable environment and spread of disease.<br><br>Findings:<br><br>a. During group interview of alert and oriented (awake and responsive, and oriented to person, place and time) residents on August 4, 2017 at 10:30 a.m. one resident stated that there were flies in the facility. The resident stated that they annoyed her especially when she was eating. The residents stated that the staff knew of the problems with the flies.<br><br>b. During a shower observation for Resident 8 on August 4, 2017 at 9:05 a.m., when resdient returned to his room from the shower room, observed a black fly on top of the resident's heel protector in the presence of the director fo staff development (DSD). The DSD verified it was a fly and stated that she will change the heel protector right away.<br><br>c. During an interview with Resident 12 on August 7, 2017 at 11:30 a.m., he stated that there were | F 469 | | 8/25/17 |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555719 | A. BUILDING _____ B. WING _____ | 08/07/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| IMPERIAL CREST HEALTH CARE CENTER | 11834 INGLEWOOD AVENUE HAWTHORNE, CA 90250 |

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| F 469 | Continued From page 55<br>flies everyday in his room. During a room visit to Resident 12 on August 7, 2017 at 3:20 p.m. in the presence of licensed vocational nurse 12 (LVN 12), observed a black fly in the room by the window screen. Resident 12's roommate stated that "they are here all the time" and he gets something to swat them with to get rid of them. | F 469 | We will monitor for compliance via Resident council meetings and Town Hall Meetings.<br>**Monitoring of Corrective Action and Quality Assurance**<br>On a monthly basis, the Administrator or designee during rounds will monitor for flies in the facility and to ensure that the windows and doors remain closed so as to prevent flies from entering the facility. All findings will be brought to the Administrator who will review and bring to the QA committee. | |
| F 517 SS=D | 483.75(m)(1) WRITTEN PLANS TO MEET EMERGENCIES/DISASTERS<br><br>The facility must have detailed written plans and procedures to meet all potential emergencies and disasters, such as fire, severe weather, and missing residents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review, one facility employee failed to demonstrate how to use the fire extinguisher in the event of fire disaster. The deficient practice had the potential of poor fire control in the vent of fire disaster.<br><br>Findings:<br><br>During an interview on August 2, 2017, at 6:40 a.m., Certified Nurse Assistant (CNA 11) stated is she witnessed staff to resident abuse, she would separate the two, ensure resident was safe, immediately notify the Administrator and nursing supervisor, call 911, report to Department of Health (DPH), and the ombudsman.<br><br>During an interview on how to use of a fire extinguisher on August 2, 2017, at 11:20 a.m., through Interpreter, Housekeeping (HK 1) stated if she witnessed resident to resident fight, she would not get involved and would also run away to save herself. HK 1 also stated incase of fire | F 517 | **F-517**<br><br>**Corrective Action for Affected Residents**<br><br>No residents were identified. Housekeeper 1 was counseled immediately on 8/02/17 by Maintenance Supervisor and DON on how to properly use the fire extinguisher in the event of an emergency.<br><br>**Procedure for Identifying Potentially Affected Residents**<br><br>All residents had the potential to be affected. | 8/25/17 |

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| F 517 | Continued From page 56<br>she would call code red. HK 1 also stated she would use the fire extinguisher by squeezing the handle, aim at the fire, and sweep from top to bottom.<br><br>a) A review of the facility's document titled RACE indicated the following;<br><br>R-Rescue the Resident.<br><br>A-Activate the Alarm.<br><br>C-Contain the fire.<br><br>E-Extinguish the fire.<br><br>b) A review of the facility's document titled PASS indicated the following;<br><br>P-Pull the pin.<br><br>A-Aim.<br><br>S-Squeeze.<br><br>S-Sweep.<br><br>c) A review of the facility's document titled Lesson Outline dated June 30, 2017, indicated to remove all occupants from involved room, make a thorough search, shut off and remove any oxygen in use, close all windows, and call fire department. | F 517 | **Corrective Action for Potentially Affected Residents**<br>**Measures Adopted for Systemic Change**<br>Under the supervision of the DON, facility staff including Housekeepers were in-serviced on 8/10/17 regarding proper use of a fire extinguisher in the event of an emergency.<br><br>**Monitoring of Corrective Action and Quality Assurance**<br>On a quarterly basis the Administrator or designee, during rounds will monitor for facility process of emergency preparedness with an emphasis of proper use of fire extinguisher in the event of an emergency.<br>All findings will be brought to the Administrator who will review and bring to the QA committee. | |