California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA010000074	A. BUILDING: _____ B. WING _____	08/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGS ROAD HEALTHCARE	1527 SPRINGS ROAD VALLEJO, CA 94591

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	Initial Comments The following represents the findings of the California Department of Public Health during a Re-Licensing Survey. Representing the California Department of Public Health: Health Facilities Evaluator Nurses 38322, 37148, and 41436. The facility census on 8/5/19, the day of entry, was 54 with four bed-holds.	C 000	**DISCLAIMER CLAUSE** **Preparation and/or execution of this plan of correction does not constitute the provider's admission of or agreement with the facts alleged or conclusions set forth in the statement of deficiencies . The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law.**	
C 690	T22 DIV5 CH3 ART3-72301(f) Required Service (f) The facility shall ensure that all orders, written by a person lawfully authorized to prescribe, shall be carried out unless contraindicated. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to implement a physician order for a psychiatric evaluation for Resident 10. As a result, Resident 10 potentially received excessive doses of two antipsychotic medications for nearly three months, a failure which could compromise Resident 10's mental and physical health and well-being. Findings: In an 8/7/19, review of Resident 10's medical record, it was noted Licensed Staff D had conducted a Medication Regimen Review on 5/17/19, and identified a concern that Resident 10 may be unnecessarily receiving two antipsychotic medications. On 5/22/19, Resident 10's attending physician responded to this concern, documenting, "No GDR (Gradual Dose Reduction), stable, psych evaluation."	C 690	C 690 T22 DIV5 CH3 ART3-72301(f) Required Service **<u>Corrective action for resident affected by deficient practice:</u>** Resident 10 was evaluated by the Psychologist on August 8, 2019 and August 19, 2019 with no order or recommendations. — 08/09/19 Resident 10 scheduled for Psychiatrist for evaluation on September 25, 2019. — 08/25/19 **<u>Identification of residents having potential to be affected by deficient practice and corrective action to be taken:</u>** No other residents were affected for this deficiency per audit by the Psychotropic Committee team, — 08/13/19	

Licensing and Certification Division

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: EXECUTIVE DIRECTOR — (X6) DATE: Revised 9/24/19

9/25/19 1:33 pm Spoke c Corazon Lucina Administrator-in-training. Informed her POC accepted.

CM Hobbs HFEN

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C 690	Continued From page 1 Facility staff never processed the psychiatric evaluation request of 5/22/19, and thus it was not conducted. The DON confirmed in an interview at 1:20 p.m. on 8/7/19, that the psychiatric evaluation order had never been processed, but stated, "the provider will do it tomorrow."	C 690	consisting of DON/SSD/MDS/ACT; on September 13, 2019. Residents residing in the facility have the potential to be affected by the deficient practice.	
C 790	T22 DIV5 CH3 ART3-72307(a) Physician Services--Supervision of Care (a) Each patient admitted to the skilled nursing facility shall be under the continuing supervision of a physician who evaluates the patient as needed and at least every 30 days unless there is an alternate schedule, and who documents the visits in the patient health record. This Statute is not met as evidenced by: Based on interview and record review, four of eight sampled residents (Residents 7, 8, 9, and 10) were not seen by an attending physician at least every thirty days, as required. This placed each patient at risk of not having timely medical assessments performed and interventions initiated, either of which could compromise residents' current and ongoing health status. Findings: During a medical record review on 8/7/19 at 9:20 a.m., the following deficits were noted: (a) Resident 7 was not visited by an attending physician, and no progress note was recorded after 6/4/19, indicating Resident 7 had gone at least 60 days without an attending physician visit; (b) Resident 8 was not visited by an attending physician, and no progress notes were recorded in March, April or May of 2019, a 90-day period;	C 790	**Systematic changes to ensure deficient practice does not recur:** Licensed nurses will be re-educated with the policy and procedures of Physician Order by the Director of staff Development by 09/30/19. The Health Information Manager will bring all the Telephone Orders to the Daily Clinical Meeting for review and follow-up by the Interdisciplinary Team, consisting of DON/MDS/SSD/ACT/DSM/ED. The Supervisor will audit all the Telephone Orders during the monthly recap. **Monitoring corrective action:** The Supervisor will submit the audits to the Director of Nursing monthly. Identifiable trends are addressed through the QAPI and submitted to the Quality Assurance and Assessment Committee monthly for follow up and recommendation.	09/30/19 09/16/19 09/30/19 09/30/19 09/30/19

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C 790	Continued From page 2 (c) Resident 9 was not visited by an attending physician, and no progress note was recorded in March, April or May of 2019, a 90-day period; and, (d) Resident 10 was not visited by an attending physician, and no progress notes were recorded in May, June or July of 2019, a 90-day period. In an interview on 8/7/19 at 2:30 p.m., the DON confirmed neither she nor Medical Records personnel could locate any of the above missing progress notes or locate other evidence of attending physician visits. Documentation of attending physician visits were requested but not provided.	C 790	C 790 T22 DIV5 CH3 ART3-72307(a) Physician Services – Supervision Of Care **Corrective action for resident affected by deficient practice:** Resident 7 was evaluated by the Primary Care Physician on 09/01/19. Resident 8 was evaluated by the Primary Care Physician on 09/05/19. Resident 9 was evaluated by the Primary Care Physician on 09/05/19. Resident 10 was evaluated by the Primary Care Physician on 09/08/19 **Identification of residents having potential to be affected by deficient practice and corrective action to be taken:** Health Information Manager audited the all residents residing in the facility on 09/08/19. Affected residents evaluated and completed by the Primary Care Physician and his team on 09/12/19. Residents residing in the facility have the potential to be affected by the deficient practice.	09/01/19 09/0519 09/05/19 09/08/19 09/08/19 09/12/19
C 945	T22 DIV5 CH3 ART3-72313(a)(7) Nursing Service--Administration of Medication (a) Medications and treatments shall be administered as follows: (7) Patients shall be identified prior to administration of a drug or treatment. This Statute is not met as evidenced by: Based on observation, interview and record review, the facility failed to follow its own policy, when two of four sampled residents (Residents 7 and 8) were not properly identified prior to staff administering their medications. This practice failure potentially placed all residents receiving medications at risk of being given an incorrect medication, which could compromise their health and/or safety. Findings: During an interview on 8/5/19 at 3:15 p.m., Licensed Nurse A stated the residents in the	C 945		

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C 945	Continued From page 3 facility did not wear arm bands for identification. When asked how residents were identified prior to medication administration, Licensed Nurse A stated, "We look at the name on the wall outside the door, ask them their name and date of birth, and if they are not able to answer, we use the picture in the MAR (Medication Administration Record)." During a medication pass observation on 8/7/19 at 8:45 a.m., Licensed Nurse A greeted Residents 7 and 8 by their names. However, she failed to confirm either resident's identity by asking them to state their names or their dates of birth, prior to administering their medications. When asked about the process for patient identification, Licensed Nurse A stated, "Ask their name, sometimes ask birth date, and there's a picture on each page of the MAR." On 8/7/19 at 9:35 a.m., the DON was asked to describe the process for patient identification during medication administration. She stated the identification process was, "Do the Five Rights. You have to ask the patient his name, ask his birth date, and look at the photo in the MAR." Review of facility policy, "Medication Administration" (dated March 2014, updated June 2017), revealed in Section 5. a. of the, "5 Rights of Medication Administration: Right Person: validated via photo, wrist band, and/or asking resident name with DOB (Date of Birth)."	C 945	**Systematic changes to ensure deficient practice does not recur:** The Director of Nursing in-service the Health Information Manager regarding Title 22 § 72307 Physician Services -Supervision of Care and facility policy of Physician Visits on 09/16/19. Monthly, Health Information Manager audits the medical records for physician visits to confirm visits not to exceed timeframes (with a 10 day allowance for each). Negative findings will be reported immediately to the Director of Nursing for immediate correction and Physician notification. **Monitoring corrective action:** The Health Information Manager will submit the audits to the Director of Nursing monthly. Identifiable trends are addressed through the QAPI and submitted to the Quality Assurance and Assessment Committee monthly for follow up and recommendation.	09/16/19 09/20/19 09/20/19
C1925	T22 DIV5 CH3 ART3-72357(h) Pharmaceutical Service--Labeling and Storage (f) Drugs shall be stored in appropriate temperatures. Drugs required to be stored at	C1925		

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C1925	Continued From page 4 room temperature shall be stored at a temperature between 15 degrees C (59 degrees F) and 30 degrees C (86 degrees F). Drugs requiring refrigeration shall be stored in a refrigerator between 2 degrees C (36 degrees F) and 8 degrees C (46 degrees F). When drugs are stored in the same refrigerator with food, the drugs shall be kept in a closed container clearly labeled "drugs." This Statute is not met as evidenced by: Based on observation, interview and record review, the facility did not ensure the internal temperature of the Unit 1 medication refrigerator was sufficiently low enough to provide safe storage for resident medications. This placed all residents, receiving refrigerated medications, at risk of receiving one or more ineffective or contaminated drugs, which could compromise their health and safety. Findings: During an interview and observation with the Director of Nursing (DON) on 8/6/19 at 8:33 a.m., a small refrigerator unit was on the counter in the Unit 1 medication room. This unit contained refrigerated injectable and oral medications for both units within the facility. The temperature on the refrigerator's internal thermostat (as observed by both the DON and surveyor) was 50°F. The temperature was rechecked at 9 a.m., and the thermostat read 52°F (confirmed with the DON). The temperature was again checked at 9:30 a.m., and the thermostat registered 48°F (confirmed with the DON). Drugs requiring refrigeration must be stored in a refrigerator at temperatures between 36°F and 46°F to ensure their safety and integrity.	C1925	C 945 T22 DIV5 CH3 ART3-72313(a)(7) Nursing Service-Administration Of Medication **Corrective action for resident affected by deficient practice:** Resident 7 and 8 provided wrist band on 08/07/19. Licensed A had in-service regarding the policy and procedures of Medication Administration by the Director of Staff Development on 08/07/19. **Identification of residents having potential to be affected by deficient practice and corrective action to be taken:** Residents reside in the facility provided a wrist band on 08/09/19. Residents residing in the facility have the potential to be affected by the deficient practice. **Systematic changes to ensure deficient practice does not recur:** Health Information Manager will prepare wrist band for the new admit resident.	08/07/19 08/07/19 08/09/19

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C1925	Continued From page 5 During a review of the facility's refrigerator temperature monitoring log, each of the last eleven entries for the month indicated the internal refrigerator temperature was 40°F.	C1925	Monthly,Health Information Manager audit residents for use of wrist band and missing wrist band(s) will be replaced immediately by the Licensed Nurse.	09/20/19
C4470	T22 DIV5 CH3 ART5-72527(a)(19) Patients' Rights (a) Patients have the rights enumerated in this section and the facility shall ensure that these rights are not violated. The facility shall establish and implement written policies and procedures which include these rights and shall make a copy of these policies available to the patient and to any representative of the patient. The policies shall be accessible to the public upon request. Patients shall have the right: (16) To retain and use personal clothing and possessions as space permits, unless to do so would infringe upon the health, safety or rights of the patient or other patients. This Statute is not met as evidenced by: Based on observation, interview and record review, the facility failed to follow its own policies to effectively monitor and manage the process of laundering and distributing resident personal clothing. This failure compromised the rights of residents to retain and use their personal clothing, potentially compromising their dignity and perceptions of self-worth. Findings:	C4470	The Director of Staff Development in-service the Licensed Nurses regarding policy and procedures of Medication Administration on 09/05/19. Monthly, Licensed Nurses skill check regarding Medication Administration by Director of Staff Development. Director of Staff Development will in-service new hired Licensed Nurses regarding policy and procedures of Medications Administration and skill check of Medication Administration before working with the residents. **Monitoring corrective action:** Monthly, Health Information Manager audits for wrist band will submit to the Director of Nursing. Monthly, Director of Staff Development will submit audit of	09/05/19 09/24/19 09/30/19 09/20/19 09/20/19

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C4470	Continued From page 6 During an interview on 8/5/19 at 10:20 a.m., Resident 6 stated half of her blouses and her blanket were missing. Resident 6 stated she had spoken with her Registered Nurse about it, and had filled out two complaints. When queried, Resident 6 stated her blouses were labeled with her name. They were brand new, and her mom had to go shopping to replace them. Resident 6 stated her blanket had been a gift, and she wanted it back. During an observation and interview on 8/6/19 at 8:10 a.m., in the rear laundry room area, multiple stacks of laundered, but undistributed, resident belongings were noted. Three stacks of clothing items on the counter, the largest stack being at least 36 inches high. Two wheeled laundry carts, each approximately three feet wide by five feet high, contained more resident clothing items. A covered linen shelving unit, six feet high by five feet wide, contained clothing items hung on hangers. A plastic shelving unit, approximately five feet high and two feet wide, contained eight drawers of belongings Staff B stated were, "Items like scarves and bras." Staff B stated the clothing items in this room belonged to the residents of two separate nursing facilities. He added this facility had been short-staffed by at least one person, thus it, "has been difficult to keep up with the distribution of belongings." Staff B added, "Some of this has been here for years, and someone needs to go through it and toss some of it out." In an 8/6/19 10:05 a.m. interview, the Director of Social Services (SSD) stated she had received some complaints of missing resident belongings in May and June (of 2019), but, "there were fewer complaints in July." She stated she had	C4470	Licensed Nurses Medication Administration skills check to the Director of Nursing. Identifiable trends are addressed through the QAPI and submitted to the Quality Assurance and Assessment Committee monthly for follow up and recommendation. C 1925 T22 DIV5 CH3 ART3-72357(h) Pharmaceutical Service-Labeling And Storage **Corrective action for resident affected by deficient practice:** No resident was identified in the deficient. Unit 1 Medication refrigerator was replaced immediately, and new thermometers were installed on 08/06/19. Medications that were stored in the refrigerator were re-ordered by Nurse Supervisor through pharmacy on 08/06/19. **Identification of residents having potential to be affected by deficient practice and corrective action to be taken:** Residents were affected by this deficiency, had medications re-	09/30/19 08/06/19 08/06/19 08/06/19

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C4470	Continued From page 7 observed that, "there's quite a bit out there," (referring to the laundry area). The SSD stated she had not been informed Resident 6 had lost any items. The SSD got down a binder off a shelf and looked through it, and stated she did not have any grievance forms from Resident 6, regarding lost items. The SSD stated if a resident reported a personal item missing and it could not be immediately found, a grievance form would be filled out and brought to her. She stated if a grievance form was filled out, the issue would have to be addressed and resolved. Review of Resident 6's medical record revealed a document titled, "Inventory of Personal Effects," not dated. The inventory indicated Resident 6 had ten shirts, then written next to the word shirts, "[plus] 4 more 6-30-19." Resident 6's face sheet indicated an admission date of 6/14/19. Resident 6's MDS (Minimum Data Set, an assessment tool), dated 7/12/19, indicated a BIMS score of 15 (Brief Interview for Mental Status, a score of 15 indicates cognitively intact). During an interview on 8/6/19 at 3:20 p.m., the Administrator stated he assessed the quality of the performance of the contracted laundry service by doing a monthly walk-through, checking the linen counts, the wear and tear on the clothing, the turn-around time for washing the clothing and returning it to the residents, and the number of grievances residents submit. When asked about the accumulation of lost articles in the laundry department, the Administrator stated he planned to hold a clinic to display the items and invite the residents and families to come see if any of the items belonged to them. Review of Resident Council minutes from April, May, June, and July of 2019, revealed grievances	C4470	ordered on 08/06/19. Residents residing in the facility have the potential to be affected by the deficient practice. **Systematic changes to ensure deficient practice does not recur:** Licensed nurses will be in-serviced on the policy and procedures of the following: Storage of Medication, temperature reading, tracking log and steps that will be followed if temperature falls out of range by the Director of Staff Development by 08/07/19. The Director of Staff Development will in-service the new hired Licensed Nurses regarding the policy and procedures of the following: Storage of Medication, temperature reading, tracking log and steps that will be followed if temperature falls out of range. Licensed Nurses will monitor the refrigerator temperature twice a day. Director of Staff Development will validate the refrigerator temperature recorded by Licensed Nurses on weekly basis.	08/07/19 09/20/19

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C4470	Continued From page 8 had been filed against the laundry department on 3/19/19 and 4/16/19. On both grievance forms, under section, "Nature of Grievance," was written, "Clothes not being returned timely." The QAA committee minutes of 6/26/19, indicated as, "Issues from Previous Meeting: Missing clothes - working on 3-day turnaround." In the minutes of the 5/23/19, QAA meeting, "Issues from Previous Meeting," included, "Clothing/labeling - missing clothes - getting better, no missing clothes but late delivery." Under, "New Business," the 5/23/19, minutes reflect, "Missing clothes." In the minutes of the 4/17/19, QAA meeting, under, "New Business," it indicated a problem with, "Clothing labeling/missing clothes." In the minutes of the 3/20/19, QAA committee minutes, under, "Issues from Previous Meeting," it indicated, "Missing clothes - 6 months." In the minutes of the 2/26/19, QAA meeting, under, "Issues from Previous Meeting," it indicated, "Personal belongings - QAPI done." Review of the laundry contract with Healthcare Services Group, Inc., dated 9/28/11, indicated in Section 1, Scope of Work: "Healthcare will provide all management, supervision, labor and materials necessary to perform the housekeeping and laundry services on the premises of the Facility. A document from this vendor, titled, "Personal Clothing," revised 1/2016, indicated on Page 7, "In long-term care, no area of laundry management is more critical to patient care and dignity issues than the area of resident clothing." Page 40 of this document indicated, "If clothing is unmarked, do not let it accumulate in the laundry. All missing clothing grievances must be researched, answered and clothing returned (either found or replaced) within 24 - 48 hours."	C4470	Monthly, Director of Nursing or designee will skill check Licensed Nurses regarding policy and procedures of the following: Storage of Medication, temperature reading, tracking log and steps that will be followed if temperature falls out of range. **Monitoring corrective action:** Identifiable trends are addressed through the QAPI and submitted to the Quality Assurance and Assessment Committee monthly for follow up and recommendation. C 4470 T22 DIV5 CH3 ART5 72527(a)(19) Patients' Rights **Corrective action for resident affected by deficient practice:** Resident 6 blouses and blanket were found and returned to the patient on 08/13/2019 by the Social Service Director. All clothing items identified in the shelving units, counter and laundry carts are distributed by the Laundry staff on 08/07/19. Laundry clinic for unlabeled clothing has been scheduled 10/12/19 to assist the residents and	09/30/19 09/30/19 08/13/19 08/07/19 10/12/19

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C4470	Continued From page 9 The policy statement of the facility's policy titled, "Personal Care Items and Clothing," dated 5/22, and updated 7/15, indicated, "Residents have personal care items and clothing available."	C4470	family members to identify any clothing that are missing, and not on inventory. **Identification of residents having potential to be affected by deficient practice and corrective action to be taken:**	
C5840	T22 DIV5 CH3 ART6-72619(a)(1) Provision for Privacy Visual privacy for each patient shall be provided to meet the requirements of Section T17-070 of Title 24. Doors providing access to the corridor shall not be considered as meeting this requirement. This Statute is not met as evidenced by: Based on observation and interview, the facility failed to provide bed curtains of a sufficient width, to ensure simultaneous privacy of residents housed in eight of the facility's ten three-bed rooms. This failure had the potential to compromise the privacy and dignity of at least one of three residents in each of these eight rooms, should all three require privacy protection at the same time. Findings: In an observation and interview 8/5/19 at 10:15 a.m., Resident 11 stated there was no privacy curtain at the foot of her bed, so she was always bothered by the light and activity in the bathroom, located directly opposite the foot of her bed. (This bathroom was shared by six residents from two different rooms, increasing the frequency of its use.) Though there were several (empty) hooks on the curtain track, there was no curtain	C5840	No other resident was identified per Empres Care Representatives rounds on 08/08/19. Residents residing in the facility have the potential to be affected by the deficient practice. **Systematic changes to ensure deficient practice does not recur:** Director of Staff Development will in-service the License Nurses, Certified Nursing Assistants and Laundry Staff regarding Patients' Rights to retain and use of their personal clothing by 09/30/19. Patients' Rights to retain and use of their personal clothing will be included in the new hire orientation by the Director of Staff Development. Health Care Services Group Supervisor will in-service the Laundry personnel regarding their Personal Clothing policy and timely distribution of residents personal	08/08/19 09/30/19 09/30/19 09/30/19

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C5840	Continued From page 10 present at the foot of Resident 11's bed. Though a curtain by another bed [in the room] could be pulled to provide privacy for two adjacent beds, it was too short to also extend fully across to Resident 11's bed. During an observation on 8/5/19 from 2 p.m. - 2:30 p.m., in four of four three-bed-rooms, privacy curtains did not provide complete simultaneous coverage, to ensure visual privacy for residents. In rooms 15, 17, and 18, full extension of the privacy curtain, around the foot of the beds, did not allow for complete coverage and privacy, at the same time, placing residents in jeopardy of being partially-to-fully exposed to visualization from the bedroom/hallway door and the bathroom/room door. In room 16, a single privacy curtain, at the foot of bed C, and side privacy curtains, provided full visual privacy to the resident in this bed. For beds A and B, the privacy curtain around the foot of these beds did not allow for complete coverage and privacy, at the same time, placing residents in jeopardy of being partially-to-fully exposed to visualization from the bedroom/hallway door and the bathroom/room door. On 8/5/19 at 11 a.m., a piece of metal was attached to the ceiling curtain track between Room 8B and 8C, at the foot of both beds. This metal piece prevented the curtain from being drawn to provide privacy to the resident in Room 8C. As a result, the 8C resident had no privacy from the light or activity in the (shared and busy) bathroom, located at the foot of her bed. In an observation and interview on 8/6/19 at 2:55 p.m., the surveyor, Staff E and Staff C noted the curtains in Rooms 6, 8, 10, 15, 17, 18, 26 and 27, and confirmed the curtains were all of an	C5840	belongings by 09/30/19. Activity Director will include in the monthly resident council minutes the purpose, procedures and location of the Grievance form. Empres Care Representatives will monitor their assigned residents for any concern during weekly rounds. Any negative findings will be discussed on the Daily Stand Up Meeting for follow up and resolutions. Executive Director reviews the Grievance Log in the Daily Stand-Up Meeting for needed resolution and/or follow-up. **Monitoring corrective action:** Social Services/designee analyzes grievances monthly for tracking and trending. Identifiable trends are addressed through the QAPI and submitted to the Quality Assurance and Assessment Committee monthly for follow up and recommendation. C 5840 T22 DIV5 CH3 ART6-72619(a)(1) Provision for Privacy **Corrective action for resident**	09/16/19 09/30/19 09/23/19 09/30/19 09/30/19

California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA010000074	A. BUILDING: _____ B. WING _____	08/07/2019

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C5840	Continued From page 11 insufficient width to provide simultaneous privacy for all three beds in each of these eight rooms. During the above interview, Staff C further stated some curtains had been removed for laundering. Patient privacy must be maintained at all times, including during the laundering process, utilizing options such as a spare or other temporary privacy curtain as the facility chose.	C5840	**affected by deficient practice:** Resident 11 provided a privacy curtain by the Maintenance Supervisor on 08/05/19. Room 6, 8, 10, 15, 17, 18, 26 and 27 curtains were replaced to provide complete coverage and privacy on 08/06/19 by the Housekeeping staff. Metal piece attached to the ceiling curtain between 8b and 8C was removed to provide complete coverage and privacy by the Maintenance Supervisor on 08/05/19. **Identification of residents having potential to be affected by deficient practice and corrective action to be taken:** Maintenance Supervisor checks resident's room privacy curtains and affected rooms was provided complete coverage and privacy curtains by the Housekeeping staff on 08/06/19. Residents residing in the facility have the potential to be affected by the deficient practice.	08/05/19 08/06/19 08/05/19 08/06/19

California Department of Public Health

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C5840	Continued From page 11 insufficient width to provide simultaneous privacy for all three beds in each of these eight rooms. During the above interview, Staff C further stated some curtains had been removed for laundering. Patient privacy must be maintained at all times, including during the laundering process, utilizing options such as a spare or other temporary privacy curtain as the facility chose.	C5840	**Systematic changes to ensure deficient practice does not recur:** Empres Care Representatives will be in-service by the Maintenance Supervisor regarding Provision for Privacy and use of Privacy Curtain on 09/20/19. Nursing, housekeeping and laundry staffs will be in-serviced on Provision for Privacy and use of Privacy Curtain by Director of Staff Development by 09/30/19. Housekeeping staff will monitor the privacy curtains of the resident rooms during their daily cleaning. Empres Care Representatives will monitor their assigned residents for Provision for Privacy and use of Privacy Curtain on weekly rounds. Missing privacy curtain(s) will be replaced immediately by the housekeeping staff. **Monitoring corrective action:** Empres Care Representatives will submit monthly report to the Executive Director. Identifiable trends are addressed through the QAPI and submitted to the Quality Assurance and Assessment Committee monthly for follow up and recommendation.	09/20/19 09/30/19 09/20/19 09/30/19 09/30/19