STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055135	A. BUILDING _____ B. WING _____	12/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTROSE HEALTHCARE CENTER	2123 VERDUGO BLVD. MONTROSE, CA 91020

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the Department of Public Health during Recertification Survey. Representing the Department of Public Health: Surveyor ID # 25046, HFEN Surveyor ID # 22303, HFEN Residents Census: 50 Resident Sample: 13 Random Sample: 1 Highest S/S = D	F 000	The signing of this plan of correction is not an admission or agreement by this facility of the truth of the facts alleged in this statement of deficiencies and plan of correction. In fact, this plan of correction is submitted exclusively to comply with state and federal law. This plan of correction serves as the allegation of compliance F 314	
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (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 (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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that a resident	F 314	**Corrective Action** For resident # 10 The Juven nutritional drink was immediately provided by LVN1 **Identification of Others** The Director of Nursing conducted a review of facility during the dinner time to ensure residents were receiving their nutritional supplements as ordered by physician. No other residents were affected 2016 DEC 16 AM 10:55 LOS ANGELES COUNTY HEALTH FACILITIES DIVISION	12/1/14 12/1/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 12/14/14

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055135	A. BUILDING _____ B. WING _____	12/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTROSE HEALTHCARE CENTER	2123 VERDUGO BLVD. MONTROSE, CA 91020

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 1 with ulcers on the left first and third toes received Juven (targeted therapeutic nutrition drink mix that has been clinically shown to support tissue building and to help build and maintain lean body mass) as ordered by the physician for one of 13 sample residents (10). This deficient practice has the potential for delayed wound healing due to inadequate nutrition. Findings: According to the admission record, Resident 10 was admitted to the facility on January 21, 2014, and readmitted on May 31, 2016, with diagnoses that included cerebrovascular disease, peripheral vascular disease, and diabetes mellitus. The Minimum Data Set [MDS- a comprehensive assessment and screening tool] dated September 7, 2016, indicated the resident had intact cognition and needed extensive assistance from the staff for the activities of daily living except in eating. A review of the care plan dated October 21, 2016, indicated the resident had ulcers on the left first and third toes. One of the approaches was to provide/encourage adequate nutrition and hydration to promote healing. A review of the physician's order dated November 17, 2016, indicated to provide Juven one package, mix with 8 ounce of water two times a day for 60 days. On December 1, 2016, at 6 5:40 p.m. during a tour with Licensed Vocational Nurse 1 (LVN 1),	F 314	**Measures to Prevent Recurrence** DON provided in-service education to licensed nursing staff regarding the provision of nutritional supplements in a timely manner and as ordered by physician. DON will perform at least daily random checks during meal times to ensure compliance. **Monitoring Performance** The DON will present the recapitulation of the findings to the monthly QA committee for review and action as indicated. **F 323** **Corrective Action** For resident #8 the tab alarm was immediately attached to resident sitting on his wheelchair	12/9/16 12/16/16 12/16/16 12/1/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055135	A. BUILDING _____ B. WING _____	12/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTROSE HEALTHCARE CENTER	2123 VERDUGO BLVD. MONTROSE, CA 91020

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 2 Resident 10 was sitting in his bed, eating dinner. The resident's first and third toes were observed with black scabs. There was a tray card in the dinner tray indicating Juven was to be provided at lunch and dinner. However, the Juven was not in the dinner tray. During an interview with LVN 1 at the same time, she stated Juven should have been provided to the resident.	F 314	**Identification of Others** The DON conducted a round and checked to ensure residents with orders for tab alarm have a tab alarm in place No other residents were identified to be affected **Measures to Prevent Recurrence** The DON provided licensed nurses with in-service education regarding following physicians orders and ensuring proper use and placement of tab alarms The charge nurse and director of staff development will conduct random checks at least during the shift to ensure tab alarms are placed as indicated by physicians order The DON will perform periodic checks to ascertain safety and compliance	12/2/16 12/9/16 12/16/16 12/16/16
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (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. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by:	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055135	A. BUILDING _____ B. WING _____	12/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTROSE HEALTHCARE CENTER	2123 VERDUGO BLVD. MONTROSE, CA 91020

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 3 Based on observation, interview and record review, the facility failed to ensure a resident who was identified as a high risk for fall and who had an episode of fall at home prior to admission to the facility, was provided a tab-alarm on wheelchair as ordered by the physician for safety measures to prevent fall for one of 13 sample residents (Residents (8). This deficient practice had a potential for an injury from a fall. injury. Findings: A review of the admission record indicated Resident 8 was admitted to the facility on November 2, 2016, with diagnoses that included sepsis, difficulty in walking, muscle weakness and quadriplegia (paralysis of all extremities). A review of the Minimum Data Set [MDS- a comprehensive assessment and screening tool] dated November 8, 2016, indicated Resident 8 was independent with his cognitive skills and received extensive assistance by staff with activities of daily living. The Fall Risk Assessment dated November 12, 2016, indicated the resident had a fall risk score of 16 indicating that he was a high risk for fall (indicates high risk for fall). There was a physician's order dated November 2, 2016, to provide a tab-alarm while in bed and in wheelchair to alert staff from unassisted transfers and ambulation. On December 1, 2016, at 6:30 p.m., during an initial tour of the facility, Resident 8 was observed	F 323	**Monitoring Performance** The DON and DSD will present the recapitulations of the findings to the monthly QA committee for review and action as indicated. **F 329** **Corrective Action** a. Resident #5 orders were updated and the psychiatric consult and evaluation notes reflect medical justification for Abilify use b. Resident # 1was reassessed and physician was contacted, orders were updated regarding Tylenol use **Identification of Others.** The DON and the DSD checked physician orders for all residents to ensure that no other resident will be affected, no other residents were affected	12/16/16 12/5/16 12/5/16 12/5/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055135	A. BUILDING _____ B. WING _____	12/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTROSE HEALTHCARE CENTER	2123 VERDUGO BLVD. MONTROSE, CA 91020

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 4 sitting on his wheelchair at his bedside without a tab alarm. A care plan for high risk for fall dated November 2, 2016, had an intervention to provide tab alarm in bed while in bed and wheelchair to alert staff of unassisted transfer. During an interview with the DON on December 3, 2016, at 10 a.m., he agreed the tab alarm should be placed on the resident's wheelchair when at used by the resident.	F 323	**Measures to Prevent Recurrence** a.&b The DON provided in-service education to licensed nurses regarding Medication Regimen Appropriateness	12/9/16
F 329 SS=D	483.45(d) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS (d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record	F 329	The DON will conduct a medication regimen review at admission and will refer resident for psychiatric consultation as indicated The Social Services designee will follow up with the psychiatrist at least weekly to ensure compliance The Medical Records director will conduct a weekly medication activity report audit. Medical records consultant will check the audit monthly The pharmacy consultant will review medication regimen at least monthly to ensure appropriateness of residents medications	12/16/16 12/16/16 12/16/16 12/16/16.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055135	A. BUILDING _____ B. WING _____	12/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTROSE HEALTHCARE CENTER	2123 VERDUGO BLVD. MONTROSE, CA 91020

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 5 review, the facility failed to ensure that Resident 5 would not receive Ambilify (is an antipsychotic drug used to treat mental illnesses such as schizophrenia and bipolar disorder usually allowing a person to function more effectively) without a medical justification for its for one out of 13 sample residents (5). This deficient practice placed the resident at risk for complications associated with unnecessary medication. Findings: a. A review of Resident 5's Admission Records indicated she was admitted to the facility on November 12, 2016, with diagnoses including malignant neoplasm of the colon, rheumatoid arthritis, psychosis, major depressive disorder and hypertension. A review of the Minimum Data Set [MDS- a comprehensive assessment and screening tool] dated November 19, 2016, indicated Resident 5 was moderately impaired with her cognitive skills and required extensive assistance by staff with activities of daily living. A physician's order dated November 12, 2016, to administer orally Ambilify 30 milligrams (mg) at bedtime for psychosis manifested by delusions of someone taking her purse. On December 2, 2016, at 7 p.m., Resident 5 was observed lying in bed staring at the ceiling. Further review of Resident 5's clinical records disclosed no psychiatric consult documentation or a medical justification use of Abilify medication for psychosis behavior.	F 329	**Monitoring Performance** The DON will present the recapitulations of the findings to the monthly QA committee for review and action as indicated. The pharmacy consultant to provide facility with quarterly reports regarding audit findings and will report to the QA committee for review and action as indicated. The SSD and Medical Records Designee will present the recapitulations of the findings to the monthly QA committee for review and action as indicated. **F 425** **Corrective Action** 1. For resident #2, the DON provided one to one in-service education to LVN #1 regarding medication documentation 2. For resident #3 the DON provided one to one in-service education to licensed nurse regarding accuracy of medication dosage administration	12/16/16 12/16/16 12/16/16 12/3/16 12/2/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055135	A. BUILDING _____ B. WING _____	12/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTROSE HEALTHCARE CENTER	2123 VERDUGO BLVD. MONTROSE, CA 91020

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 6 On August 15, 2014, at 10 a.m., during an interview, the director of nursing (DON) stated there should be a medical justification by the psychiatrist during the first fourteen days after admission for the use of both psychotropic medications. b. According to the admission record, Resident 1 was admitted to the facility on February 7, 2015, and readmitted on December 6, 2015, with diagnoses that included depressive disorder with psychotic symptoms, Alzheimer's disease, and gastrostomy. The Minimum Data Set (MDS) assessment dated October 21, 2016, indicated the resident had severely impaired cognition, needed extensive to total assistance from the staff for the activities of daily living, and had feeding tube. It was indicated the resident had no pain. On December 1, 2016, at 5:45 p.m., December 2, 2016, at 6 p.m., and December 3, 2016, at 12:30 p.m., Resident 1 was observed lying in a bed. The resident was not able to communicate, but did not show any alteration in comfort including pain. The resident had a physician's order dated December 6, 2015, for Tylenol 325 milligram (mg) two tablets via gastrostomy tube (GT) once daily for pain management and to give 30 minutes prior to GT care. A review of the Medication Administration Record for the month of October and November 2016, indicated the resident was administered two tablets of Tylenol 325 mg everyday while the	F 329	3. For resident #14 licensed nurse immediately corrected the Mucinex dosage The DON provided one to one in-service education to LVN1 regarding medication dosage accuracy 4. Resident #5 was assessed immediately by licensed nurse and medication was administered as ordered by physician **Identification of Others** The DON and Medical records Designee conducted a review of the medication administration records to ensure that other medications are being administered according to physicians order and in the right dosage, no other findings were identified	12/2/16 12/2/16 12/2/16 12/2/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055135	A. BUILDING _____ B. WING _____	12/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTROSE HEALTHCARE CENTER	2123 VERDUGO BLVD. MONTROSE, CA 91020

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 7 resident had no pain. On December 3, 2016, at 4 p.m. during an interview with Licensed Vocational Nurse 2 (LVN 2), he stated the resident did not have any problem on the GT site. LVN 2 was not able to provide the documented justification for routine Tylenol administration 30 minutes before GT care.	F 329	**Measures to Prevent Recurrence** The DON provided licensed nurses with in-service education regarding Medication Administration Accuracy	12/9/16
F 425 SS=E	483.45(a)(b)(1) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH (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. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (1) Provides consultation on all aspects of the provision of pharmacy services in the facility; This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the licensed nursing staff failed to ensure medications ordered by the physician was administered in the correct dosage and without omission for three of 13 sample residents (Residents 2, 3, 5) and one random sample residents (RSR 14) by failing to: 1. For Resident 2, Pantoprazole sodium [Protonix- medication that reduces the amount of acid that your stomach makes] was not omitted for two days on November 29, and 30, 2016, at	F 425	The DON provided licensed nurses with in-service education regarding administering medication according to physician's orders The DON will randomly check the MAR at least once a week to ensure compliance The Medical Records Director will conduct a weekly medication activity report audit and do follow up as indicated. The medical records consultant will check the audits at least monthly **Monitoring Performance** The DON will present the recapitulations of the findings to the monthly QA committee for review and action as indicated. The Medical Records Designee will present the recapitulations of the findings to the monthly QA committee for review and action as indicated.	12/9/16 12/16/16 12/16/16 12/16/16.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055135	A. BUILDING _____ B. WING _____	12/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTROSE HEALTHCARE CENTER	2123 VERDUGO BLVD. MONTROSE, CA 91020

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 8 6:30 a.m. 2. For Resident 3, incorrect dosages of Insulin was administered on November 2, 3, 6, 11, 2016. 3. For RSR 14, incorrect dosage of Musinex (medication used to relieve the symptoms of cough and loosen mucus in the chest) was administered for Resident 14. 4. For Resident 5, two dosages of Paroxetine (Paxil) 20 milligrams (mg) ordered for treatment of depression were omitted for two days, on November 29 and 30, 2016. These deficient practices placed residents at risk for increased acid in the stomach for Resident 2, increased blood sugar and unmanaged diabetes for Resident 3, unresolved symptoms of cough for RSR 14 and interrupted treatments of depression for Resident 5. Findings: a. According to the admission record Resident 2 was originally admitted to the facility on September 19, 2015, and readmitted on October 11 2016, with diagnoses that included diabetes mellitus (group of diseases in which a person has high blood sugar) and gastro-esophageal reflux disease (GERD). The resident had a physician's order dated October 11, 2016, for Pantoprazole Sodium 40 milligram (mg) one tablet one time a day for GERD at 6:30 a.m. There was a plan of care developed on October 11, 2016, for GERD. One of the approaches was	F 425	**F 441** **Corrective Action** The DON provided one to one in service education to LVN1 regarding proper Hand Hygiene practices during med pass **Identification Of Others** The DON conducted a round of facility to ensure med pass was being completed by licensed nurses within the Hand Hygiene protocols, no other areas were identified **Measures to Prevent Recurrence** The Director of Nursing services provided in-service education to the licensed nurses regarding proper Hand Hygiene practices during med pass	12/2/16 12/2/16 12/9/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055135	A. BUILDING _____ B. WING _____	12/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTROSE HEALTHCARE CENTER	2123 VERDUGO BLVD. MONTROSE, CA 91020

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 9 to administer medications as ordered. A review of the Medication Administration Record (MAR) for the month of November 2016, indicated there were no nurse's signatures indicating Pantoprazole Sodium 40 mg was administered on November 29, and 30, 2016, at 6:30 a.m. On December 3, 2016, at 5:20 p.m., during an interview with Licensed Vocational Nurse 1 (LVN 1), she was not able to provide the documented evidence Pantoprazole Sodium 40 mg was administered on November 29, and 30, 2016, at 6:30 a.m. b. According to the admission record Resident 3 was originally admitted to the facility on July 16, 2012, and readmitted on September 23 2016, with diagnoses that included diabetes mellitus (DM) and long-term use of Insulin. The resident had a physician's order dated September 23, 2016, for fasting blood sugar testing with regular insulin injection per sliding scale coverage as follows: 150-199 milligram (mg)/deciliter (dl)=2 units 200 mg/dl -249 mg/dl=4 unit 250 mg/dl-299 mg/dl=6 units 300 mg/dl-349 mg/dl=8 units 350 mg/dl-399 mg/dl=10 units 400 mg/dl-450 mg/dl =12 unit and to notify the physician. There was a plan of care developed on September 23, 2016, for the risk of hypoglycemia/hyperglycemia. One of the approaches was to administer medications as	F 425	The DON will conduct a random review of hand washing skills of licensed staff during the Medication Pass The pharmacy nurse consultant will perform at least monthly a random check of hand washing skills of licensed staff during medication pass **Monitoring Performance** The DON will present the recapitulations of the findings to the monthly QA committee for review and action as indicated. **F 465** **Corrective Action** 1. Maintenance supervisor immediately secured the helium tank with the chain and lock 2. Housekeeper immediately locked the housekeeping cart drawer.	12/14/16 12/14/16 12/14/16 12/3/16 12/3/16.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055135	A. BUILDING _____ B. WING _____	12/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTROSE HEALTHCARE CENTER	2123 VERDUGO BLVD. MONTROSE, CA 91020

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 10 ordered. A review of the MAR dated November 2, 3, 6, 11, 2016, indicated 8 units of insulin was administered when the blood sugar (BS) was between 256 mg/dl to 293 mg/dl, while 6 units of insulin should have been administered according to the physician's order. On December 3, 2016, at 5:10 p.m., during an interview with the Director of Nursing, he confirmed that according to the resident's record the resident was not given insulin coverage as ordered. c. According to the admission record RSR 14 was admitted to the facility on September 14, 2016, with diagnoses that included elevated white blood cell count, hypertension, and retention of urine. On December 2, 2016, at 5:45 p.m., RSR 14's medication pass by Licensed Vocational Nurse 1 (LVN 1) was observed. LVN 1 took out two tablets of Musinex 400 milligram (mg) from the bottle and cut one of the tablets into half. LVN 1 separated one of the half tablets, and administered one and half tablets of Musinex to the resident, which was 600 mg. On December 2, 2016, at 7 p.m., during the reconciliation of the medication pass with the physician's order indicated the dosage of Musinex to be administered was 1200 mg, not 600 mg. During an interview with LVN 1 at the same time, she stated she should have administered Musinex three tablets (1200 mg), not one and half tablets (600 mg). A review of the facility's policy of the Medication	F 425	**Identification of Others** Administrator and maintenance supervisor conducted a round of facility to ensure that any other helium/oxygen tanks were properly secured and that all other housekeeping cart drawers containing chemicals were locked. No other tanks were identified No other carts were indentified **Measures to Prevent Recurrence** The Administrator provided the Maintenance supervisor with a one:one in service regarding facility policy on proper storage of helium/oxygen tanks Maintenance Supervisor will randomly check at least once a week x3months the helium/oxygen tank storage areas to ensure the cylinders are being stored properly, chained and secured.	12/3/16 12/3/16 12/19/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055135	A. BUILDING _____ B. WING _____	12/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTROSE HEALTHCARE CENTER	2123 VERDUGO BLVD. MONTROSE, CA 91020

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 11 Administration General Guidelines indicated Medications are administered as prescribed. c. A review of Resident 5's Admission Records indicated she was admitted to the facility on November 12, 2016, with diagnoses including malignant neoplasm of the colon, rheumatoid arthritis, psychosis, major depressive disorder and hypertension. A review of the Minimum Data Set [MDS- a comprehensive assessment and screening tool] dated November 19, 2016, revealed that Resident 5 was moderately impaired with her cognitive skills and required extensive assistance by staff with activities of daily living. A physician's order dated November 29, 2016, to administer orally Paroxetine 20 mg once a day for depression manifested by verbalization of sadness. A review of Resident 5's Medication Administration Record sheet dated November 29 and 30, 2016, indicated no documented evidence that the Paroxetine 20 mg was given. There was also no documentation for a reason why the medication was not given. A care plan dated November 16, 2016, for resident has episodes of depression manifested by verbalization of sadness; for taking Paroxetine medication had an intervention to administer anti-depressant medications as ordered. On December 2, 2016, at 7 p.m., Resident 5 was observed lying in bed staring at the ceiling. During an interview with the director of nurses	F 425	The housekeeping supervisor and Administrator met with housekeeper and provided a one:one in service to ensure that chemicals are being stored in the housekeeping cart in a locked drawer. 12/3/16 Housekeeping supervisor will randomly check at least once a week x3months the housekeeping carts to ensure that chemicals are being kept in a locked drawer at all times. 12/16/16 **Monitoring Performance** The Maintenance Supervisor and the Housekeeping Supervisor will present the recapitulations of the findings to the monthly QA committee for review and action as indicated. 12/16/16 **F 514** **Corrective Action** For resident #5 the POLST was reviewed, signed and acknowledged by the residents responsible party 12/3/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055135	A. BUILDING _____ B. WING _____	12/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTROSE HEALTHCARE CENTER	2123 VERDUGO BLVD. MONTROSE, CA 91020

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 12 (DON) on December 3, 2016, at 3 p.m., he stated the license staff should have given the medication [Paroxetine or Paxil] as ordered by the physician.	F 425		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (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); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;	F 441	**Identification Of Others** The Medical Records Designee and DON conducted a review of residents medical records to ensure POLST are complete to include signatures of patient and/or legally recognized decision maker, no other POST were identified **Measures to Prevent Recurrence** The Director of Nursing services provided in-service education to the Social Services Designee regarding the timely completion of resident care information Social services designee will ensure that during the interdisciplinary team meetings POLST are discussed and signed by the resident and/or legally recognized decision maker and the physician signature is complete The medical records designee will complete at least monthly an audit of the POLST to ensure they are completed and signed **Monitoring Performance** The SSD and Medical records designee will present the recapitulations of the findings to the monthly QA committee for review and action as indicated.	12/3/16 12/9/16 12/14/16 12/14/16 12/14/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055135	A. BUILDING _____ B. WING _____	12/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTROSE HEALTHCARE CENTER	2123 VERDUGO BLVD. MONTROSE, CA 91020

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 13 (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (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 (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility nursing staff failed to observed infection control measures as directed on the facility's policy by not wash hands before preparing medications for one random sample resident (RSR 14). This deficient practice had the potential for contamination of medications.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055135	A. BUILDING _____ B. WING _____	12/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTROSE HEALTHCARE CENTER	2123 VERDUGO BLVD. MONTROSE, CA 91020

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 14 Findings: On December 2, 2016, at 5:45 p.m., during medication pass observation, Licensed Vocational Nurse 1 (LVN 1) was observed to check RSR 14's blood pressure. After she checked the resident's blood pressure, LVN 1 prepared medications without washing her hands. LVN 1 pushed one tablet of Metopolol 25 milligram (mg) into the medicine cup out of the bubble pack, and poured out two tablets of Musinex (medication used to relieve the symptoms of cough and loosen mucus in the chest) 400 milligram (mg) from a bottle. LVN 1 split one of the tablets in half using tablet cutter and administered the medications. On December 2, 2016, at 6:10 p.m., during an interview, LVN 1, stated she should have washed her hands after she took the resident's blood pressure and before she prepared medications. A review of the facility's policy of the Hand Hygiene indicated all staff member will wash their hands before and after direct resident care and after contact with potentially contaminated substances.	F 441		
F 465 SS=D	483.90(h)(5) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON (h) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.	F 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055135	A. BUILDING _____ B. WING _____	12/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTROSE HEALTHCARE CENTER	2123 VERDUGO BLVD. MONTROSE, CA 91020

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 15 (h)(5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to maintain a safe and sanitary environment for residents, staff and the public. Findings: On December 3, 2016, at 10 a.m., during an environmental tour of the facility in the presence of the maintenance supervisor, the following were observed: 1. One of the big helium tank stored in the facility's Oxygen room was left standing by itself without securing it with a chain and lock on the wall. 2. The housekeeping cart was observed parked across Room 115 B. The drawer was closed but it was unlocked. There were eight spray bottles (housekeeping supplies) containing blue, light green and yellow liquid. The spray bottles had labeled indicating bathroom cleaner, window cleaner and toilet cleaner. There was also a warning "Caution: Keep out of reach of children." During a concurrent interview, the housekeeper staff present during the observation stated the housekeeping cart should have been locked at all times but he forgot to lock the cart drawer.	F 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055135	A. BUILDING _____ B. WING _____	12/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTROSE HEALTHCARE CENTER	2123 VERDUGO BLVD. MONTROSE, CA 91020

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 16	F 514		
F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on interview and record review the	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055135	A. BUILDING _____ B. WING _____	12/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTROSE HEALTHCARE CENTER	2123 VERDUGO BLVD. MONTROSE, CA 91020

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 17 facility's nursing administrative staff failed to ensure Resident 5's Life-Sustaining Treatment (POLST) record was complete in accordance with accepted professional standards and practices, for one out of 13 sample resident (Resident 5). This deficient practice placed the resident at risk due to incomplete resident care information on record. Findings: A review of Resident 5's Admission Records indicated she was admitted to the facility on November 12, 2016, with diagnoses including malignant neoplasm of the colon, rheumathoid arthritis, major depressive disorder and hypertension. A review of the MDS (an assessment and care screening tool) dated November 19, 2016, indicated that Resident 5 was moderately impaired with her cognitive skills and required extensive assistance by staff with activities of daily living. A review of Resident 5's clinical chart indicated that her POLST, dated November 4, 2016, was incomplete by not having a signature of patient and/or legally recognized decision maker to acknowledge regarding resuscitative measures. During an interview with the DON (director of nursing) on December 3, 2016, at 2 p.m., the DON acknowledge the POLST should be completed with a signature by the resident's legal legal representative.	F 514		