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
	CA060000089	A. BUILDING: _____ B. WING _____	06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BUENA VISTA CARE CENTER	1440 S EUCLID AVENUE ANAHEIM, CA 92802

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A 000	Initial Comments The following reflects the findings of the California Department of Public Health during a staffing audit visit for 24 randomly selected days from 03/31/2022 to 06/30/2022. Representing the Department: P.V., Associate Governmental Program Analyst. Welfare and Institutions (W&I) Code section 14126.022 sets forth the Department's authority to conduct audits of direct caregiver nursing services provided to residents of skilled nursing facilities, and to establish procedures for conducting such audits through All Facility Letters (AFLs). <http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14126.022.&lawCode=WIC> AFL 21-11, setting forth the audit process and guidelines for facilities is available through the following link: <https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-21-11.aspx> Health and Safety Code (HSC) 1337-1338.5, sets forth the requirements for Certified Nurse Assistants is available through the following link: <https://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?division=2.&chapter=2.&lawCode=HSC&article=9> W&I section 14126.022 requires the Department to assess an administrative penalty to a SNF if the Department determines that the SNF fails to meet the DHPPD requirements pursuant to HSC sections 1276.5 or 1276.65. The Department shall assess an administrative penalty to any facility that fails to meet the applicable standard	A 000	**"Preparation and/or execution of this plan of correction, does not constitute admission or agreement by the provider, of the truth of the facts alleged or the conclusions set forth in this statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of Health and Safety code section 1280 and 42CFR *et seq*".** **This Plan of Correction constitutes the facility's credible allegation of compliance.** A 200 **The Measures and Systemic changes immediately put in place to ensure the deficient practice does not recur:** On 9/20/24, a random audit was performed by the DSD on six random days in last two months and none were below 3.5 PPD for direct care hours. DSD scheduler completes the projections for the week ahead to allow for minimum of 3.5 ppd for direct care services. The facility has put in to place a PPD review system daily during every shift to	9/23/24

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A 000	Continued From page 1 for staffing requirements on any given day. The applicable standard is 3.5 DHPPD and 2.4 DHPPD (CNA), unless an approved Workforce Shortage or Patient Needs Waiver is granted. The statute was not met as evidenced by the following findings: Final Audit Result: Total Distinct Non-Compliant Day(s) = 22 Date 3.5 2.4 03/31/2022 *3.09* *1.90* 04/01/2022 *3.12* *2.07* 04/02/2022 *3.07* *1.85* 04/14/2022 *3.32* *2.03* 04/20/2022 *3.47* *2.15* 04/27/2022 *3.42* *2.19* 05/13/2022 *3.21* *1.97* 05/16/2022 *2.82* *1.54* 05/18/2022 3.76 *2.31* 05/19/2022 3.63 *2.25* 05/27/2022 *2.86* *1.77* 05/28/2022 *2.99* *1.90* 05/31/2022 *3.15* *2.05* 06/03/2022 *3.29* *2.08* 06/04/2022 *3.17* *1.99* 06/06/2022 3.76 2.47 06/07/2022 3.85 2.54 06/10/2022 *3.37* *2.08* 06/11/2022 *3.41* *2.23* 06/15/2022 *3.07* *1.96* 06/17/2022 *3.34* *2.10* 06/18/2022 *3.09* *2.08* 06/21/2022 *3.18* *1.98* 06/24/2022 *2.94* *1.85* *x.xx* = non-compliant date	A 000	monitor the staffing PPD according to the census. Our projections are reviewed daily during the morning meetings and if there are any call in's, on call staff are called to fill the open positions. **A Description of the Monitoring Process and Positions of persons responsible for monitoring:** On 9/20/24, DSD provided in-services to the supervisor Q shift to properly calculate the PPD and maintain a minimum of 3.5ppd for direct care hours. DON will review the daily PPD and report to the Administrator during daily morning meetings to confirm compliance. Any non-compliant days will be reviewed during QA meetings three months for review and recommendations. **Dates when Corrective Action will be Completed:** 9/23/24	9/23/24

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A 200	Continued From page 2 HSC 1276.65(c)(1)(B) SAS - 3.5 Standard (B) Effective July 1, 2018, skilled nursing facilities, except those skilled nursing facilities that are a distinct part of a general acute care facility or a state-owned hospital or developmental center, shall have a minimum number of direct care services hours of 3.5 per patient day, except as set forth in Section 1276.9. This Statute is not met as evidenced by: Facility failed to meet 3.5 Direct Care Service Hours Per Patient Day (DHPPD), Pursuant to HSC 1276.65(c)(1)(B) for 20 of 24 days. The total number of actual direct care nursing hours performed by direct caregivers per patient day divided by the average census during the patient day failed to meet DHPPD Staffing Standard(s). Facility failed to replace staff that did not work as scheduled, and/or did not schedule to meet the minimum staffing requirements. Facility failed to maintain current, complete and accurate personnel and payroll records for all employees in accordance with CCR Title 22, section 72533. Time spent providing direct care could not be verified. Failure to provide the information has resulted in the exclusion of all service hours for such employees. Employee(s) failed to delineate time spent providing nursing services to skilled nursing care patients, as defined in HSC section 1276.65 and	A 200 A 200	A 205 **The Measures and Systemic changes immediately put in place to ensure the deficient practice does not recur:** On 4/16/2024 facility was approved for a 2.4 certified nurse assistant workforce shortage waiver pursuant to Health and Safety Code section 1276.65(I) and in accordance with AFL 18-16. On 9/20/24, a random audit was performed by the DSD on six random days in last two months and none were below 2.4 PPD for certified nurse assistant hours. DSD scheduler completes the projections for the week ahead to allow for minimum of 2.4 ppd for certified nurse assistant. The facility has put in to place a PPD review system daily during every shift to monitor the staffing PPD according to the census. Our projections are reviewed daily during the morning meetings and if there are any call in's, on call staff are called to fill the open positions. **A Description of the Monitoring Process and Positions of persons responsible for monitoring:**	9/23/24

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A 200	Continued From page 3 CCR Title 22, section 72309, section 72311 and section 72315, while assigned to perform other duties other than direct care. The Director of Staff Development (DSD) failed to delineate time spent providing nursing services to skilled nursing care patients beyond the hours required to carry out the duties of the DSD position. The Director of Nursing (DON) failed to delineate time spent providing nursing services to skilled nursing care patients beyond the hours required to carry out the duties of the DON position.	A 200	On 9/20/24, DSD provided in-services to the supervisor Q shift to properly calculate the PPD and maintain a minimum of 2.4 ppd for certified nurse assistant hours. DON will review the daily PPD and report to the Administrator during daily morning meetings to confirm compliance. Any non-compliant days will be reviewed during QA meetings three months for review and	
A 205	HSC 1276.65(c)(1)(C) SAS - 2.4 Standard (C) Skilled nursing facilities shall have a minimum of 2.4 hours per patient day for certified nurse assistants in order to meet the requirements in subparagraph (B). This Statute is not met as evidenced by: The total number of actual direct care nursing hours performed by direct caregivers per patient day divided by the average census during the patient day failed to meet DHPPD Staffing Standard(s). Facility failed to replace staff that did not work as scheduled, and/or did not schedule to meet the minimum staffing requirements. Facility failed to maintain current, complete and accurate personnel and payroll records for all	A 205	recommendations. **Dates when Corrective Action will be Completed**: 9/23/24 **A 020** **The Measures and Systemic changes immediately put in place to ensure the deficient practice does not recur:** On 9/20/24, a random audit was performed by the DSD on six random CDPH 530 forms in the last two months all entries were accurate and legible.	9/23/24

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A 205	Continued From page 4 employees in accordance with CCR Title 22, section 72533. Time spent providing direct care could not be verified. Failure to provide the information has resulted in the exclusion of all service hours for such employees. Employee(s) failed to delineate time spent providing nursing services to skilled nursing care patients, as defined in HSC section 1276.65 and CCR Title 22, section 72309, section 72311 and section 72315, while assigned to perform other duties other than direct care.	A 205	DSD scheduler reviews the CDPH 530 forms weekly to ensure all entries are accurate and legible. The facility has put in to place a CDPH 530 form review system daily during every shift to monitor the accuracy. Our CDPH 530 forms are reviewed daily during the morning meetings for any inaccuracies	
A 020	AFL 21-11 II.B SAS-Form 530 B. Facilities must use CDPH 530. Failure to use this CDPH required form will result in a finding of non-compliance for each audited day the form is not available. The facility is responsible for ensuring all entries are accurate and legible. This Statute is not met as evidenced by: Facility failed to use CDPH Form 530 per AFL 21-11, Section II, Guidelines, subsection B, and pursuant to W&I 14126.022.	A 020	**A Description of the Monitoring Process and Positions of persons responsible for monitoring:** On 9/20/24 and 9/21/2024, DSD provided in-services to nursing staff regarding the proper usage of the CDPH 530 forms. DON will review the CDPH 530 form and report to the Administrator during daily morning meetings to confirm compliance. Any non-compliant days will be reviewed during QA meetings three months for review and recommendations. **Dates when Corrective Action will be Completed**: 9/23/24	9/23/24