POC accepted Abigail Pinicial 4/4/12

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

PRINTED: 03/23/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555119	A. BUILDING _____ B. WING _____	02/18/2012

CENTRAL FACILITIES INSPECTION DIVISION ADMINISTRATION
2012 AUG 23 AM 10:11
RECEIVED

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT VINCENT HEALTHCARE	1510 N. FAIR OAKS AVE PASADENA, CA 91103

(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 a RECERTIFICATION survey. Representing the Department of Public Health: 28074 09697 07598 Resident Population: 77 Sample Size: 18 Highest S/S = E	F 000	F 000 – Please accept this Plan of Correction (POC) as our Credible Allegation Package. The deficiencies enumerated in the Statement of Deficiencies will be corrected to prevent recurrence no later than 04/01/2012. Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truths of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Provider submits this Plan of Correction with the intention that it is inadmissible by any third party in any civil or criminal action or proceedings against the provider, its employees, officers, directors or shareholders. This Plan of Correction is prepared solely because it is required by provisions of the Health and Safety Code.	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide appropriate and proper attire for 1 of 17 sampled residents (Resident 8) wich resulted in a lack of dignity and respect. Findings: A review of the clinical record of Resident 8 indicated that he was admitted to the facility on February 5, 2012 , with diagnoses that included abnormality of gait, muscle weakness, dementia, hypertension, convulsions, depressive disorder and psychosis.	F 241	F241– 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY It is the policy of this facility to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. 1. The Director of Nursing (DON), Director of Social Services and the Director of Staff Development (DSD) in-serviced all staff with regards to promoting respect and dignity to all the residents. Housekeeping	

2012 MAR 33 AM 9:29

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	ADMINISTRATOR	3/31/12

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

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F 241	Continued From page 1 On February 17, 2012, at 7 p.m., Resident 8 was observed lying in bed . He was verbally responsive and required extensive assistance with his activities of daily living. On February 18, 2012, at 11:55 a.m. Resident 8 was observed in the rehabilitation room receiving physical and occupational therapy services. Before the occupational therapy started, an interview was conducted with the resident. The resident stated in the presence of the occupational therapist that he could not start the treatment because he was not comfortable with his pants and then proceeded to show the pants to the evaluator. The front part of the pants was open from the waist down and did not belong to him. At 12:30 p.m., the licensed nurse was called and made aware of the resident's concern with his pants. During an interview with the social service staff at 2 p.m., she stated that all CNA's were aware that if residents had no clothes, there are extra clothes available for residents who have no belongings to be used or worn upon admission.	F 241	and Laundry supervisor together with the Social Services Director and Director of Staff Development did a sweep of all resident clothes and belongings to make sure that they are properly marked with the residents name. Resident's clothes are checked to make sure that they are wearable, presentable and in good condition. 2. All residents are potentially affected by this deficiency. The Social Services Director and Director of Staff Development will check all residents belongings on a regular basis to ensure that they are properly marked. 3. The DON together with the IDT members will monitor residents and residents belongings to make sure that they promote and enhance dignity and respect. Inservice was provided on Residents Rights on 03/26/12.	
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility	F 253	4. DON , SSD and the DSD will do random checks to make sure that corrective actions are being implemented. During the monthly resident council meeting, the DON, SSD and DSD will solicit feedback from residents to determine if implemented measures to promote dignity and respect are effective. Random interviews will be performed with residents to identify any issues or concerns regarding residents belongings. Implemented	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT VINCENT HEALTHCARE	1918 N. FAIR OAKS AVE PASADENA, CA 91103

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F 253	Continued From page 2 failed to maintain the bathroom floor located between Resident Rooms 23 and 24 in good repair as evidenced by cracked ceramic floor tiles near the toilet bowl and the hand sink. Findings: On February 18, 2012, at 12:33 p.m., during an environmental inspection of the facility, the evaluator observed four cracked 12 inch by 12 inch ceramic floor tiles in the bathroom floor located between Resident Rooms 23 and 24. The tiles were covered with a rubber mat so as to prevent a tripping hazard. During an interview with the maintenance supervisor, he stated he was unaware of the cracked floor tiles and that he would repair them.	F 253	measures will then be reviewed during the monthly Quality assurance meeting to evaluate if measures were effective. The DON and the department heads will survey random residents to obtain feedback. Results of the survey will be discussed during the daily stand up meeting for corrective action plan. The Administrator will monitor for compliance. 5. Corrective action will be completed no later than 04/01/2012 **F253--483.15 (h)(2) HOUSEKEEPING AND MAINTENANCE SERVICES**	3/24/12
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided	F 279	It is the policy of this facility to provide housekeeping and maintenance services necessary to maintain a sanitary and comfortable interior. 1. Upon learning of this deficiency, the Maintenance supervisor replaced and fixed the ceramic floor tiles near the toilet bowl and hand sink in the bathroom floor located in rooms 23 and 24. 2. The Maintenance supervisor completed a thorough check of the bathroom floors in all the residents rooms. No other residents have been affected by this deficiency.	

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F 279	Continued From page 3 due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to identify and evaluate changes in the resident's skin condition by failing to conduct daily skin checks as required in the care plan for 1 of 18 sample residents (Resident 1). Resident 1 had a discoloration on the left upper arm. Findings: The clinical record of Resident 1 was reviewed on February 17, 2012, at 5:15 p.m. The Admission and Discharge Summary indicated the resident was admitted on December 20, 2011, with diagnoses that included muscle weakness, urinary tract infection, diabetes mellitus (high sugar in the blood), and chronic bronchitis (an inflammation of the air passages within your lungs). The Admission Minimum Data Set (MDS-comprehensive assessment tool) dated January 1, 2012, indicated the resident usually made himself self understood, was usually able to understand others and was totally dependent on staff for all of his Activities of Daily Living (ADL's.) Further review of the clinical records indicated, that Resident 1 had a Stage three (3) pressure sore (occurs when a full layer of skin is destroyed) located on his right ischial tuberosity (lower back portion of the hip bone)	F 279	3. The Maintenance supervisor will conduct a daily bathroom check to maintain sanitary conditions and ensure compliance. Any findings and report will be added during the quarterly Quality assurance review. The Administrator will monitor to ensure compliance. 4. Corrective action to be completed no later than 04/01/2012. **F 279 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS** It is the policy of this facility to have in place a Plan of Care that includes procedures for monitoring changes in resident's skin condition. The facility did not show a plan of care for monitoring any signs of bleeding, bruises, swelling, redness, irritation and breakdown when Resident 1 received Heparin 5000 units for deep vein thrombosis. 1) The DON did a comprehensive assessment of Resident 1 to evaluate for potential harm. None noted. The DON implemented corrective actions for Resident 1 by reviewing and revising the residents comprehensive plan of care. A care plan was done on 02/19/2012 and included monitoring	4/1/12

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F 279	Continued From page 4 During a treatment observation on February 18, 2012, at 9:30 a.m., the resident had a dark brown discoloration on the left upper arm that measured 6 centimeters long and 2 centimeters in width. During an interview with the resident on February 18, 2012, at 10 a.m., he stated that he was not aware that he had a skin a discoloration to his left arm and that it probably was due to the bed side rails. During an interview with the Treatment Nurse, on February 18, 2012, at 10:30 a.m., she stated that the discoloration could have been the result of the Heparin injection that was administered for deep vein thrombosis (DVT- formation of a blood clot in a vein that is deep inside a part of the body). A review of the physician's order dated December 20, 2011, indicated to administer Heparin 5000 units for deep vein thrombosis. A review of the Clinical record for Resident 1 on February 18, 2012, at 9 a.m., indicated there was no entry or documentation of the resident's skin condition. The care plan dated December 20, 2011 and titled "Anti-Coegulant Care Plan, indicated to monitor for bleeding, bruises, and to conduct a weekly skin check. Another care plan dated 12/10/12, titled "Fragile Skin," also indicated to monitor the resident's skin during care for bruises, swelling, redness, irritation and breakdown and to perform weekly skin checks. Both care plans also indicated to inform the physician for interventions.	F 279	changes in residents skin condition and implementing daily skin checks. The facility will use the results of the assessments to develop, review, and revise the residents plan of care and develop a comprehensive plan of care that includes measurable objectives and timetables that meet medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. 2) The DON and IDT members will assess resident's having the potential to be affected by this deficient practice to ensure that residents are properly monitored for any changes in resident's skin condition. There were no other residents affected by this deficient practice. 3) To ensure compliance, under the direction of the DON, the Treatment nurse and IDT was in-serviced on 02/24/12 regarding the use of assessments to develop, review and revise the resident care plan which includes measurable objectives and timetables to meet residents need. The DON will conduct audits of changes in residents skin conditions to ensure they are properly assessed and a comprehensive care plan is done.	

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F 279	Continued From page 5 During an interview with the Treatment Nurse on the same date, she stated that she failed to monitor the resident's skin during care as stated in the care plan. The Treatment nurse further stated that she would also inform the physician of the resident's skin discoloration.	F 279	4) The DON and Administrator will monitor corrective action to ensure effectiveness of these actions. Any significant findings will be reported to the quarterly CQI meeting for further review. The DON will monitor for compliance.	
F 315 SS=E	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to attempt bowel and bladder training for 2 of 17 sampled residents (Resident 12 and 13). Findings: a. A review of the clinical record of Resident 12 indicated that she was admitted to the facility on April 26, 2002, with diagnoses that included diabetes mellitus, (a chronic disease associated with abnormally high levels of sugar in the blood) peripheral neuropathy, (refers to the conditions	F 315	5) Corrective action completed on 03/26/2012.	3/26/12

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F 315	Continued From page 6 that result when nerves that connect to the brain and spinal cord from the rest of the body are damaged or diseased) gastritis (lining of the stomach becomes inflamed and irritated) and paranoid schizophrenia (mental disorder characterized by disordered thinking). The annual Minimum Data Set (MDS- a standardized comprehensive assessment of the resident's needs and problems) dated May 10, 2011, indicated that the resident was alert but confused, required assistance with all of her activities of daily living and was frequently incontinent of bowel and bladder. According to the quarterly bowel and bladder training assessments dated May 10, 2011, August 10, 2011, November 10, 2011, and February 10, 2012, the resident's score was an 11, which means the resident was a candidate for an individualized training/toileting schedule (timed voiding). On February 17, 2012, at 7 p.m., the resident was observed ambulating in a slow steady gait and was able to respond to simple questions. On February 18, 2012, at 11 a.m., the resident was observed ambulating in the facility, and was observed using an incontinent diaper. On February 17, 2012, at 11:10 a.m., during an interview with Resident 12, when asked if she could go to the bathroom to urinate or move her bowel, she stated that she can use the bathroom if she needed to use it. She was not aware of a toileting plan nor remembered if she was on a bowel and bladder training program.	F 315	F 315 - 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER The facility must ensure that a resident who enters the facility without an indwelling catheter is not catherized unless the resident's clinical condition demonstrates that catheterization was necessary and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. 1) Upon knowledge of the above incident, The DON immediately assessed Residents 12 and 13 and all residents who are candidates for the bowel and bladder training program for any adverse condition. None noted. 2) To identify residents having the potential to be affected by this deficiency, the DON did a sweep and reviewed all in- house residents charts to identify any resident that can be a candidate for the bowel and bladder training program. The DON and MDS supervisor will review all initial and quarterly assessments for residents who are candidates for bowel and bladder training program.	

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F 315	Continued From page 7 On February 17, 2012, at 2 p.m., the licensed nurse was interviewed to determine if a bowel and bladder training had been implemented for the resident as indicated on the quarterly assessment. The facility staff was unable to provide documented evidence that a bowel and bladder/toileting program was implemented for the resident. b. A review of the clinical record of Resident 13 revealed that she was readmitted to the facility on October 21, 2011, with diagnoses that included diabetes mellitus, chronic obstructive pulmonary disease, schizophrenia and bipolar disorder. The annual Minimum Data Set dated November 8, 2011, noted the resident was alert and verbally responsive, required extensive assistance with her activities of daily living and was frequently incontinent of bowel and bladder. According to the quarterly bowel and bladder training assessment dated October 21, 2011, and November 27, 2011, the resident's score was an 11, which means the resident was a candidate for an individualized training/toileting schedule (timed voiding). On February 18, 2012, at 8:30 a.m. and 11 a.m., the resident was observed wheeling herself around the facility in a wheelchair and was observed using an incontinent diaper. During an interview with the resident, when asked if she could go to the bathroom, she responded she can use the bathroom if somebody helped her. She was not aware of a toileting plan nor remembered if she was on a bowel and bladder	F 315	3) An in-service was held by the DON with the IDT group and the Administrator present on 02/24/2012. The meeting covered proper procedures for identifying residents who are candidates for the bowel and bladder training program. 4) To monitor for compliance, the DON will conduct periodic checks and audit charts for assessments and evaluations of residents who are on bowel and bladder training program. Medical records will conduct monthly audits of assessments to ensure that quarterly assessments are done on each resident every three months by the IDT members, and the records are properly filed. Compliance issues will be addressed during quarterly CQI meetings. 5) Corrective action completed on 02/25/2012.	2/25/12

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F 315	Continued From page 8 training program. On February 16, 2012, at 2 p.m., the licensed nurse was interviewed to determine if a bowel and bladder training program had been implemented for the resident as indicated on the quarterly assessment. The facility staff was unable to provide any documented evidence that a bowel and bladder/toileting program was implemented for the resident. On February 17, 2012, the Administrator provided the survey team with a CMS 672 Resident Census and Conditions of Residents. It indicated that there were 33 residents who were occasionally or frequently incontinent of bowel and bladder, and there were no residents on an individually written bladder/bowel training program. The Administrative nursing staff did not provide or attempt a bladder and bowel training program for any of the 33 residents who were incontinent of bowel and bladder.	F 315	F 328 – 483.25 (k) TREATMENT/ CARE FOR SPECIAL NEEDS It is the policy of the facility that residents with special needs receive proper treatment and care, including treatment and care for oxygen therapy. The facility failed to ensure and follow the doctors order for oxygen inhalation for Resident 5. 1) Upon knowledge of the above incident, Resident 5 was immediately assessed and evaluated for any adverse condition. None noted. The DON, Medical Records designee, and the RN supervisor reviewed all orders for oxygen inhalation. 2) To identify other residents having the potential to be affected by this deficiency, the DON and the charge nurse assessed all other residents receiving oxygen therapy. There were no other resident's identified as "affected" by this deficiency. 3) The Medical Records designee will review all oxygen orders on a monthly basis. The DON will review oxygen orders on a weekly basis. The DON held an in- service on 02/24/12 with all licensed staff and went over proper care and procedures with regards to "Oxygen Administration". The DON put	
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.	F 328		

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F 328	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to follow the doctor's order for oxygen inhalation for 1 of 2 residents receiving oxygen inhalation in a total sample of 18 residents. Resident 5 was observed with oxygen inhalation by nasal cannula at 2 liters per minute (l/m), however, there was no documentation that the oxygen was being used continuously. Findings: During the initial tour of the facility accompanied by the Charge Nurse on February 16, 2012, at 6:20 p.m., Resident 5 was observed lying in bed with oxygen (O2) infusing through a nasal cannula at 2 liters per minute (l/m) attached to the oxygen concentrator. During an interview with the Charge Nurse, February 16, 2012, at 6 p.m., she stated that the resident was on continuous use of oxygen because the resident had shortness of breaths. Another general observation was conducted on February 17, 2012, at 5 p.m., Resident 5 was observed lying in bed with oxygen infusing at 2 lpm by nasal cannula. A review of the Admission and Discharge Summary Form on February 17, 2012, at 5:30 p.m., indicated Resident 5 was admitted on December 13, 2011, and readmitted on December 27, 2011, with diagnosis that included chronic obstructive pulmonary disease (a lung disease that makes it hard to breathe),	F 328	into place new procedures that require charge nurses to cross-check to make sure this deficient practice does not recur. 4) The DON and Medical Records designee will perform weekly chart audits to identify any discrepancies on oxygen orders. The DON will review the monthly recaps and M.A.R to ensure that correct oxygen orders were transcribed and carried out. The Medical Records designee will review newly admitted residents with oxygen orders to ensure proper documentation and are being followed. The DON will review the Plan of Care for each resident with oxygen orders to ensure they are obtaining proper care and medication. The DON will monitor as part of their daily rounds and record any concerns/issues, as well as immediate corrective actions. Any significant findings will be reported and presented to the CQI Committee. The Administrator will monitor for compliance. 5) Corrective action completed on 02/25/2012.	2/25/12

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	555118	A. BUILDING _____ B. WING _____	02/15/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT VINCENT HEALTHCARE	1510 N. FAIR OAKS AVE PASADENA, CA 91103

(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 328	Continued From page 10 hypertension (high blood pressure), muscle weakness and dementia (a loss of mental skills that affects your daily life). A review of the admission Minimum Data Set (MDS- an comprehensive assessment tool) dated January 8, 2012, indicated the resident had impaired speech, sometimes was able to be understood and sometimes had the ability to understand others. The MDS also indicated that the resident was totally dependent on staff for the performance of all activities of daily living and received oxygen therapy during the last 14 days. A review of the physician's order dated December 27, 2011, indicated to administer oxygen at 3 l/min by nasal cannula as needed (prn) for shortness of breath (sob). A review of the Treatment Record for the month of February 2012, indicated that there was no entry or record that the oxygen was used by the resident. On February 17, 2012, at 6 p.m., the Director of Nursing accompanied the Surveyor to the room of Resident 5. When he checked the rate of the oxygen infusion, he stated that it was 2 l/m. He also stated that he would verify the physician's order in the chart. After verifying the physician's order he stated that the oxygen inhalation should have been at 3 l/m. The DON also stated that there should be documentation in the treatment record that the oxygen was administered continuously. He further stated that the order should have been verified with physician. A review of the facility's undated policy and	F 328	F371 – 483.35(i) Food Procure, Store/Prepare/Serve - Sanitary It is the policy of the facility to maintain a clean environment to ensure food is stored, prepared and/or distributed under sanitary conditions. 1) Upon learning of this deficiency, the Maintenance supervisor together with the Dietary supervisor fixed and checked the water temperature used for hand washing to ensure that it is the right temperature. 2) To identify residents having the potential to be affected by this deficiency, the Dietary staff supervisor and maintenance supervisor checked the water temperature for hand washing in the kitchen. No residents were adversely affected by the deficiency. 3) To ensure that this deficient practice does not recur, the Dietary supervisor will monitor the water temperature on a daily basis to ensure that it is within the normal range of 110° F. 4) To make sure that solutions are sustained, the Administrator and Maintenance Supervisor will monitor on a weekly basis . Any significant findings will be reported to CQI	

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	555119	A. BUILDING _____ B. WING _____	02/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT VINCENT HEALTHCARE	1510 N. FAIR OAKS AVE PASADENA, CA 91103

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F 328	Continued From page 11 procedure titled "Oxygen Administration" indicated to turn the oxygen on the prescribed amount.	F 328	committee for review. The Compliance Officer and Administrator will monitor for compliance. 5) Corrective action completed by 04/01/2012.	4/1/12
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility kitchen staff failed to serve food under sanitary conditions. Findings: During the initial tour on February 18, 2012, at 6:22 p.m., the evaluator using a probe thermometer, measured the hot water from the two employee hand wash sinks located in the kitchen. Both sinks indicated a temperature of 100 degrees Fahrenheit. On February 18, 2012, at 10:40 a.m., the evaluator took a second reading of the hot water from the two employee hand wash sinks located in the kitchen. Again both sinks indicated a temperature of 100 degrees Fahrenheit. The federal public health food code recommends a	F 371		

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	555119	A. BUILDING _____ B. WING _____	02/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT VINCENT HEALTHCARE	1510 N. FAIR OAKS AVE PASADENA, CA 91103

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F 371	Continued From page 12 minimum temperature of 110 degrees Fahrenheit for hand washing in a kitchen. During an interview with the dietary supervisor, she stated the plumbing pipes leading to the hand wash sinks did not distribute the heat to the water in the hand sinks as well as to the dishwasher and the two 2-compartment food sinks in the kitchen. A review of the facility policy regarding hand washing indicated to wet hands and forearms with warm water (minimum 100 degrees Fahrenheit).	F 371	F 431- 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS AND BIOLOGICALS It is the policy of the facility to employ and obtain the services of a licensed pharmacist who establishes a system of records and receipts and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. 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. 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	F 431	1) Upon knowledge of the above incident, the DON immediately removed the two house supply medications that were expired from the medication room. The container of Assure solution that should have been discarded 90 days after opening was also removed from the medication room. The DON called the pharmacy to replace the Emergency Kit that had been opened nine days ago. 2) To identify residents having the potential to be affected by this deficiency, the DON did a sweep and checked all the medications stored in the medication room to	

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	555119	A. BUILDING _____ B. WING _____	02/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT VINCENT HEALTHCARE	1510 N. FAIR OAKS AVE PASADENA, CA 91103

(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 431	Continued From page 13 have access to the keys. 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to discard expired medications after the expiration date, which had the potential to result in unsafe medication administration. The facility also failed to ensure that emergency medications were replaced according to the facility's policy and procedure. Findings: An inspection of the facility's medication room in the North Nursing Station on February 16, 2012, at 8:50 p.m., revealed two house supply medications that were expired. The medications were Vitamin B 12 (used as a supplement) 250 milligrams (mg) which had an expiration date of February 2, 2012, and Gas X (used to reduce bloating, discomfort and pain caused by excess gas in the stomach or intestinal tract) 125 mg had expired on November 2011. A container of Assure solution (used to verify the accuracy of	F 431	ensure that there are no expired meds. No residents were adversely affected by this deficiency. 3) A new medication cabinet was made to separate all expired medications, discontinued and controlled medications to ensure compliance. All licensed nurses were in-serviced on 03/24/2012 regarding the new medication cabinet. 4) The DON will check on a weekly basis the medications stored in the new medication cabinet. Pharmacy consultant will conduct random audits on a monthly basis with all the medications to ensure compliance. Any significant findings will be reviewed on the quarterly QA meetings. Administrator will monitor for compliance. Corrective action was completed on 03/01/2012.	3/1/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555119	A. BUILDING _____ B. WING _____	02/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT VINCENT HEALTHCARE	1510 N. FAIR OAKS AVE PASADENA, CA 91103

(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 431	Continued From page 14 blood glucose test.) with an open date of November 2004 was also observed in the medication room. According to the manufacturer, this solution should be discarded 90 days after opening. During the medication room inspection of the South Nursing Station on February 16, 2012, at 6 p.m., it was revealed that the emergency kit (E-kit) had been opened nine days ago on February 7, 2012. During an interview with the Charge Nurse on February 16, 2012, at 6:30 p.m., she acknowledged the facility's failure of not discarding expired medications and not replenishing the emergency kit. The facility's policy and procedures dated April 2008, indicated, "Medications awaiting disposal are to be stored in a locked secure area designated for that purpose until destroyed and the pharmacy will replace the emergency drug supply within 72 hours of opening."	F 431		
F 457 SS=B	483.70(d)(1)(i) BEDROOMS ACCOMODATE NO MORE THAN 4 RESIDENTS Bedrooms must accommodate no more than four residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that 2 (rooms # 13 and 14) of of 27 resident rooms did not accommodate more than 4 residents.	F 457		

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	555119	A. BUILDING _____ B. WING _____	02/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT VINCENT HEALTHCARE	1810 N. FAIR OAKS AVE PASADENA, CA 91103

(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 457	Continued From page 15 Findings: On February 16, 2012, at 6:30 p.m. during an initial tour of the facility, resident rooms 13 and 14 were observed to have five beds each, with all five beds occupied by residents. All ten residents in these two rooms were observed to be fully ambulatory displaying no difficulties getting in and out of the rooms The evaluator did not observe any problems when the facility staff provided care to the residents in these two rooms. During an interview with the residents during a group meeting on February 18, 2012, at 10:00 a.m., and during individual interviews, none of the residents complained that the number of beds in their room hindered their daily routine in the facility. A review of the facility's room waiver request indicated the health and safety of the residents would not be adversely affected by the waiver request.	F 457	F457 – 483.70 (d)(1)(i) BEDROOMS ACCOMMODATE NO MORE THAN 4 RESIDENTS and F458 483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT 1. Facility requested continued waivers for both deficiencies. Facility continues to monitor safety at all times in all patient rooms to ensure that it is free of clutter and debries and accessible for wheelchairs and emergency personel in case emergencies. 2. The whole facility may be affected by this deficiency but staff is aware and continues to follow it's protocols to accommodate the needs of all residents.	
F 458 SS=C	483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that 25 out of 27 resident rooms measured at least 80 square feet per resident in multiple resident bedrooms.	F 458	3. Although the rooms fall short of the minimum requirement, the needs of the residents are fully accommodated; they are able to move about freely; toilets and ample closet space are easily accessible; the facility is adequately equipped environmentally for comfort, privacy and safety of it's residents. Delivery of care is unimpeded in any way. Further, the residents can be quickly and safely evacuated in the event of an emergency. Facility shall continue to monitor this deficiency and meet the needs and maintain health, safety and welfare of all residents.	

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	555119	A. BUILDING _____ B. WING _____	02/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT VINCENT HEALTHCARE	1918 N. FAIR OAKS AVE PASADENA, CA 91103

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F 458	Continued From page 16 Findings: On February 18, 2012, at 1:00 p.m., a review of the client accommodations analysis form and room waiver request filled out by the facility administrator indicated that 2 five-bed rooms, 18 three-bed rooms, and 5 two-bed rooms, did not meet the 80 square feet per resident in multiple resident bedrooms. The 18 three-bed rooms were measured at 72.7 square feet per resident (Minimum of 80 square feet required). The 5 two-bed rooms ranged from 70.5 to 73.5 square feet per resident (Minimum of 80 square feet required). The measurement of the two 5-bed rooms ranged between 71.6 and 72.2 square feet per resident in multiple bedrooms (Minimum of 80 square feet required) . During interview with the residents during a group meeting on February 18, 2012, at 10:00 a.m., and during individual interviews, none of the residents complained that the room size hindered their daily routine in the facility. A review of the facility's room waiver request indicated that the health and safety of the residents would not be adversely affected. All of the residents in the above mentioned rooms were observed to be fully ambulatory or able to propel themselves in wheelchairs and displayed no difficulties getting in and out of the rooms. The evaluator did not observe any problems when the facility staff provided care to the residents in these rooms.	F 458	5. Administrator monitors this deficiency on a daily basis. Any concerns on safety will be reported during the facility quarterly QA meeting for evaluation and continued compliance. F499 EMPLOY QUALIFIED FT/PT/CONSULT PROFESSIONALS 1. It is the policy of the facility to hire qualified employees at all times. The CNA renewed her certificate but the facility has not received the renewal certificate. During survey, the facility was able to verify that the CNA has indeed renewed her certificate. 2.No residents were affected by this deficiency. Only one CNA was found to have a pending verification. All other qualified employees were verified correctly. 3. DSD shall continue to verify that all required professionals are currently certified and or licensed at all times, specially prior to starting work. 4. DSD shall report to QA committee any non-renewed or late renewal licenses or certificates. If found not in compliance, employee shall be suspended until verification is complete.	4/1/12
F 499 SS=D	483.75(g) EMPLOY QUALIFIED FT/PT/CONSULT PROFESSIONALS	F 499		

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	555119	A. BUILDING _____ B. WING _____	02/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT VINCENT HEALTHCARE	1910 N. FAIR OAKS AVE PASADENA, CA 91103

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F 499	Continued From page 17 The facility must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements. Professional staff must be licensed, certified, or registered in accordance with applicable State laws. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that employee A was certified in accordance with applicable state law. Findings: On February 18, 2012, a review of the personnel file of employee A indicated she was hired on November 2, 2011, as a certified nursing assistant. Her certificate indicated an expiration date of January 20, 2012. When asked about the status of her certificate renewal, the administrator presented the evaluator a copy of her renewal application which was dated February 7, 2012, eighteen days after her certificate had expired. A name search conducted by the facility staff on February 18, 2012, on the State of California internet web site for verification of certification of certified nursing assistants did not result in information on her name or her certification number in their data base system.	F 499	5. Completed during survey. 02/21/12	2/21/12