Plan of Correction received and approved 10-2-12 07598

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

PRINTED: 09/24/2012
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
	05A134	A. BUILDING _____ B. WING _____	09/15/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDMARK MEDICAL CENTER	2030 N. GAREY AVE. POMONA, CA 91767

(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: 07598 09697 14065 Total Resident Sample: 18 Total resident Population: 94	F 000		
F 246 SS=D	Highest Scope & Severity=D 483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility staff failed to provide the services to accommodate the resident's hearing needs for one of 18 sample residents (Resident 7). Resident 7's hearing aid that was kept in an office, was not provided to the resident to serve for effective communication. Findings:	F 246	°Resident #7's ability to handle hearing aid will be assessed. Plan will be developed with client. Client will be guided re: safe use of hearing aid. °All residents with devices such as hearing aid will be assessed as well as functional capacity as part of the care plan approach and guidance for safe us developed with residents. °Interdisciplinary team will include the care plan process with client. On-going follow up at the IDT	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rosemary C. Kilby	Administrator	10/1/12

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 246	Continued From page 1 On September 13, 2012, at 6 p.m., during initial tour, Resident 7 was observed in bed. The resident was alert and verbally responsive and the facility staff indicated the resident had hearing difficulty and was lip reading as a means of communication. The licensed nurse stated the resident has a hearing aid but the hearing aid was kept at the office. A review of the annual MDS (Minimum Data Set), a standardized assessment and care planning tool, dated December 12, 2011, revealed Resident 7's cognitive (mental) status for short and long term memory was intact and was independent with his activities of daily living and required supervision in his personal hygiene. On September 15, 2012, at 11 a.m., an interview with Resident 7 indicated that he needed the hearing aid and felt despondent for not communicating with others. When asked what he meant by being despondent he stated he is depressed. On the same day, at 11:30 a.m., in an interview with the social service staff, he stated that he let the resident use the hearing aid, but sometimes he found the resident's hearing aid at his bedside table or another resident had the hearing aid. The social service staff's concern was the hearing aid might get stolen/lost and it was difficult to replace. Furthermore, the social service staff stated the resident refused to use it sometimes. However, there was no documentation in the clinical record that Resident 7 can access his hearing aid when needed. The social service staff confirmed that it was not documented in the record that the resident can access his hearing aid.	F 246	Quality Assurance meeting. °Director of Nursing and Administrator to monitor IDT meetings directed at discussion of safe use of residents who use hearing devices. °Full compliance in effect	10/15/12
F 272	483.20(b)(1) COMPREHENSIVE	F 272		

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F 272 SS=D	Continued From page 2 ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272	°Resident #5 will be re-assessed for pain and followed up carried out using a pain scale and document the reason for the pain. Effectiveness will be evaluated and documented on the MAR using the pain scale. °All residents will be assessed for pain when they verbally tell staff of being in pain. °The Licensed Charge Nurse will document pain rating in weekly summary. Staff will be instructed on adequate pain scale documentation and clinical assessment prior to administering the medication and following. Documentation for pain will be in assessment section of chart, care plan section, MAR and weekly summary section. °Quarterly documentation review of the use of pain medication, reasons and effectiveness will be part of the quarterly IDT process. Nursing staff will be inserviced re: pain	

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F 272	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity for 1 of 18 sampled residents (5). Resident 5 was not assessed for pain as evidenced by a lack of a pain assessment tool. Furthermore, Resident 5 did not have a comprehensive pain assessment upon admission to the facility. Findings: The admission information indicated Resident 5 was admitted to the facility on April 13, 2010, with diagnoses that included schizoaffective disorder and gastroesophageal reflux disease. A review of the Minimum Data Set (MDS), a standardized assessment and care planning tool, dated July 17, 2012, revealed he was alert and able to make his needs known to staff. The resident was assessed to have mild to moderate pain intensity on a daily basis and would request pain medications. There was a physician's order dated April 13, 2010, for Mylanta 30 cubic centimeters (cc) every 4 hours as needed for epigastric pain and an order dated January 18, 2012, for Tylenol 650 mg every 6 hours as needed for mild to moderate pain.	F 272	assessment requirements, follow up evaluation and documentation by Director of Nursing. °Full compliance in effect	10/15/12

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F 272	Continued From page 4 A review of the Medication Administration Record indicated that from August 16, 2012, to September 15, 2012, Resident 5 received Tylenol for pain a total of 18 times. However, during a medical record review with the charge nurse on September 14, 2012 at 7 p.m., the charge nurse failed to locate a pain assessment or a pain assessment tool. During an interview at the same time, the charge nurse stated some of the medication nurses would document a resident's pain level and others would just give the medication and check on the resident afterwards. The charge nurse stated the staff would usually assess the resident before giving the pain medication and reassess the resident's pain level afterwards. The charge nurse stated sometimes the staff just forget to document resident's pain level, but that the staff do assess the resident for pain. However, the charge nurse could not locate a pain assessment tool or other documentation to show that the staff did a pain assessment. Further review of the medical record with a registered nurse on September 15, 2012 at 10:45 a.m., revealed the registered nurse could not locate a pain assessment tool or a comprehensive pain assessment for Resident 5. During an interview on September 14, 2012 at 7:30 p.m., Resident 5 stated he often gets headaches that are relieved with Tylenol. The resident stated he does not recall staff asking him about his pain. The resident stated the staff just give the pain medicine. During an interview with a licensed nurse on	F 272		

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F 272	Continued From page 5 September 15, 2012, at 11:35 a.m., she stated the facility did not have a specific policy for pain assessments. The licensed nurse stated she could not locate a policy to provide to the evaluator. During an interview with the administrator on September 15, 2012 at 12 p.m., she stated although the facility did not have a specific policy for pain assessments, the facility staff will discuss a resident's pain level and treatment during the interdisciplinary treatment plan meetings. In further interview with the administrator on September 15, 2012 at 1 p.m., she stated she will give an in-service to the staff to address assessing a resident's pain and documenting the findings on a pain assessment tool.	F 272		
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	°Resident #1 interdisciplinary team will meet and review the care plan and guidance needed for increased adaptave behaviors. IDT contract and plan as part of their daily living and personal responsibility. Ongoing instruction and evaluation will be done by IDT for personal and responsible behavior. °All residents will be reviewed for increased need for guidance and care plans related to personal responsibility and adaptive behavior.	

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F 279	Continued From page 6 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 develop a resident's care plan to meet the resident's needs for 1 of 18 sampled residents (Resident 1). Resident 1 did not have a current care plan to address her sexual inappropriate behaviors. This deficient practice could result in inconsistent behavioral interventions meant to accommodate for Resident 1's behavioral disturbance. Findings: The admission information indicated that Resident 1 was re-admitted to the facility on October 13, 2011, with diagnoses that included schizophrenia (mental illness). A review of the Minimum Data Set (MDS) dated July 10, 2012, indicated the resident was alert and able to make her needs known to staff. The resident was independent with all activities of daily living and had sexual tendencies and sexually inappropriate behaviors. However, there was no care plan to address the resident's sexual tendencies and sexually inappropriate behaviors. During the initial tour with a licensed psychiatric technician (LPT) on September 13, 2012 at 6:55	F 279	Nursing staff and IDT will be inserviced on personal responsibility behavior and supervision requirements as well as personal privacy of the individual. Nursing staff will keep the Program Director informed regarding residents who need care plans reviewed and /or added counseling on behavior. *Quality Assurance will monitor incidents that would determine lack of personal responsibility. Administrator to monitor. *Full compliance in effect10/15/12	

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F 279	Continued From page 7	F 279		

p.m., Resident 1 was observed in a resident's room with a male resident. The privacy curtains were drawn and according to the resident, she had been there for at least 30 minutes. During an interview with the LPT at the same time, he stated Resident 1 has a tendency to go into the male residents room.

On the same day, at 7:05 p.m., another LPT shouted for Resident 1 to get out of the room. The LPT stated to the resident that she should not be in a male resident's room. Resident 1 was observed pulling up her pants as she left the room.

During an interview with the LPT at the same time, he stated that female residents are not allowed to go into the male residents room without adequate supervision. The LPT stated he did not know Resident 1 was in the male resident's room until it was brought to his attention by the evaluator.

During an interview with the administrator on September 15, 2012 at 8:55 a.m., she stated the facility did not have specific policies regarding sexual activity of the residents and she did not have a policy to provide to the evaluator. However, the administrator further stated the expectation is, that the staff know where Resident 1 is at all times. The administrator stated male residents are not allowed in the female residents room and vice versa, without the knowledge of the staff.

During an interview with a LPT on September 15, 2012 at 9:50 a.m., he stated the staff have been in-service to check the residents' rooms at least

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F 279	Continued From page 8 every 30 minutes and to document every hour on a log book the location of the residents. Furthermore, the LPT stated there used to be a care plan for Resident 1's sexual tendencies and sexually inappropriate behaviors but the care plan was discontinued. A review of the facility's undated policy titled "Interdisciplinary Treatment Plan", indicates a care plan is completed so that it can provide staff with the information to provide appropriate care and service for each resident. Further review of the policy indicates care plans are a necessary tool in providing quality care. Any time a problem is identified, a care plan entry must be done immediately. The process of care planning is one of looking at a resident as a whole, and building on the individual resident's characteristics. There was no documented evidence that the facility staff had an ongoing care plan so as to provide care and services related to Resident 1's continuing sexual tendencies and sexually inappropriate behaviors.	F 279		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	F 323	°Resident #1 will receive supervision adequate to prevent harm from accidents and hazards. °All resident's will receive supervision adequate to prevent harm from accidents and hazards. °Nursing staff and IDT	

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F 323	Continued From page 9 by: Based on observation, interview and record review, the facility failed to provide adequate supervision for 1 of 18 sampled residents. As a result, Resident 1 entered a male resident's room without the knowledge of the licensed psychiatric technician (LPT). Findings The admission information indicated Resident 1 was re-admitted to the facility on October 13, 2011, with diagnoses that included schizophrenia (mental illness). A review of the Minimum Data Set (MDS), a standardized assessment and care planning tool, dated July 10, 2012, indicated she was alert and able to make her needs known to staff, was independent with all her activities of daily living and had hallucinations, inattention and inappropriate behaviors. A review of Resident 1's care plan dated October 13, 2011, revealed she had suicidal tendencies, potential for injury to self and others, delusional ideation and social inappropriate behaviors. The plan of care included supervision. During the initial tour with a LPT on September 13, 2012 at 6:55 p.m., Resident 1 was observed in a resident's room with a male resident. The privacy curtains were drawn and according to the resident, she had been in the room for at least 30 minutes. On the same day, at 7:05 p.m., another LPT shouted for the resident to get out of the room. The LPT stated to Resident 1 should not be in a male resident room. Resident 1 was observed	F 323	will be inserviced on supervision of clients to prevent accidents. Program Director to create education for clients on how staff supervise them and why. °Quality Assurance will monitor incidents connected to supervision. Administrator to monitor. °Full compliance in effect	10/15/12

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F 323	Continued From page 10 pulling up her pants as she left the male resident room. During an interview with the LPT at the same time, he stated female residents are not allowed to go into male residents room without adequate supervision. The LPT stated he did not know Resident 1 was in the room until it was brought to his attention by the evaluator. During an interview with the administrator on September 15, 2012 at 8:55 a.m., she stated the facility did not have specific policies regarding sexual activity of the residents and she did not have a written policy to provide to the evaluator. However, the administrator further stated the expectation is that the staff know where Resident 1 is at all times. The administrator stated male residents are not allowed in the female residents room and vice versa, without the knowledge of the staff. During an interview with a LPT on September 15, 2012 at 9:50 a.m., he stated the staff have been in-service to check the residents' rooms at least every 30 minutes and to document every hour on a log book the location of the residents.	F 323		
F 411 SS=D	483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS The facility must assist residents in obtaining routine and 24-hour emergency dental care. A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for	F 411	°Resident #15 will have timely dental treatment. Medical Doctor will provide intial emergency treatment for infection of mouth and gums. Dentist will be contacted for appointment. °All residents will have timely Dental treatment	

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F 411	Continued From page 11 routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to obtain dental services to meet the needs of 1 of 18 sampled residents. Resident 15 was not referred for dental care in a timely manner as ordered by the physician. Findings: Record review of the admission face sheet revealed Resident 15 was admitted to the facility on November 5, 2005, with diagnoses that included schizophrenia (mental illness), diabetes (a blood sugar disorder) and chronic obstructive pulmonary disease (a lung disease). A review of the most recent Minimum Data Set (MDS), a standardized assessment and care planning tool, dated August 14, 2012, revealed Resident 15 was alert and able to make her needs known to staff. The resident required minimal assistance with activities of daily living and had dental concerns that required treatment. During an observation on September 13, 2012 at 6:55 p.m., Resident 15 was observed with carious teeth. The gums had thick, yellowish substance build up around the teeth and gums. The resident	F 411	°Medical Doctor will provide initial emergency treatment for infection of mouth and gums. Dentist will be contacted for appointment. °Following client complaint of mouth or tooth pain. Charge Nurse will notify doctor. Charge Nurse will notify unit clerk to contact dentist for emergency appointment. This will trigger the initiation of a care plan and pain assessment. °Care plan will be reviewed weekly by licensed charge nurse. Director of Nursing to monitor. °Full compliance in effect	10/15/12

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F 411	Continued From page 12 was observed with missing and broken teeth in the back of her mouth. During an interview with the resident at the same time, she denied pain or discomfort. A review of the physician's orders dated April 30, 2012, indicated to provide dental care as needed. The plan included an exam, x-rays and further treatment and cleaning. However, a review of the dental progress notes revealed Resident 15 was not seen until September 10, 2012, over 4 months after the plan was developed. During an interview with the social worker on September 14, 2012, at 9:30 a.m., he stated it was the responsibility of the unit clerk to follow up on appointments and the charge nurse was responsible to ensure that it is done. However, during an interview with the charge nurse on September 14, 2012 at 10 a.m., she stated they are not responsible for social service duties such as dental care or consults. The charge nurse further stated the the unit clerk does the follow up for appointments for as long as she remembers. Further interview with the social worker on September 14, 2012 at 10:15 a.m., he stated he would take over the responsibility if there are medical concerns or care that needs more specialized referrals. The social worker stated that if there were delays in follow up care, he would like to be notified. The social worker stated he was not aware of the delay in obtaining dental services for Resident 15. A review of the facility's undated policy, titled "Dental Services", indicated it is the responsibility of the facility staff to obtain dental care to meet	F 411		

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LANDMARK MEDICAL CENTER	2030 N. GAREY AVE. POMONA, CA 91767

(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 411	Continued From page 13 the resident's needs. A review of the facility's undated policy, titled "Oral Hygiene", indicated it is the responsibility of the charge nurse to evaluate oral care and to report any unusual observations to the physician. During an interview with the administrator on September 14, 2012, at 11 a.m., she stated she would implement a system to ensure orders for dental care are carried out in a timely manner. According to the National Institute of Dental and Craniofacial Research, the symptoms of gum disease include bad breath that won't go away, red or swollen gums, tender or bleeding gums, painful chewing, loose teeth, sensitive teeth, receding gums or longer appearing teeth. Any of these symptoms may be a sing of a serious problem which should be checked by a dentist. Periodontal disease ranges from simple gum inflammation to serious disease that results in major damage to the soft tissue of the bone that support the teeth. In worst cases teeth are lost. (Publication No. 11-1142, July 2011).	F 411		