Alcertuel 2128/19 36201

PRINTED: 02/06/2019 FORM APPROVED OMB NO. 0938-0391

NAME OF PROMDER OR SUPPLIER MONTEREY HEALTHCARE & WELLNESS CENTRE, LP SUMMARY STATEMENT OF DEFCIENCIES PREFERY TAG PROVIDERS PLAN OF CORRECTION PREFERY TAG PROVIDERS PLAN OF CORRECTION PROVIDER PROVIDERS	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
MONTEREY HEALTHCARE & WELLNESS CENTRE, LP (A) TO PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES PUBLIFIED PROVIDENCY BLUST SERVED DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY ON LSC IDENTIFYING INFORMATION TO BE CAUSE THE PROVIDENCY MUST BE PRECEDED BY FULL REGULATORY ON LSC IDENTIFYING INFORMATION TO BE CAUSE THE PROVIDENCY MUST BE PRECEDED BY FULL REGULATORY ON LSC IDENTIFYING INFORMATION TO BE CAUSE THE PROVIDENCY MUST BE PRECEDED BY FULL REGULATORY ON LSC IDENTIFYING INFORMATION TO BE CAUSE THE PROVIDENCY BY AND GROWN AND INFORMATION TO BE CAUSE THE PROVIDENCY MUST BE PRECEDED BY FULL REGULATORY ON LSC IDENTIFYING INFORMATION TO BE CAUSE THE PROVIDENCY MUST BE PRECEDED BY FULL REGULATORY ON LSC IDENTIFYING INFORMATION TO BE CAUSE THE PROVIDENCY MUST BE PRECEDED BY FULL REGULATORY ON LSC IDENTIFYING INFORMATION TO BE CAUSE THE PROVIDENCY MUST BE PRECEDED BY FULL REGULATORY ON LINE AND ASSOCIATED TO BE CAUSE AND ASSOCIATED ASSOCIATED AND ASSOCIATED ASSOCIATED AND ASSOCIATED AND ASSOCIATED AND ASSOCIATED ASSOCIATED AND ASSOCIATED ASSOCIATED AND ASSOCIATED ASSOCIATED ASSOCIATED AND ASSOCIATED A		555897	B. WING		_	5/2019
FRESULATORY OR ISC IDENTIFYING INFORMATION) FOOD INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during the investigation of a complaint. Complaint number: CA00615486. Representing the Department: HFEN # 33638. The inspection was limited to the specific complaint interflecting so a full inspection of the facility. Three deficiencies was issued for complaint number CA00615486. F622 SS=D F622 SS=D F622 SS=D F622 Transfer and Discharge Requirements: (i) The facility unsternit each resident to remain in the facility, and not transfer or discharge is necessary for the resident's welfare and the resident roo meters have been affected by the facility. (g) The transfer or discharge is perpopriate because the resident to onlical or behavioral status of the resident, (ii) The health of individuals in the facility would otherwise be endangered, (iii) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility.			1	257 SAN GABRIEL BLVD		
The following reflects the findings of the California Department of Public Health during the Investigation of a complaint. Complaint number: CA00615486. Representing the Department: HFEN # 33638. The Inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility. Three deficiencies was issued for complaint number CA00615486. F622 SS=D S483.15(c) Transfer and discharge-S483.15(c)(1) Facility requirements: (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless-cannot be met in the facility. (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident no longer needs the services provided by the facility; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicard) a stay at the facility.	PRÉFIX (EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	
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Representing the Department: HFEN # 33638. The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility. Three deficiencies was issued for complaint number CA00615486. F 622 SS=D CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and Discharge Requirements (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless-(A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility.	California Departr investigation of a	nent of Public Health during the complaint.		and federal law. By submitting this of correction, Monterey Healthca	plan re &	
The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility. Three deficiencies was issued for complaint number CA00815486. F 622 SS=D CFR(s): 483.15(c)(1)(i)(i)(i)(2)(i)-(iii) \$483.15(c) Transfer and Discharge Requirements (i) The facility, and not transfer or discharge the resident from the facility unless-(A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility.				deficiency listed on this form exist	s, nor	
Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(i)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident, (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility.	complaint investig the findings of a fu Three deficiencies	ated and does not represent Ill inspection of the facility. s was issued for complaint		for the alleged deficiency. The conserves the right to challenge in regulatory, or administration or administration of the conservation of the con	enter legal, rative nents,	
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ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X8) DATE	§483.15(c)(1) Fac (i) The facility must remain in the facility for the facility must remain in the facility for the facility of the resident's welfare cannot be met in the facility of the facility so the services provided (C) The safety of the facility o	stility requirements- st permit each resident to ity, and not transfer or dent from the facility unless- r discharge is necessary for the and the resident's needs the facility; r discharge is appropriate ent's health has improved resident no longer needs the by the facility; individuals in the facility is to the clinical or behavioral ent; individuals in the facility would angered; has failed, after reasonable and to to pay for (or to have paid or Medicaid) a stay at the facility.	NATURE	found to have been affected by deficient practice: Resident #1 written notific of the transfer and dischar was called to sister on 12/2 Written notification of tran and discharge was mailed to sister on 2/6/19. Resident #1 was readmitte 12/10/18. Corrective action for resident to may be affected by same deficient practice:	ation ge 2/18. nsfer to d on	5 PH 3: 36

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.

PRINTEID: 02/06/2019 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	•	555897	B. WING				C 06/2019	
	PROVIDER OR SUPPLIER REY HEALTHCARE &	WELLNESS CENTRE, LP		12	REET ADDRESS, CITY, STATE, ZIP CODE 167 SAN GABRIEL BLVD OSEMEAD, CA 91770			
(X4) ID PREFIX TAG	REFIX EACH DEFICIENCY MUST BE PRECEDED BY FULL			,	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during the investigation of a complaint.			00	"Monterey Healthcare & We Centre submits this plan of correcti part of the requirements under		3/1719	
					and federal law. By submitting this of correction, Monterey Healthca	plan ire &		
	Complaint number: . Representing the D	CA00615486. epartment: HFEN # 33638.		•	Wellness Centre does not admit the deficiency listed on this form exist does the center admit to any staten	s, nor		
	The inspection was complaint investiga	limited to the specific ted and does not represent inspection of the facility.			for the alleged deficiency. The creserves the right to challenge in regulatory, or administration	enter legal, rative		
F 622	number CA006154		F 6	22	proceedings, the deficiency, statem facts, and conclusions that from basis of the deficiency."			
SS≃D	CFR(s): 483.15(c)(§483.15(c) Transfe	1)(i)(ii)(2)(i)-(iii) r and discharge-			F622			
	remain in the facility discharge the resid	permit each resident to y, and not transfer or ent from the facility unless-			Corrective action for residents found to have been affected by deficient practice:			
	resident's welfare a cannot be met in th (B) The transfer or	discharge is appropriate			 Resident #1 written notific of the transfer and dischar was called to sister on 12/2 	ge	·	
	sufficiently so the reservices provided b	nt's health has improved esident no longer needs the y the facility; dividuals in the facility is			Written notification of tran and discharge was mailed sister on 2/6/19.		·	
	endangered due to status of the reside	the clinical or behavioral nt; dividuals in the facility would			 Resident #1 was readmitte 12/10/18. 	d on		
	(E) The resident ha appropriate notice, under Medicare or	s failed, after reasonable and to pay for (or to have paid Medicaid) a stay at the facility.	•,		Corrective action for resident of may be affected by same deficient practice:			
ABORATORY	DIRECTOR'S OR PROVE	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE .		TITLE		(X6) DATE	

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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	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED
		555897	B. WING		C 02/06/2019
	PROVIDER OR SUPPLIER REY HEALTHCARE &	WELLNESS CENTRE, LP		STREET ADDRESS, CITY, STATE, ZIP CODE 1267 SAN GABRIEL BLVD ROSEMEAD, CA 91770	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		LD BE COMPLETION
F 622	Nonpayment applies submit the necessary payment or after the Medicare or Medicaresident refuses to resident who become admission to a facility resident only allowed or (F) The facility cease (ii) The facility may resident while the as \$431.230 of this of exercises his or her discharge notice from \$431.220(a)(3) of this discharge or transfer safety of the residentity. The facility	is if the resident does not any paperwork for third party including aid, denies the claim and the pay for his or her stay. For a nes eligible for Medicaid after ity, the facility may charge a able charges under Medicaid; sees to operate. In transfer or discharge the papeal is pending, pursuant to papeal is pending, pursuant to right to appeal a transfer or or the facility pursuant to § is chapter, unless the failure to the rewould endanger the health dent or other individuals in the must document the danger	F 6	affected by this deficient practice. Measures will be put in place ensure that the deficient practice does not occur: DNS reeducated licenses nurses on 2/11/19 regard completion of Notificati Transfer & Discharge. Administrator/designee provided in-service to Seservices director regard providing copy of writter notice of transfer and directors.	e to ctice d rding on of ccial ing in ischarge
	§483.15(c)(2) Docu When the facility tra- resident under any in paragraphs (c)(1 section, the facility or discharge is docu medical record and communicated to transitution or provide (i) Documentation in must include: (A) The basis for the (i) of this section. (B) In the case of pasection, the specific be met, facility atter	ansfers or discharges a of the circumstances specified)(i)(A) through (F) of this must ensure that the transfer umented in the resident's appropriate information is ne receiving health care		form to resident/respondantly. Measures to monitor its performance to make sure the solution are sustained: Medical record will perform audit on discharge reside provide copy to DNS to DNS will report any trensissue to QAA committee monthly x3 months.	hat orm ent and review. ids or

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		555897	B. WING			02/6	C 06/2019
NAME OF F	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		X.130.10
MONTER	EV HEALTHCARE &	WELLNESS CENTRE, LP		13	267 SAN GABRIEL BLVD	•	• •
111014121	ET HEALINGANE &	WELLINESS OF THE, EF		R	OSEMEAD, CA 91770		
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 622	Continued From pa	age 2	F	522			315/19
	facility to meet the						, , ,
	(ii) The documenta	tion required by paragraph (c)	1				
	(2)(i) of this section						•
		physician when transfer or sary under paragraph (c) (1)					
•	(A) or (B) of this se						
		en transfer or discharge is					
		aragraph (c)(1)(i)(C) or (D) of	Ì	•			
·	this section.			•			
		vided to the receiving provider					•
•		imum of the following: ation of the practitioner					
		care of the resident.					
		sentative information including					
	contact information	· -			·		
	(C) Advance Direct						
		uctions or precautions for					
•	ongoing care, as a (E) Comprehensive						
•		sary Information, including a					
		it's discharge summary,					
	consistent with §48	33.21(c)(2) as applicable, and					
		ntation, as applicable, to ensure					
	a safe and effective	e transition of care. NT is not met as evidenced	ļ				
	by:	N I is not met as evidenced					
		v and record review, the facility					,
		written notification of the					
		arge to a resident and/or					
		or one of two sampled					
		t 1). Resident 1 transferred to	1				
	the Responsible Pa	Care Hospital 1 (GACH 1), and arty 1 (RP 1) for resident was					
	not provided a writt	ten document of the transfer					
	and discharge, on	12/2/18, transfer to GACH 1,			·		ļ
		nen resident was unable to be					
	readmit to the facili	ity.					
	This deficient pract	tice resulted in the violation of					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		555897	B. WING			i	C 06/2019
•	PROVIDER OR SUPPLIER REY HEALTHCARE &	WELLNESS CENTRE, LP		12	REET ADDRESS, CITY, STATE, ZIP CODE 67 SAN GABRIEL BLVD DSEMEAD, CA 91770		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
·F 622			F	622			3/5719
	for the transfer and	s to know in writing the reason discharge and ability to file an untary transfer and discharge.				٠.	
	Findings:						
	was conducted to t complaint regarding to the facility follow Resident 1, on 12/7	60 AM, an unannounced visit he facility to investigate a g permitting residents to returning GACH 1 hospitalization for 7/18 (6th day of bed hold) and o return because there was no	Opportunity and the second sec		•		
	resident was admit and readmitted bac with diagnoses that (mental disease that and thoughts may a one topic to anothe	nt 1's Face Sheet indicated ted to the facility, on 11/7/18, it to the facility, on 12/10/18, it included schizophrenia at affects how the brain works not be clear, or may jump from the Face Sheet indicated tonsible party (RP 1).					
	(MDS, a standardiz planning tool), date resident was alert a	nt 1's Minimum Data Set ted assessment and care d 9/28/18, indicated the and required extensive nsfers, walking, dressing, and					
	Orders, dated 12/2 transferred to GAC (emergency service)	nt 1's Physician and Telephone /18, indicated Resident 1 H 1 via paramedics es). The physician order ity to hold Resident 1's bed for					
-		ail correspondence from 7/18, indicated the facility's		i			

STATEMENT AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		TE SURVEY MPLETED
		555897	B. WING _		02	C 2/06/2019
	PROVIDER OR SUPPLIER REY HEALTHCARE &	WELLNESS CENTRE, LP		STREET ADDRESS, CITY, STATE, ZIP CODE 1267 SAN GABRIEL BLVD ROSEMEAD, CA 91770	•	
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 622	1's Case Manager open beds available email indicated that CM 1 that the facility would be returning a cn 12/10/18. A review of Resident Transfer and Dischaindicated Resident was notified by telepto GACH 1.	ge 4 ector (SSD 1) informed GACH 1 (CM 1) that there was no e in the facility on 12/7/18. The the facility's DON informed y was not sure Resident 1 and could readmit Resident 1 et 1's Notice of Proposed arge, notification date 12/2/18, 1's responsible party (RP 1) chone of Resident 1's transfer mented evidence in Resident	F 62			31871.09
	1's medical records transfer and dischar There was no secon and discharge to the 12/7/18, when Resid	of a written notification of the ge to the RP 1 on 12/2/18. In notification of the transfer e resident and/or RP 1, on dent 1 was ready to return to not permitted to return.				
	A review of the facili indicated no open m 12/9/18.	ty's Daily Census Report nale beds from 12/4/18 to			•	
,	Admission's Coordir not readmit Residen	on 12/12/18, at 9:22 AM, the nator (AC 1) stated they could it 1 on 12/7/18, because ed was returned to the bed			,	
	record review of faci the Director of Nursi could read mit Resid bed was in the facilit of the facility's Daily	5 AM, during an interview and lity's Daily Census Report, ng (DON) stated the facility ent 1, if resident's bariatric y. A concurrent record review Census Report with the DON there was no open male	•			

	r of deficiencies Of correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER REY HEALTHCARE &	WELLNESS CENTRE, LP		5° 12 R				
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F 622	would have to move accommodate Resi another resident (R Resident 1's previo Resident 1 was awa	day. The DON stated they e residents around to ident 1. The DON stated that lesident 2) was occupying us room temporarily while ay.	F	522			3/1/1/9	
	PM, the Administration facility staff did not proposed transfer with transferred to the G of proposed dischareadmit the resident's needs	Interview, on 1/31/19 at 4:10 tor Designee (AD) stated the provide the written notice of when Resident 1 was GACH, on 12/2/18, and a notice rge when the facility could not at on 12/7/18. The AD stated is could not be met by the esident 1's bariatric bed was 77/18.						
	titled, "Bed Hold," ro that if the facility de was transferred with to the facility could	lity's policy and procedure evised date 7/17, indicated termined that the resident who han expectation of returning not return to the facility, the lete a Notice of Transfer and nt.						
	titled, "Notice of Tra 10/17, indicated that resident and respon notice of transfer/di of transfer/discharg Notice of Bed Hold CFR(s): 483.15(d)(lity's policy and procedure ansfer/Discharge," revised date at the facility would provide the asible party with a written scharge prior to or at the time se and their appeal rights. Policy Before/Upon Trnsfr 1)(2)	Fſ	625	F625 Corrective action for residents found to have been affected by deficient practice: • Resident #1 written Notification of bed hold we called to sister on 12/2/18	y the		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		555897	B. WING	i			C 06/2019	
	PROVIDER OR SUPPLIER SEY HEALTHCARE &	WELLNESS CENTRE, LP		12	TREET ADDRESS, CITY, STATE, ZIP CODE 267 SAN GABRIEL BLVD OSEMEAD, CA 91770			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 625	§483.15(d)(1) Notice nursing facility transitive resident goes of nursing facility must the resident or resistance (i) The duration of the second sec	be before transfer. Before a sfers a resident to a hospital or in therapeutic leave, the trovide written information to dent representative that the state bed-hold policy, if	F	625	Written notification of bed was mailed to sister on 2/6 • Resident #1 was readmitted 12/10/18. Corrective action for resident may be affected by same deficitions.	5/19. ed on that	31549	
	return and resume facility; (ii) The reserve bed plan, under § 447.4 (iii) The nursing fact bed-hold periods, we paragraph (e)(1) of resident to return; a	he resident is permitted to residence in the nursing dipayment policy in the state to of this chapter, if any; sility's policies regarding which must be consistent with this section, permitting a and a specified in paragraph (e)(1)	•		No other residents were affected by this deficient practice. Measures will be put in place ensure that the deficient practice does not occur: DNS reeducated license not occur.	tice		
	the time of transfer hospitalization or the facility must provide resident represents specifies the duration described in parage. This REQUIREME by: Based on interview failed to provide a resident and/or really for one of two services. The form of two services are services and the factor of the	nerapeutic leave, a nursing e to the resident and the ative written notice which on of the bed-hold policy raph (d)(1) of this section. NT is not met as evidenced wand record review, the facility written bed hold notification to esident's responsible party (RP ampled residents (Resident 1). The to the General Acute Care 1), and the Responsible Party in twas not provided a written old notice, on 12/2/18, transfer			on 2/11/19 regarding completion of Notification bed hold. • Administrator/designee provided in-service to Sociate services director regarding providing copy of written notification of bedhold for resident/responsible part. Measures to monitor its performance to make sure the solution are sustained:	n of ial g of rm to y		
	This deficient prac	ice resulted in the violation of				;		

STATEMEN AND FLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		LE CONSTRU	JCTION		0	(X3) DATE SURVEY COMPLETED		
	PROVIDER OR SUPPLIER	555897	B. WINC	s			. STATE, ZIP CO	ODE	·	C /06/2019	_
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY	WELLNESS CENTRE, LP TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF	IX	P (EA	ROVIDER'S	PLAN OF COR	SHOULD	RF	(X5) COMPLETIO	N
	Continued From pay the resident's rights facility during the time ready to return. Findings: A review of Resident resident was admitted and readmitted back with diagnoses that if (mental disease that and thoughts may no	to resume residency at the neframe that the resident was at 1's Face Sheet indicated at to the facility, on 11/7/18, to the facility, on 12/10/18, included schizophrenia affects how the brain works at be clear, or may jump from the Face Sheet indicated.		625	·	Medical audit or provide DNS will issue to	record will record will discharge copy to DN report any QAA comm x3 months	performersiden S to revolution	m t and view.	3/3719	
	(MDS, a standardize planning tool), dated resident was alert an assistance with transtoileting. A review of Resident Orders, dated 12/2/1 transferred to GACH (emergency services adicated for a facility seven (7) days.	fers, walking, dressing, and 1's Physician and Telephone 8, indicated Resident 1 1 via paramedics 1. The physician order to hold Resident 1's bed for									
f iii 1 1 1	sach 1, dated 12/// acility's Social Service aformed GACH 1's Office was no open be 2/7/18. The e-mail in the facility's director of 's bariatric bed was no ompany, on 12/6/18, aying "for it (bed) to	es Director (SSD 1) case Manager (CM) that ds available in the facility on dicated that according to f nurses (DON), Resident returned to the bed because the facility was									

STATEMEN	T OF DEFICIENCIES	- & WEDICAID SERVICES			OMB NC	2. 0938-039
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILE	TIPLE CONSTRUCTION	(X3) D.A	TE SURVEY MPLETED
NAME OF	DDGWDED OF STREET	555897	B. WING		02	C /06/2019
MONTE		WELLNESS CENTRE, LP	·	STREET ADDRESS, CITY, STATE, ZIP CO 1267 SAN GABRIEL BLVD ROSEMEAD, CA 91770	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE
F 625	A review of Resider dated 12/2/18, indice was notified of their started 12/2/18 and notification indicated maintained (not to expend the resident's bed whospital for seven distribution of the resident of the re	at 1's Notification of Bed Hold, cated that Resident 1's RP 1 resident's bed hold rights that ends on 12/9/18. The d, "A bed hold will be exceed 7 days)." on 12/12/18, at 8:40 AM, the ector (SSD) stated the facility would hold thile away in the acute	F6	225		31119
F 626 SS=D	trued, "Bed Hold," refacility would notify the representative (respithe bed hold option, transferred to an acutherapeutic leave. Permitting Residents CFR(s): 483.15(e)(1) §483.15(e)(1) Permit facility. A facility must establi	ensible party), in writing, of any time the resident was atte care hospital or requests to Return to Facility (2) thing residents to return to ask and follow a written policy at to return to the facility	F 62	F626 Corrective action for resident found to have been affect deficient practice: • Resident #1was read 12/10/18	ed by the	

STATEMENT	T OF DEFICIENCIES	& MEDICAID SERVICES		<u></u>	OMB N C	D. 0938-03
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	LTIPLE CONSTRUCTION DING	(X3) DA	TE SURVEY MPLETED
NAME OF	PROVIDER OR SUPPLIER	555897	B. WING		02	C 2/06/2019
MONTER	REY HEALTHCARE &	WELLNESS CENTRE, LP		STREET ADDRESS, CITY, STATE, ZIP 1267 SAN GABRIEL BLVD ROSEMEAD, CA 91770	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG		N SHOULD BE EAPPROPRIATE	COMPLETIC DATE
F 626	therapeutic leave. T following. (i) A resident, whose leave exceeds the b State plan, returns to room if available or	ge 9 the policy must provide for the hospitalization or therapeutic ed-hold period under the the facility to their previous immediately upon the first in a semi-private room if the	F 6	Corrective action for resmay be affected by sampractice: No other residents affected by this definition practice.	e deficient were	3/5119
	resident- (A) Requires the ser and (B) Is eligible for Me services or Medicaid nursing facility servic (ii) If the facility that who was transferred returning to the facility must facility, the facility must resident.	vices provided by the facility; dicare skilled nursing facility l ces. determines that a resident with an expectation of ty, cannot return to the		Measures will be put in pensure that the deficient does not occur: • Administrator/design educate Admission coordinator, Social director & DNS regarded bedhold policy & procession 2/6/2019	t practice gnee re- service arding	
i di	distinct part. When the returns is a composite of an available bed in composite distinct particles at the time of return, the option to return to availability of a bed the This REQUIREMENT by:	is not met as evidenced		Admission coordination check daily census resure bed is hold to who was transferred acute care hospital to bed hold policy a procedure. Any issu concern will be reposadministrator/designal.	report to ro resident d to an according nd e or	
r h e p s tr	alled to implement the color of the resident's be and be permitted to reprevious room following the color of	neral Acute Care Hospital 1		Measures to monitor its performance to make sur solution are sustained: • Administrator/desig report any trends re	nee will	

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AND	EMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING					(X3) DATE SURVEY COMPLETED	
		555897	B. WING				<u> </u>	С	
1	NAME OF PROVIDER OR SUPPLIER MONTEREY HEALTHCARE & WELLNESS CENTRE, LP			STREET ADDRESS, CITY, STATE, ZIP CODE 1267 SAN GABRIEL BLVD					
PR		TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	x	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	II D RE		(X5) COMPLETO DATE	ON
F	626 Continued From page (GACH 1) on 12/2/1	8. .	F 6	26	bedhold to QAA commit monthy x 3 months	tee		3/1719	`
	care hospital stay an rights to return to the	ce resulted in Resident 1 unnecessary days of acute and violated the resident's a facility during the seven day (started 12/2/18 and ends on			,				
	complaint regarding to the facility following Resident 1, on 12/7/1	AM, an unannounced visit efacility to investigate a permitting residents to return g GACH 1 hospitalization for 8 (6th day of bed hold) and return because there was no							
	and readmitted back to with diagnoses that in (mental disease that a and thoughts may not	be clear, or may jump from							
	A review of Resident 1 (MDS, a standardized planning tool), dated 9, resident was alert and assistance with transfetoileting.	assessment and care			•			·	
RM CMS-2	A review of Resident 1' Orders, dated 12/2/18, transferred to GACH 1 (emergency services). 2567(02-99) Previous Versious Obso	via paramedics The physician order	• .						