STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055693	A. BUILDING _____ B. WING _____	C 12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTHCARE CENTER OF BELLA VISTA	933 EAST DEODAR STREET ONTARIO, CA 91764

(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 California Department of Public Health during the investigation of an Entity Reported Incident. Complaint number: CA00371901 Representing the California Department of Public Health: 22232 The inspection was limited to specific complaints investigated and does not represent the findings of a full inspection of the facility. For complaint number CA00371901, a deficiency was written under 483.75(k)(2)(ii).	F 000	Healthcare Center of Bella Vista submits this Plan of Correction as part of the requirements under State and Federal law. The Plan of Correction is submitted in accordance with specific regulatory requirements. It shall not be construed as admission of any alleged deficiency cited or any liability. The provider submits this Plan of Correction with the intention that it is inadmissible by any third party in any civil, criminal action or proceedings against the provider of its employees, agents, officers, directors, or shareholders. Any changes to provider policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the federal rules of evidence and California evidence code section 1151 and should be inadmissible in any proceeding on that basis.	
F 511 SS=D	483.75(k)(2)(ii) RADIOLOGY FINDINGS-PROMPTLY NOTIFY PHYSICIAN The facility must promptly notify the attending physician of the findings. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure the physician was promptly notified following an x-ray result, which reflected a fracture to the right arm of one resident , in a universe of residents. This failure resulted in a delay of treatment for a fractured arm for the resident. Findings:	F 511	**F511 Radiology Findings – Promptly Notify Physician** *Director of Nursing and Director of Staff Development conducted training and education to Licensed Nurse on January 14, 15 & 16, 2014 regarding timeliness notification of physician and responsible party following an x-ray result or any laboratory results especially when the	1/18/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055693	A. BUILDING _____ B. WING _____	C 12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTHCARE CENTER OF BELLA VISTA	933 EAST DEODAR STREET ONTARIO, CA 91764

(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 511	Continued From page 1 Or. ., an unannounced visit to the facility was conducted to investigate an Entity Reported Incident. A record review, of medical record, was conducted on (was admitted to the facility on with diagnoses which included Further record review showed documentation on the Minimum Data Set (MDS, a tool used by long-term care facilities to assess and plan care for residents) under, "functional status", that required a one person extensive assist when ambulating. An interview with the facility's Administrator was conducted on The facility's investigative report, for an unusual occurrence fo was provided. The report reflected that a Certified Nursing Assistant (CNA 1) reported to the nurse (LVN 1) that had gotten up out of bed, without any help, "bumpec on the side rail of the bed the evening of the time was not documented). The investigative report revealed that the certified	F 511	results is critical or abnormal and resident's change of condition (COC). *MRD, DSD and DON conducted audit on x-ray order & result, COC with lab orders and lab results for the month of August, September, October, November and December 2013 on January 14, 15, & 16, 2014. No other resident were identified to be affected by the same deficient practice. *Director of Nursing and Director of Staff Development conducted training and education to Licensed Nurse on January 14, 15 & 16, 2014 regarding timeliness notification of physician and responsible party following an x-ray result or any laboratory results especially when the results is critical or abnormal and resident's change of condition. Medical Records Designee (MRD) will conduct five times a week audit of x-ray results, COC and lab results and RN Supervisor during the weekend, any identified issue will be validated by the MRD and RN Supervisor if notification was done timely, report will be submitted to the DON for follow-up and validation. DON will give	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055693	A. BUILDING _____ B. WING _____	C 12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTHCARE CENTER OF BELLA VISTA	933 EAST DEODAR STREET ONTARIO, CA 91764

(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 511	Continued From page 2 nursing assistant (CNA 1) reported to the charge nurse (Licensed Vocational Nurse. LVN 1) that was anxious and was discolored. LVN 1 administered for, There was no documented evidence that physician was notified of the of the A record review of the nurses' notes, on revealed that o. complained of pain to at a level c on a pain scale of 1 - 10, with '10' being the worst pain. LVN 1 administered (2) after the ad been given. At the time of the dministration, LVN 1 completed a body check (a visual observation of the resident's body by the nurse) and noted the discoloration of During continued record review of the nurse's notes, documentation showed LVN 1 telephoned the physician on ollowing the administration of the , to report the discoloration. The physician gave an order to monitor the ( ) tid During continued review of the nurses' notes, on t was revealed that LVN 2 administerec	F 511	report to the Administrator during the weekday department mangers meeting for follow-up and resolution. *MRD and/or designee will monitor facility compliance five times a week and RN Supervisor will monitor facility compliance during the weekend. Any identified non compliance will be corrected immediately, report will be submitted to the DON for follow-up and validation. DON will submit report to the Administrator during department managers meeting for follow-up and immediate resolution. DON will do trending and analysis and will report to the quarterly Continuous Quality Improvement (CQI) Steering Committee for further evaluation and/or recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055693	A. BUILDING _____ B. WING _____	C 12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTHCARE CENTER OF BELLA VISTA	933 EAST DEODAR STREET ONTARIO, CA 91764

(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 511	Continued From page 3	F 511		

on [illegible] at [illegible] At [illegible] on [illegible] LVN 2 documented continued discoloration of [illegible] LVN 2 telephoned the physician on [illegible] and a stat (Immediately) x-ray of the [illegible] was ordered and completed.

On [illegible] review of the x-ray report, dated Se[illegible] was conducted. The report result noted,

There is associated [illegible]

which connects to the

On [illegible] a review of a nurse's note was conducted. A nurse's note, dated [illegible] was conducted. The note reflected "Noted x-ray report done on [illegible] ult, [illegible]---Dr. (physician) called." The stat x-ray report, reflecting the [illegible] was phoned to the physician on [illegible] days after the incident in which [illegible] acquired

A nurse's note, dated [illegible] documented [illegible] was transported to the General Acute Care Hospital (GACH) emergency room on [illegible] at [illegible] returned to the facility on [illegible] with a [illegible] and a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055693	A. BUILDING _____ B. WING _____	C 12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTHCARE CENTER OF BELLA VISTA	933 EAST DEODAR STREET ONTARIO, CA 91764

(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 511	Continued From page 4	F 511		

in place.

A nurse's note, dated documented had removed the splint and and refused to allow staff to put the t and back in place.

Continued review of the nurses' notes showed documentation that was transported to an Orthopedic (a medical specialty that provides care for injuries or diseases to the

On returned to the facility with a hard cast to the right arm.

On an interview was conducted with the Registered Nurse (RN 1). RN 1 was asked what the procedure and follow-up for diagnostic tests would be. RN 1 stated that the nurse who provided care to the resident at the time that the x-ray was taken would be responsible for ensuring that the results were reported to the physician.

RN 1 further stated the results of the stat x-ray should have been received and reported to the physician within 4 hours.

On an interview was conducted with daughter.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055693	A. BUILDING _____ B. WING _____	C 12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTHCARE CENTER OF BELLA VISTA	933 EAST DEODAR STREET ONTARIO, CA 91764

(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 511	Continued From page 5	F 511		

stated she was notified on
hat rm was
ut she was not n ttil
that was
days after the x-ray results showed
here was a fracture).

On observation
revealed situng in a with a
cast on om
was asked how n got hurt
stated, "I fell."

An interview was conducted with the Director of Staff Development (DSD) on at The DSD stated that following the delayed reporting of the x-ray to the physician, on had given inservice presentations to all staff regarding reporting injuries and diagnostic test results to nurses and physicians promptly following any incident.

Or an interview was conducted with the Director of Nurses (DON). The DON stated that her expectation would be that any stat orders would have the results received and reported to the physician within 4 hours. The DON could not provide a facility policy regarding reporting test results to the physician timely. The DON further stated she realized there was a delay in reporting the fracture o arm.