POC accepted + implemented + reviewed on 12/8/11. — Mylanata, HFEN — 12:30 pm

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555690	A. BUILDING _____ B. WING _____	11/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMEDA CARE CENTER	925 W. ALAMEDA AVE BURBANK, CA 91506

(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: [redacted], RN. HFEN [redacted], RN. HFEN [redacted], RN. HFEN Total Population: 89 Sample Size: 18	F 000	The signing of this plan of correction is not an admission or agreement by the facility of the truth of the facts alleged in this statement of deficiency and plan of correction. In fact, this plan is submitted exclusively to comply with state and federal law. This plan of correction serves as the allegation of compliance.	
F 226	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to implement its policy procedures related to Abuse Prevention and Prohibition by not conducting background screening checks before employees were hired and/or start working in the facility for five newly hired certified nursing attendants out of five epmployee records reviewed. Findings: On November 11, 2011 at 12:05 P.m., during the survey, a review of five direct care employee files for CNAs revealed that the facility did not	F 226		

2011 DEC -7 PM 4:18

LOS ANGELES COUNTY HEALTH FACILITIES DIVISION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
N. Tehrani	Administrator	12/7/11

y deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that er safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days owing 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 ys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued gram participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555690	A. BUILDING _____ B. WING _____	11/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMEDA CARE CENTER	925 W. ALAMEDA AVE BURBANK, CA 91506

(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 226	Continued From page 1 Implement the Abuse Prevention and Prohibition policy and procedures. For example: 1. CNA 1 was hired on June 8, 2011. The background screening date was June 21, 2011. 2. CNA 2 was hired November 4, 2011. There was not documented screening in the employee file. 3. CNA 3 was hired June 8, 2011. The background screening date was June 17, 2011. 4. CNA 4 was hired November 4, 2 011, There was no documented background screening in the employee file. 5. CNA 5 was hired October 12, 2011. There was no documented screening in the employee file. A review of the facility's abuse policy and procedure indicated that prior to hiring of any employee, the facility shall ensure provisions covering employment screenings for potential history of abuse, neglect or mistreatment of residents, this includes, but not limited to, disclosure of information via application forms, obtaining information from previous and current employers, making appropriate inquiries to applicable licensing boards and registries. During an interview with the Director of Staff Development (DSD) on November 11, 2011 at 1:50 p.m., she stated that it is part of the facility's procedure to do background screening before hiring CNAs. The DSD stated that because she was a fairly new employee to the facility, she did not yet have access to the facility's computer	F 226	F 226 DEVELOP/IMPLEMENT ABUSE/NEGLET, ETC POLICIES All C.N.A's Background screening was completed and filed on 11/15/11 D.S.D was given access to program to do screen of employees before hire on 11/10/11. Consultant will do random file audits to monitor for compliance. Overall compliance will be monitored quarterly by QA Committee.	11/15/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555690	A. BUILDING _____ B. WING _____	11/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMEDA CARE CENTER	925 W. ALAMEDA AVE BURBANK, CA 91506

(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 226	Continued From page 2 program to do the pre-hire background checks and had to depend on outside sources to do the background checks. The DSD's hire date was April 16, 2011.	F 226		
F 250	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that a resident assessed as a possible candidate for discharge to the community had a discharge plan in place and/or reassessed by the interdisciplinary team (IDT) to evaluate the feasibility for discharge for one out of 18 sample residents (13). Findings: On November 2, 2011, at 3 p.m., the resident was observed sitting in the wheelchair watching the television in the activity room. He was alert, awake, and oriented. According to the admission record, the resident was readmitted to the facility on April 1, 2011, with diagnoses that included debility, symbolic dysfunction, and contact dermatitis. The quarterly review Minimum Data Set (MDS) assessment dated October 8, 2011, indicated the	F 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555690	A. BUILDING _____ B. WING _____	11/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMEDA CARE CENTER	925 W. ALAMEDA AVE BURBANK, CA 91506

(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 250	Continued From page 3 resident had a severe impairment for cognitive patterns, needed supervision from staff members for bed mobility, transfer, walking in room and corridor, locomotion on and off the unit, eating, and toilet use, needed extensive assistance from staff members for personal hygiene and bathing. The resident was always continent of bowel and bladder. The discharge plan indicated discharge to community was determined to be not feasible. The Admission Assessment dated April 1, 2011, indicated in the section of the discharge evaluation that long term care with discharge possible was marked with a check. A review of the clinical records did not indicate that the facility attempted to assist the resident to be placed on a lower level of care as part of the discharge plan. There was no documented evidence that a discharge planning was done. On November 2, 2011, at 3:15 p.m., during an interview with the Director of Social Service (DSS), he stated the resident was appropriate to be placed for an assistive living. However, there was not documented evidence that indicated social service staff members in coordination with the IDT made an assessment to determine whether the resident can be discharged to to the community was indicated on the MDS assessment. The facility's undated policy and procedure titled "Social Services" , indicated the services of the social staff shall be incorporated in the development and implementation of the discharge plan for each resident admitted to the	F 250	F 250 PROVISION OF MEDICALLY RELATED SOCIAL SERVICE Discharge Plan was reviewed by IDT and resident was assessed for discharge on 11/14/11. Medical waiver program was called by Social Services for evaluation on 11/22/11. All residents appropriate for discharge to ALF's were evaluated for Medical waiver program on 11/14/11. IDT will assess residents on an ongoing basis for appropriate discharge to lower level of care. Overall Compliance will be monitored by QA Committee on a quarterly basis.	11/22/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555690	A. BUILDING _____ B. WING _____	11/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMEDA CARE CENTER	925 W. ALAMEDA AVE. BURBANK, CA 91506

(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 250	Continued From page 4 facility. The social services designee participates in the development of the resident care plan and discharge plan and shares the information with the resident and/or person acting on his/her behalf. The resident's response to the information is recorded in his/her medical record and is considered in the implementation of the plan.	F 250		
F 278	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement.	F 278		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555690	A. BUILDING _____ B. WING _____	11/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMEDA CARE CENTER	925 W. ALAMEDA AVE BURBANK, CA 91506

(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 278	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that the resident's height was assessed accurately recorded on the on the Minimal Data Set (MDS) to reflect the actual height of the resident for one out of 18 sample residents (18). Findings: According to the admission record, the resident was admitted to the facility on November 29, 2010, with diagnoses that included [redacted] and abnormality of gait. A review of the MDS (Minimum Data Set) assessment dated December 3, 2010, indicated the resident's height was 62 inches and the MDS assessment dated August 26, 2011 3, indicated the resident's height was 58 inches. A review of the resident's admission height dated November 29, 2010, indicated the resident's height was 58 inches. On November 12, 2011, at 3:10 p.m., during an interview with Registered Nurse 4 (RN 4), she stated that the MDS dated December 3, 2010, was not documented correctly and should have been documented as 58 inches.	F 278	F 278 ASSESSMENT ACCURACY/ COORDINATION/CERTIFIED Residents height was reviewed. MDS was in-serviced by DON to accurately document on 11/12/11 Heights will also be reviewed by IDT members during meetings for accuracy. Monthly heights will be recorded and reviewed by DON for accuracy. Overall compliance will be monitored quarterly by QA Committee.	11/12/11
F 279	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.	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555690	A. BUILDING _____ B. WING _____	11/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMEDA CARE CENTER	925 W. ALAMEDA AVE. BURBANK, CA 91506

(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 279	Continued From page 6 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 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 interview and record review, the facility failed to ensure an integrated care plan was developed with the facility and the hospice provider to indicate designated responsibilities for providing care and services to the resident for two out of 18 sample residents (2,9). Findings: a. According to the admission record, Resident 9 was originally admitted to the facility on September 8, 2010, and readmitted on August 7, 2011, with diagnoses that included breast malignancy and secondary liver malignancy. The Minimum Data Set (MDS) assessment dated August 19, 2011 indicated the resident was	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555690	A. BUILDING _____ B. WING _____	11/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMEDA CARE CENTER	925 W. ALAMEDA AVE BURBANK, CA 91506

(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 279	Continued From page 7	F 279		

[redacted] for daily decision making and needed extensive assistance in activities of daily living.

The resident had a physician's order dated August 9, 2011, to admit to the hospice under routine level of care for breast cancer with liver metastasis.

There was a plan of care developed on August 9, 2011, for admission to hospice program due to terminal illness of breast cancer metastasis to liver, and dementia. One of the approaches was to provide level of routine care and to see hospice calendar for detailed hospice duty, responsibility, and its frequency.

A review of the resident's calendar from August 2011, to November 2011, indicated there were schedules when the skilled nurse or certified home health aid were going to visit the patient. On the calendar of November 2011, it was indicated that the case manager will do supervised visits once or twice a month and the patient will have one to two skilled nursing visits per week and as needed for any changes. However, there was no other documented information related to detailed hospice duty and responsibility as indicated in the facility's care plan dated August 9, 2011.

A review of the resident's clinical record indicated there was no individualized and integrated care plan developed for the resident by the facility and the hospice provider to indicate designated responsibilities for providing care and services to the resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555690	A. BUILDING _____ B. WING _____	11/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMEDA CARE CENTER	925 W. ALAMEDA AVE BURBANK, CA 91506

(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 279	Continued From page 8 On November 11, 2011, at 5:35 p.m. during an interview with RN 1, she was not able to provide the documented evidence that integrated plan of care was developed with the hospice agency personnel indicating who was responsible for providing what kind of care and services to the resident, and RN 1 agreed the integrated care plan should have been developed with the hospice provider for the resident. A review of the Contract Agreement between the facility and the hospice provider dated August 8, 2011, indicated both the plan of care and nursing care plan developed by the agency will be part of the patient's record in the facility. Both these will be developed in collaboration with the agency and facility staff. b. On November 11, 2011, at 4:40 p.m., Resident 2 was observed sitting in the wheelchair in the activity room and was able to converse with a tab alarm attached to the wheelchair. According to the admission record, the resident was admitted on September 27, 2010, with diagnoses that included [redacted], paralysis, and [redacted]. The significant change Minimum Data Set (MDS) assessment dated October 1, 2011, indicated the resident's [redacted], needed extensive assistance from staff members for transfer, locomotion on and off the unit, dressing, eating, hygiene, and bathing. The resident was always incontinent of bowel and bladder. The Physician's Orders dated September 19, 2011, indicated admit to hospice on routine level	F 279	F279 DEVELOP COMPREHENSIVE CARE PLANS DON and MDS met with hospice to develop an integrated care plan for resident on 11/23/11 and 12/2/11 In-service was given to licensed nurses by hospice on developing an integrated care plan on 11/23/11 Medical Records will audit monthly for compliance Overall Compliance will be monitored by QA Committee on a quarterly basis.	12/2/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555590	A. BUILDING _____ B. WING _____	11/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMEDA CARE CENTER	925 W. ALAMEDA AVE BURBANK, CA 91506

(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 279	Continued From page 9 of nursing home care. A review of the care plan revealed that the resident had two care plans, one from the facility and the other one was from the hospice provider. However, the facility's care plan was not integrated in the hospice's care plan and both plan of cares did not indicate designated responsibilities for providing care and services to the resident . On November 11, 2011, at 6:55 p.m., during an interview with Registered Nurse 1 (RN 1), she stated the hospice care plan should have been integrated. On September 2, 2011, the resident had a poor oral intake and appetite. The facility's undated policy and procedure titled "Hospice", indicated the plan of care shall address the needs of the resident and all services provided to the resident and will be updated as needed. However, it did not indicate that the care plan needs to be integrated.	F 279		
F 314	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555690	A. BUILDING _____ B. WING _____	11/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMEDA CARE CENTER	925 W. ALAMEDA AVE BURBANK, CA 91506

(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 314	Continued From page 10	F 314		

by:
Based on observation, interview and record review, the facility failed to ensure a resident was provided heel protectors (pressure relieving devices) to the heels as directed by the the physician in order to prevent the potential for the development of pressure ulcers to the heels for one out of 18 sample residents (9).

Findings:

According to the admission record, Resident 9 was originally admitted to the facility on September 8, 2010, and readmitted on August 7, 2011, with diagnoses that included breast malignancy and secondary liver malignancy.

The Minimum Data Set (MDS) assessment dated August 19, 2011 indicated the resident was [redacted] for daily decision making and needed extensive assistance in activities of daily living.

The resident had a physician's order dated August 7, 2011, to check both heels for redness at every shift and to apply heel protectors.

On November 11, 2011, at 3:45 p.m., the resident was observed lying in her bed without wearing heel protectors in the presence of Registered Nurse 2 (RN 2). As RN 2 assessed both of the resident's heels, there was redness noted on the resident's right heel. RN 2 stated the size of the redness seemed approximately one inch by one inch and stated the heel protectors should have been applied to the resident when the resident was in her bed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555690	A. BUILDING _____ B. WING _____	11/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMEDA CARE CENTER	925 W. ALAMEDA AVE BURBANK, CA 91506

(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 314	Continued From page 11 A review of the treatment sheet from August 7, 2011, to November 12, 2011, there were licensed nurses' initials documented indicating both heels were checked for redness at every shift. However, there was no result documented whether the resident had redness on her heels or not. On November 12, 2011, at 3:10 p.m. during an interview with RN 2 again, she stated she was not able to say if the resident had redness on her heels from August 7, 2011, to November 11, 2011, by reviewing the resident's clinical record and stated the licensed nurse should have documented in the treatment sheet whether the resident had redness on her heels.	F 314	F 314 TREATMENT/SVCS TO PREVENTHEAL PRESSURE SORES Heel protectors were applied immediately to resident. All licensed nurses were in-serviced by DON on 11/14/11 and on care and documentation of skin treatments. Treatment order sheet modified to indicate presence of redness or not	11/14/11
F 323	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 by: Based on observation and interview, the facility failed to maintain the residents' environment free of accident hazards by not securing televisions sets that could cause the potential for accidents in four resident's rooms, failed to keep a bottle of peri-wash out of reach the residents to prevent from being swallowed by accident, and failed to place floor mats on both sides of the bed for a	F 323	All department heads, licensed nurses will monitor for compliance on daily rounds for application of the heel protectors DON will monitor for compliance weekly Overall Compliance will be monitored by QA Committee on a quarterly basis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	556690	A. BUILDING _____ B. WING _____	11/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMEDA CARE CENTER	925 W. ALAMEDA AVE BURBANK, CA 91506

(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 323	Continued From page 12 resident who was at risk for fall as per physician's order for one out of 18 sample residents (9). Findings. a. On November 10, 2011, from 6:20 p.m. to 7:05 p.m. during a tour of the facility in the presence of Registered Nurse 3 (RN 3), four television sets in Rooms 16 Bed-C, 17 Bed-A, 22 Bed-A, 22 Bed-B were observed not secured to prevent potential accidents. During an interview, RN 3 who was present during the observation stated stated the television sets should have been secured to prevent possible accidents. b. On November 10, 2011, at 6:35 p.m. during an initial tour with RN 3, a peri-fresh contained in a bottle was observed unattended in the resident's bathroom without cap. During an interview with RN 3 present during the observation he stated there was more than 100 cubic centimeters (cc) of peri-fresh solution left in the bottle. He also stated the bottle should have been kept in the Nursing Station because the residents could drink it. On November 11, 2011, at 9:10 a.m. during an interview with RN 1, she stated there were approximately 68 ambulatory residents in the facility. A review of the guideline of the peri-fresh solution provided by the facility, indicated it would be irritating if the solution was placed in eyes or if ingested. If the solution was ingested, the guideline directed to drink large amounts of water and call the physician and to keep in closed container.	F 323	The television sets were secured immediately by Maintenance Supervisor 11/11/11 Social Services will alert Maintenance Supervisor to secure when family brings in television. Maintenance Supervisor will monitor for compliance on daily rounds Department heads will monitor for compliance on daily rounds. Overall Compliance will be monitored by QA Committee on a quarterly basis.	11/11/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555690	A. BUILDING _____ B. WING _____	11/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMEDA CARE CENTER	925 W. ALAMEDA AVE BURBANK, CA 91506

(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 323	Continued From page 13 c. According to the admission record, Resident 9 was originally admitted to the facility on September 8, 2010, and readmitted on August 7, 2011, with diagnoses that included [redacted] and [redacted]. The Minimum Data Set (MDS) assessment dated August 19, 2011 indicated the resident was [redacted] for daily decision making and needed extensive assistance in activities of daily living. A review of the Care Area Assessment (CAA) dated September 2, 2011, indicated fall was triggered. A review of the Fall risk assessment dated August 8, 2011, indicated the risk of fall was scored 16, and the total score above 10 represents the resident was in high risk of fall. The resident had a physician's order dated August 7, 2011, for a low bed and the floor pad at bedside for fall and injury precautions. There was a plan of care developed on September 14, 2010, for the potential of fall and injury related to unsafe ambulation, poor eyesight, forgetful/confused related to [redacted]. One of the approaches was to put a tab alarm on a lower bed and to put non skid floor mattress at bed side. On November 10, 2011, at 7 p.m., November 11, 2011, at 12:30 p.m. and 3:45 p.m., the resident was observed lying in her low bed. There was one floor mat on the resident's left side of the bed, but there was no floor mat on her right side of the bed.	F 323	Peri-wash removed immediately from the resident's bathroom The assigned C.N.A was in-serviced immediately by DSD 11/10/11 All C.N.A's were in-serviced by DSD on proper storage and risk of leaving peri-wash unattended on 11/11/11 Compliance will be monitored daily by DSD, licensed nurse and department heads on rounds Overall Compliance will be monitored by QA Committee on a quarterly basis. F 323 Extra floor mat was provided and put on both sides on 11/13/11 All C.N.A's and housekeeping staff were in serviced to put back floor mats after cleaning of room by DSD on 11/14/11 and 11/16/11 Compliance will be monitored by DSD, licensed nurse and department heads on the daily rounds. Overall Compliance will be monitored by QA Committee on a quarterly basis.	11/11/11 11/16/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555690	A. BUILDING _____ B. WING _____	11/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMEDA CARE CENTER	925 W. ALAMEDA AVE BURBANK, CA 91506

(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 323	Continued From page 14 On November 11, 2011, at 3:45 p.m. during an interview with RN 2, she stated the floor pads should have been placed on both right and left side of the bed.	F 323		
F 329	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to monitor for the resident for baseline serum iron or ferritin level and periodic laboratory	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555690	A. BUILDING _____ B. WING _____	11/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMEDA CARE CENTER	925 W. ALAMEDA AVE BURBANK, CA 91506

(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 329	Continued From page 15 tests such as complete blood count (CBC) or hematocrit/ hemoglobin when Ferrous sulfate was ordered for a long-term use to prevent the potential of accumulation of iron in the tissue if used for a long duration for two months for two out of 18 sample residents (1,3). Findings: a. According to the admission record, Resident 1 was readmitted on July 28, 2011, with diagnoses that included acute upper respiratory infection and debility. The quarterly review Minimum Data Set (MDS) assessment dated August 26, 2011, indicated the resident was [redacted] The physician's orders dated July 28, 2011, indicated an order for ferrous sulfate 330 milligrams (mg) equals seven and a half cubic centimeters (cc) liquid by gastrostomy tube (GT) twice a day for severe anemia. The Medication Record dated November 2011, indicated the resident had been receiving ferrous sulfate twice a day as ordered by the physician for approximately four and one-half months. A review of the clinical record revealed there was no documented evidence that indicated the clinical rationale for the long-term use of ferrous sulfate for more than two months. On November 11, 2011, at 3:50 p.m., during an interview with the Director of Nursing (DON), she stated the physician should have written a justification and she was unable to find	F 329	F 329 DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Resident #1 Ferritin level was checked on 11/17/11. Physician discontinued use of Ferrous Sulfate. 11/30/11	11/30/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555690	A. BUILDING _____ B. WING _____	11/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMEDA CARE CENTER	925 W. ALAMEDA AVE BURBANK, CA 91506

(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 329	Continued From page 16 documentation by the physician on why the ferrous sulfate should be used for more than two months. b. According to the admission record, Resident 3 was admitted on March 3, 2004, with diagnoses that included [redacted], osteoarthritis, and chronic kidney disease. The quarterly review Minimum Data Set (MDS) assessment dated August 5, 2011, indicated the resident was [redacted] The physician's orders dated May 15, 2011, indicated an order fro ferrous sulfate 325 mg by mouth daily for severe anemia. The Medication Record dated November 2011, indicated the resident received ferrous sulfate every day for approximately six months as ordered by the physician. A review of the clinical record revealed there was no documented evidence that indicated the clinical rationale for the long-term use of ferrous sulfate for more than two months. According to the State Operation Manual (SOM), clinical rationale should be documented if iron is ordered for a long-term use (greater than two months), or if administered more than once daily (daily for greater than a week), because of side effects and the risk of accumulation of iron in the tissues. Monitoring of the baseline serum iron or ferritin level and periodic complete blood count (CBC) or hematocrit/hemoglobin is needed. Adverse consequences includes constipation, dyspepsia, accumulation of iron in stores that	F 329	Resident #3 Iron level results were reviewed with physician, Ferrous Sulfate was discontinued on 11/21/11. In-service given by Pharmacist consultant regarding Anemia, use of Ferrous Sulfate and Laboratory tests needed on 11/22/11 DON will monitor all residents on Ferrous Sulfate as needed. Overall Compliance will be monitored by QA Committee on a quarterly basis.	11/22/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555690	A. BUILDING _____ B. WING _____	11/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMEDA CARE CENTER	925 W. ALAMEDA AVE BURBANK, CA 91506

(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 329	Continued From page 17 cause multiple complications if given chronically despite normal or high iron stores (SOM, October 2010, page 390).	F 329		
F 371	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, interview and record review, the facility failed to ensure opened food items were labeled with opened dates, prepared foods were labeled with prepared dates. Findings: On November 10, 2011, at 5:45 p.m., the following was observed in the kitchen: 1. One box (20 dozen) of frozen roll bread dough was opened from the packages, and a box of 'Garden burger patties' was opened without date labeled. According to the policy of sanitation and food handling, all unused food must be securely covered with fresh piece of plastic film or aluminum foil. All items are to be dated and	F 371	F 371 FOOD PROCEDURE, STORE/PREPARE/SERVE – SANITARY All items were dated and labeled immediately. Dietary Staff was in-serviced by Dietary Supervisor regarding dating and labeling of food on 11/11/11 In- service was also given by Dietary Supervisor to Dietary Staff regarding. accurate dating of food served for breakfast on 11/11/11 Compliance will be monitored daily by DSS Overall Compliance will be monitored by QA Committee on a quarterly basis.	11/11/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555690	A. BUILDING _____ B. WING _____	11/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMEDA CARE CENTER	925 W. ALAMEDA AVE BURBANK, CA 91506

(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 371	Continued From page 18 labeled as to their content. 2. There were 60 cups of 4-ounce milk and 30 cups of 8-ounce milk in the walk-in refrigerator covered with plastic film and dated 11/11/11. During an interview with the dietary assistant who prepared the milk, stated he had prepared the milk on November 10, 2011, at 5 p.m., but he had labeled those cups of milk as November 11, 2011, because that milk would be served on November 11, 2011. He stated he had been labeling the date when the milk were supposed to be served. On November 11, 2011, at 12 p.m. during an interview with dietary supervisor, she stated the dietary personnel should have labeled the same that he had prepared the milk.	F 371		
F 425	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation	F 425		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555690	A. BUILDING _____ B. WING _____	11/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMEDA CARE CENTER	925 W. ALAMEDA AVE BURBANK, CA 91506

(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 425	Continued From page 19 on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a resident's mouth was rinsed out with water after inhalation of corticosteroid medication (Symbicort) to minimize dry mouth and local infection for one out of 18 sample residents (17). Findings: According to the admission record, the resident was originally admitted to the facility on September 15, 2006, and readmitted on August 31, 2009, with diagnoses that included pulmonary embolism, chronic obstructive pulmonary disease (COPD) with exacerbation, and congestive heart failure. The resident had a physician's order dated November 13, 2009, for Symbicort 160 mcg/4.5 one puff two times a day for COPD. (Symbicort inhalation is corticosteroid medication). On November 11, 2011, at 8:35 a.m. during a medication pass observation for the resident, Licensed Vocational Nurse 2 (LVN 2) administered one puff of Symbicort inhalation to the resident and gave her half cup of cranberry juice. The resident drank the cranberry juice instead of rinsing her mouth out with water, and	F 425	F425 PHARMACEUTICAL SVC-ACCURATE PROCEDURES, RPH Licensed nurse was in-serviced immediately by DON. Medication order sheet was modified to add "rinse mouth after each use" Licensed nurses were in-serviced on 11/14/11medication pass by DON and on 11/16/11 Pharmacy consultant in-serviced licensed nurses on administration of Symbicort inhalation on 11/22/11 DON will monitor for compliance randomly at medication pass. Overall Compliance will be monitored by QA Committee on a quarterly basis.	11/22/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555690	A. BUILDING _____ B. WING _____	11/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMEDA CARE CENTER	925 W. ALAMEDA AVE BURBANK, CA 91506

(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 425	Continued From page 20 LVN 2 stepped out of the resident's room. During an interview with Registered Nurse 1, on the same day at 9:10 a.m., she stated the resident should have been instructed to rinse out her mouth with water instead of drinking juice after administration of Symbicort inhalation. A review of the facility's Administration information of Symbicort indicated to instruct the resident to rinse mouth with water to minimize dry mouth and local infection after administration of Symbicort. A review of the product information- "Spacing and Proper Sequence of Inhaled Medications" indicated to rinse the mouth out following use and do not swallow the water after administration of corticosteroids to help preventing oropharyngeal fungal infections.	F 425		
F 441	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555690	A. BUILDING _____ B. WING _____	11/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMEDA CARE CENTER	925 W. ALAMEDA AVE BURBANK, CA 91506

(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 441	Continued From page 21 (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the respiratory care equipment such as an oxygen tube, and humidifier bottle used for a residents were properly labeled with dates changed and not touch the floor (9) and failed to have an infection control program designed to disinfect Clostridium difficile (C. difficile) by not mixing cleaning disinfect and water mix were in proper proportions accordance with the manufacturer's specifications and failed to observe infection precautions as ordered by the physician (11) for two out of 18 sample residents (9,11).	F 441	F441 INFECTION CONTROL, PREVENT SPREAD, LINENS Oxygen tubing and humidifier bottles were changed and placed in a bag on 11/11/11 Treatment order sheets were modified to add instruction "Care of Oxygen Tubing / Humidifier." In-service given to licensed nurses on dating and care of O2 tubing and humidifier bottles by DON on 11/14/11 Licensed nurses, DSD, Department heads and team leaders will check for compliance during daily rounds Overall Compliance will be monitored by QA Committee on a quarterly basis.	11/14/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555690	A. BUILDING _____ B. WING _____	11/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMEDA CARE CENTER	925 W. ALAMEDA AVE BURBANK, CA 91506

(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 441	Continued From page 22 Findings: a. According to the admission record, Resident 9 was originally admitted to the facility on September 8, 2010, and readmitted on August 7, 2011, with diagnoses that included acute respiratory failure and congestive heart failure. The Minimum Data Set (MDS) assessment dated August 19, 2011 indicated the resident was [redacted] for daily decision making and needed extensive assistance in activities of daily living. On November 10, 2011, at 7 p.m. during an initial tour of the facility in the presence of Registered Nurse 3 (RN 3), the resident was observed lying in her bed. There was oxygen machine connected to a tubing next to the resident's bed. The oxygen tubing was observed coiled around the oxygen machine and a portion of the tubing was was observed on the floor. There was a humidifier bottle connected to the oxygen machine. There tube and the humidifier bottle were not labeled with dates to help determine the date(s) the humidifier and the tubing has to be changed. During an interview with RN 3 present at the time of the observation when asked was not able to tell or provide evidence when the oxygen tube and the humidifier bottle would be change or replaced. RN 3 stated the oxygen tube should have been stored in a plastic bag, not touch the floor. A review of the facility's policy and procedure of oxygen administration indicated the date, time	F 441	The dolls clothes were washed and body disinfected on 11/12/11 In-service was given to nursing staff by DON on 11/14/11. To disinfect doll with use of alcohol wipes hand wipes or Sani-cloths. Individual dolls will be provided to residents as needed to avoid sharing of dolls. All staff will monitor for compliance Overall Compliance will be monitored by QA Committee on a quarterly basis.	11/14/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555690	A. BUILDING _____ B. WING _____	11/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMEDA CARE CENTER	925 W. ALAMEDA AVE BURBANK, CA 91506

(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 441	Continued From page 23 and initial should be noted on oxygen equipment when it was initially used and when changed. When not in use, the oxygen tubing should be stored in a clean bag. b. According to the admission record, Resident 11 was readmitted to the facility on November 27, 2008, with diagnoses that included [redacted], and [redacted]. The Minimum Data Set dated October 31, 2011, indicated the resident was [redacted] for daily decision-making, only needed supervision with mobility and some activities of daily living, and needed extensive assistance with dressing, hygiene, and bathing. The resident had a physician ' s order dated November 1, 2 011 to apply Elimite Cream 5% times one dose from head to toe, in between fingers, to leave for 8-12 hours then shower in the morning and to follow infection precautions for prophylaxis of rashes. The resident had a second physician's order dated November 8, 2011 for a second treatment with Elimite Cream 5% for prophylaxis treatment for rashes. On November 11, 2011 at 10 a.m., the resident was observed in the Large Dining Room seated at a table. The resident was cuddling and kissing a doll. On November 11, 2011 at 12:30 p.m., during a meal observation, the resident was in the Family Dining Room seated at a table with two other female residents one of these female residents was Resident 19. Resident 11 was observed during the lunch meal holding the same doll that she had in her arms earlier in the day.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555690	A. BUILDING _____ B. WING _____	11/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMEDA CARE CENTER	925 W. ALAMEDA AVE BURBANK, CA 91506

(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 441	Continued From page 24 After finishing with her lunch the resident was observed talking to the doll, putting the doll's hands in her mouth and kissing the doll. Resident 19 stated that the doll was hers and that she (Resident 11) had taken the doll but that they take turns sharing it. The plan of care dated November 11, 2011 with a target date of December 1, 2011, for Resident 11, indicated the resident was symptomatic and was on prophylaxis related to possible exposure to scabies. The goal in the care plan stated the resident would have no rash or itching daily for eight weeks. However the interventions in the care plan did not address how the facility would take infection precautions with items that resident's share such as the doll. On November 11, 2011 at 6:10 p.m., Resident 19 was observed going by Nursing Station 1 holding a doll in her arms and stated that she got her doll back. It looked like the same doll that Resident 11 had earlier in the day. At the same time Social Services staff stated that Resident 19 had taken the doll from Resident 11. Registered Nurse 2 (RN 2) who was also at Nursing Station 1 stated that the two residents share the doll but that Resident 19 doesn't kiss the doll she just hold it. During an interview with RN 2 on November 11, 2011 at 6:25 p.m., she stated that sharing a doll between residents does become an infection control issue and added that the doll should be wiped down with a disinfectant wipe. According to the facility's policy reated to Scabies Prevention and Control, non-washable personal clothes and items should be placed in a plastic	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555690	A. BUILDING _____ B. WING _____	11/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMEDA CARE CENTER	925 W. ALAMEDA AVE BURBANK, CA 91506

(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 441	Continued From page 25 bag and keep sealed for seven days. c. On November 11, 2011 at 5 p.m., during an interview, the Housekeeping Supervisor (HKS) stated that his staff uses gowns, gloves and masks to clean "isolation rooms". He also stated the Director of Nursing (DON) informs him during the daily stand-up meetings when to use bleach to clean "infection rooms". When asked about cleaning a room that had been in contact isolation precautions for Clostridium difficile, he stated he doesn't know when to use bleach because he is not familiar with the different types of infections. He only knows that bleach is to be used with "scabies infection." When asked how he used the bleach he stated he uses eight ounces of bleach to a gallon of water (eight ounces equals one cup and there are 16 cups in a gallon, therefore eight ounces of bleach in a gallon of water would be a 1:16 ratio). The HKS demonstrated how he mixes the bleach and water solution by filling an eight ounce measuring cup with bleach and measure the water in a one gallon container and once mixed he fills a sprayer bottle with the solution. He stated he saves any solution that is left over to use the following days. On November 11, 2011 at 5:20 p.m., during an interview with Housekeeping Staff 1 she indicated that to clean a room in contact isolation she uses gloves only and a disinfectant called 3m U-1 Plus. To mop the floors she uses either 3m U-1 Plus or Citrus Solvent, and states they are both the same. She demonstrated with a measuring cup how she mixes half-a-cup of 3M U-1 Plus or Citrus Solvent and two gallons of water in the mop bucket to mop the floors. She also stated that she uses the same process to do routine	F 441	All Housekeeping/ Laundry employees have been in-serviced with demonstration provided on 11/12/11 by senior manager on accurate mixing and solution for room cleaning. In-service for isolation room and regular room cleaning has been provided on 12/1/11. Cleaning procedures will be monitored and demos provided on a routine basis by senior manager Overall Compliance will be monitored by QA Committee on a quarterly basis.	12/1/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555690	A. BUILDING _____ B. WING _____	11/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMEDA CARE CENTER	925 W. ALAMEDA AVE BURBANK, CA 91506

(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 441	Continued From page 26 cleaning of a room and a room in contact isolation. According to a U-1 Plus Efficacy Data sheet provided by the Housekeeping Supervisor C. difficile is not included in the list of organisms it is effective against. According to a Housekeeping In-Service on Chemicals: Use and Dilution U-1 is a germicide it is to be diluted with two ounces to one gallon of water and if used properly, it will ensure all surfaces are cleaned and disinfected, and Citrus Solvent is a heavy duty cleaner and degreaser, it does not indicate if it is to be used straight from the container or if it is to be diluted. According to Transmittal 55 dated December 2, 2009, sent by The Center for Medicaid and Medicare Services (CMS), C. difficile can survive in the environment (on floors, bed rails or around toilet seats) in its spore form for up to six months. Rigorously cleaning the environment removes C. difficile spores, and can help prevent transmission of the organism. Once mixed, the solution is effective for 24 hours. According to the Housekeeping policy on procedures for deep cleaning C. difficile infected rooms a bleach sanitizing solution of 1:10 bleach water ration in a spray bottle is to be used and a yellow apron, face mask and gloves are to be worn.	F 441		
F 465	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional,	F 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555690	A. BUILDING _____ B. WING _____	11/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMEDA CARE CENTER	925 W. ALAMEDA AVE BURBANK, CA 91506

(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 465	Continued From page 27 sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to provide a sanitary environment for residents and staff. Findings: On November 11, 2011 at 3:15 p.m., during a general observation tour of the facility in the presence of the Maintenance Supervisor and Housekeeping Supervisor the following was observed: On Station 1 1. Clean linen closet across from Room 4 had dirt and debris accumulated in the corners of the floor. 2. In the Male Shower the door had water damage on the side towards the inside; the paint was chipped off in an area covering approximately 3 feet by 3 feet. 3. Outside the door of Room 18 the wallpaper was missing in an area approximately 3 feet by 10 feet. 4. In the Emergency Food storage room there was an accumulation of build-up dirt on the floor around the entry way. 5. Room 15 the screen to the sliding glass door was off its track.	F 465	F 465 SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRONMENT Linen closet was cleaned and debris removed from corner on12/1/11 Door of shower room was sanded down and repaired and painted 12/1/11 Wallpaper was replaced outside room 18 11/11/11 Dirt and debris cleaned around entry way in emergency food storage 12/1/11 Screen door was put back on track on room 15. 11/11/11	12/1/11 12/1/11 11/11/11 12/1/11 11/11/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555690	A. BUILDING _____ B. WING _____	11/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMEDA CARE CENTER	926 W. ALAMEDA AVE BURBANK, CA 91506

(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 465	Continued From page 28 On Station 2 1. Room 24 the screen to the sliding glass door was off its track. 2. The Storage Room next to room 24 had the door threshold with the paint peeling off and had dirt stains; the door had water damage on the side towards the inside, paint chipped off and bare wood visible. 3. Clean linen closet across from the employee lounge had accumulated dirt and debris and the shelves had old stains with build-up dirt. 4. The Female Shower emitted a severely strong feces-type malodor, although, the only item in the shower room was a shower chair. The Maintenance Supervisor stated that it might be the shower floor that had the malodor. 5. The wall paper was peeling off the wall by the time clock in an area approximately 2 feet by 2 feet. 6. In the Housekeeping Storage Room by the Laundry Room there was a spray bottle labeled 3M Quart Disinfectant, however, the Housekeeping Supervisor identified the contents of this bottle to be 3M u-1 Plus disinfectant. In Laundry Room 1. The washing machines had build-up detergent stains and accumulated detergent scum around the area where the detergent and washing solutions pour into the machine. 2. There was accumulated lint and dust behind	F 465	Screen door was put back on track in room 24. 11/11/11 Storage room door was repaired and painted 12/1/11 Linen closet was cleaned of stains and debris and painted on 12/1/11 The shower room was cleaned immediately and housekeeping will continue to clean and monitor. 11/11/11 The wallpaper was glued on near time clock. 11/14/11 Housekeeping Supervisor was in-serviced to insure all chemical spray bottles have corresponding chemicals to labels on 11/12/11. Washing machines were cleaned and scrubbed on 12/1/11 Lint and dirt was cleaned behind the washing machines on 12/1/11 Housekeeping Supervisor, Maintenance Supervisor and Department heads will monitor for compliance on daily rounds. Overall Compliance will be monitored by QA Committee on a quarterly basis.	11/11/11 12/1/11 12/1/11 11/11/11 11/14/11 11/12/11 12/1/11 12/1/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555690	A. BUILDING _____ B. WING _____	11/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMEDA CARE CENTER	925 W. ALAMEDA AVE BURBANK, CA 91506

(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 465	Continued From page 29 the washing machines.	F 465		