accepted 4/27/2012

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FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555340	A. BUILDING _____ B. WING _____	03/29/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARINA CARE CENTER	5240 SEPULVEDA BLVD CULVER CITY, CA 90230

(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] Total Population: 76 Sample Size: 16 Randomly Selected: 2	F 000	This plan of correction constitutes the written credible allegation for Marina Care Center.	
F 248 SS=D	Highest scope and severity: E 483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the 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's nursing staff failed to provide activities according to the assessed resident's interests and needs to enhance the physical, mental and psychosocial well-being for one of 16 sampled residents (5). Resident 5, who was on contact isolation, was observed in her room either lying in bed or sitting in a wheelchair alone. According to the facility's assessment, the resident enjoys reading and reads the newspaper	F 248	Resident 5's responsible party established newspaper subscription services to be delivered on a daily basis. Activity staff will continue to assess each resident for their individual needs and interests and make every effort to ensure that those needs are met. In addition, Activities staff will document all efforts in the resident's medical record.	3/30/12

BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 4/26/12

y deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ier safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days lowing 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 ogram participation.

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F 248	Continued From page 1 however, this was not provided. This deficient practice had the potential to cause further isolation and decreased self-esteem for Resident 5. Findings: On March 22, 2012 at 9:46 a.m., during the initial tour, Physical Therapist (PT) Aide 1 stated Resident 5 was on contact isolation. Resident 5 was observed sitting in a wheelchair roaming around the room. When interviewed on March 23, 2012 at 10:50 a.m., Resident 5 stated she likes to read the newspaper every day. Resident 5 stated she had asked the staff to provide her with a newspaper and no one had provided her with one. A review of the clinical record disclosed Resident 5 was admitted to the facility February 23, 2012, with diagnoses that included urinary tract infection and Clostridium difficile (bacteria and toxins that causes inflammation of the colon and intestines). The Activity Assessment record, dated March 6, 2012, indicated the resident enjoys reading and reads the newspaper. On March 23, 2012 at 2 p.m., an interview was conducted with Activity Director 1 (AD1). She stated she informed Resident 5 that she (resident) would have to pay for a subscription for the newspaper. AD1 stated she receives a newspaper daily for the residents in the activity room for current events and that Resident 5 could have the paper afterwards but the resident have not asked.	F 248	Activity staff will conduct admission assessments and quarterly assessments to ensure that all resident's individual needs and interests are met. The Activity Director will report to the QA committee on a quarterly basis in regard to all resident's individual needs and interests are in fact being met. The committee will provide recommendations for those residents with needs that are unable to be met in an effort to ascertain acceptable alternatives.	

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F 248	Continued From page 2 On March 23, 2012 at 2:30 p.m., during an interview, Resident 5 stated she was not provided with the newspaper.	F 248		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure care plans were developed addressing the care needs for two of 16 sampled residents (Residents 4 and 6). Resident 4 had complaints of abdominal and left foot pain and Resident 6 had a hand mitten on due to pulling on the gastrostomy tube (a tube	F 279	A care plan was completed for Resident 4 to include documentation addressing resident complaints of pain. A care plan was completed for Resident 6 to address the resident pulling of the GTube. The MDS nurse has reviewed all residents care plans to ensure that each care plan is individualized and specific to each resident. The Director of Nurses in serviced all licensed nursing staff regarding the procedure for developing comprehensive care plans.	3/26/12

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F 279	Continued From page 3 surgically inserted directly in the stomach for feeding), however these needs were not care planned. This had the potential to cause discomfort and lack of care to Resident 4 and 6. Findings: a. On March 23, 2012 at 10:04 a.m., during the wound treatment observation, Resident 4 complained of pain in her upper abdomen and left foot. The resident had deep tissue injury to the left foot with gangrene. The resident stated the medication nurse gave her Tylenol about 45 minutes ago, but it did not relieve the pain. A review of the clinical record disclosed Resident 4 was readmitted to the facility on February 24, 2012, with diagnoses that included esophageal reflux (acid reflux or heartburn) and pressure ulcers (areas of damaged skin caused by staying in one position for too long). The Minimum Data Set, a standardized assessment and care screening tool, dated December 25, 2011, indicated the resident's cognition was moderately impaired, decisions were poor and was totally dependent on staff for her care needs. There was a physician order dated February 24, 2012, for Tylenol 325 milligrams, 2 tablets as needed for mild pain. There was another order dated February 24, 2012, for [redacted] milligrams 2 tablets by gastrostomy tube as needed for severe pain. There was no documentation in the Licensed Nurses Progress Notes about the resident's	F 279	The ID Team will review and revise the plan of care for each resident as needed. The ID Team will meet weekly and/or as needed to ensure that all residents have an individualized comprehensive plan of care. The MDS nurse will be responsible for monitoring and ensuring that a care plan is comprehensive and accurate for each resident. Any trends will be reported to the QA committee for evaluation and recommendations will be made as deemed necessary by the committee.	

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F 279	Continued From page 4 complaints of pain and there was no plan of care developed to address the resident's pain. b. On March 26, 2012 at 8:30 a.m., Resident 6 was observed lying in bed with a hand mitten on the left hand. On March 26, 2012 at 11:05 a.m., during the wound treatment observation, Licensed Vocational Nurse 2 (LVN 2) stated the resident would only pull on the gastrostomy tube (GT) when she changed the dressing on the GT site, but the resident did not normally pull on the GT tubing. LVN 2 stated the nurse on the nightshift noticed a small amount of blood on the GT site dressing and notified the physician. The physician assumed the resident was pulling on the GT so he ordered the hand mitten. A review of the clinical record disclosed Resident 6 was readmitted to the facility September 18, 2012, with diagnoses that included diabetes mellitus and renal failure. The Minimum Data Set, dated January 20, 2012, indicated the resident's cognition was severely impaired, decisions were poor and was totally dependent on staff for her care needs. The resident was assessed as having no behavioral problems. A review of the Licensed Nurses Progress Notes, dated from February 1, 2012, to March 25, 2012, revealed there was no documentation of the resident pulling the gastrostomy tube. There was no assessment or plan of care developed to address the pulling of the GT.	F 279		
F 312	483.25(a)(3) ADL CARE PROVIDED FOR	F 312		

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F 312 SS=D	Continued From page 6 DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility's nursing staff failed to provide incontinence care promptly for one resident (6) in a sample of 16. During the medication pass at 8:45 a.m., Resident 6 was observed incontinent of urine and feces. The medication nurse notified the nursing assistant that Resident 6 needed changing at 9:35 a.m., an hour after. The nursing assistant did not change the resident until 10:05 a.m., 30 minutes after. Resident 6 was left lying on her urine and feces for approximately one hour and 15 minutes. This had the potential to cause embarrassment, a foul odor and skin breakdown. Findings: On March 26, 2012 at 8:45 a.m., during the medication pass for Resident 6, the resident was observed lying in bed and was incontinent of urine and feces. Licensed Vocational Nurse 3 (LVN3), the medication nurse, continued to pass medications. At 9:35 a.m., LVN3 informed Certified Nursing Assistant 2 (CNA2) the resident was incontinent and needed changing. There was a light brown color ring on the bottom sheet of the resident's bed. CNA 2 did not go to the room to	F 312	The CNA assigned to Resident 6 provided incontinence care to the resident, this included linen change and mattress disinfectant to remove all traces of odor. The Charge Nurse assessed the resident at bedside to ensure Resident 6's skin integrity. The Staff Developer provided in service training to all CNA's regarding proper and timely incontinence care. The DSD, RN supervisors and charge nurses will monitor proper and timely incontinence care on a daily basis to ensure continued compliance. Patterns of deficient practices will be brought to the safety committee on a monthly basis and reported to the QA committee for further recommendation as needed.	3/29/12

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F 312	Continued From page 6 change the resident until 10:05 a.m., which was approximately 30 minutes after LVN 3 informed her that the resident needed changing. A review of the clinical record disclosed Resident 6 was readmitted to the facility on September 18, 2012, with diagnoses that included diabetes mellitus and renal failure. The Minimum Data Set, a standardized assessment and screening care tool, dated January 20, 2012, indicated the resident's cognition was severely impaired, decisions were poor and was totally dependent on staff for her care needs. The resident was assessed as being incontinent of both bladder and bowel. When interviewed on March 26, 2012 at 11: 30 a.m., CNA 2 stated the night shift staff usually changes the residents at 6 a.m. and that she had not been in the room to check on the resident since the start of shift at 7 a.m.	F 312		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced	F 315	Resident 4's catheter tubing was repositioned to prevent any kinks within the tubing and the catheter was removed from the side rail and lowered to ensure proper bladder drainage.	3/23/12

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F 315	Continued From page 7 by: Based on observation, interview, and record review, the facility's nursing staff failed to ensure two residents (4 and 6) in a sample of 16 received appropriate indwelling catheter care and services by not keeping the indwelling catheter drainage tubing from being kinked and coiled and by not keeping the urinary drainage bag lower than the bladder at all times that could cause back flow of urine into the bladder according to the facility's policy and procedure. These deficient practices place residents at risk for urinary tract infections. Findings: a. On March 22, 2012, at 10:15 a.m., during a general observation, Resident 4 was observed lying in bed with an indwelling catheter that was attached to the side rail of the bed in level with the resident's bladder. The indwelling catheter was on the side of the bed next to the wall and could not be seen. On March 22, 2012, at 12:15 p.m., the resident's indwelling catheter was observed attached to the side rail of the bed. On March 23, 2012 at 8:20 a.m., the resident's indwelling catheter drainage tubing was observed kinked during the morning care. Certified Nursing Assistant 1 (CNA1) did not reposition the tubing after she completed the care. On March 23, 2012 at 10:04 a.m., during the treatment observation, Licensed Vocational Nurse 2 (LVN 2) placed the resident on her right side with the indwelling catheter tubing coiled in bed and did not reposition the tubing. A review of the clinical record disclosed Resident	F 315	Resident 5's catheter tubing was repositioned to prevent pain from the tubing pulling due to the tubing being too tight. All residents with foley catheters and drainage bags have been assessed to ensure that the tubing and the drainage bags are properly positioned to ensure optimal drainage. The Director of Nurses has provided in service training to all licensed staff on the proper care, placement and maintenance of foley catheters.	

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F 315	Continued From page 9 4 was readmitted to the facility on February 24, 2012, with diagnoses that included esophageal reflux and pressure ulcers. The Minimum Data Set, a standardized assessment and screening care tool, dated December 28, 2011, indicated the resident's cognition was moderately impaired, decisions were poor and was totally dependent on staff for her care needs. When interviewed on March 23, 2012 at 11:59 a.m., CNA 3 stated she did not notice the tubing being kinked. b. On March 23, 2012 at 11:30 a.m., Resident 5 was observed sitting in a wheelchair in her room. The indwelling catheter drainage tubing was observed touching the floor. On March 26, 2012 at 11:45 a.m., the resident was observed sitting in a wheelchair in her room and was complaining of pain in the vaginal area. CNA 3 removed the resident's diaper, the catheter was observed anchored to the resident's right thigh, the catheter was tight and was pulling on the resident's meatus (external opening of the urethra [the tube through which urine is excreted from the urinary bladder to outside the body]). A review of the clinical record disclosed Resident 5 was admitted to the facility February 23, 2012, with diagnoses that included urinary tract infection and Clostridium difficile (bacteria and toxins that causes inflammation of the colon and intestines). The Minimum Data Set, dated March 12, 2012, indicated Resident 5 had no cognitive impairments and able to make her needs known.	F 315	The Staff Developer and the RN supervisor will monitor compliance of foley catheters on a monthly basis. Any incidents will be brought to the DON for further individual training. Patterns of deficient practice will be reported to the QA committee on a quarterly basis to ensure effectiveness of corrective action.	

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F 315	Continued From page 9 A review of the facility's Policy /Procedure Urinary Catheter Care revised December 2007 indicated the urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder. The catheter and drainage bag should be free of kinks. The nurses are to ensure the catheter remains secured with a leg strap to reduce friction and movement at insertion site. An interview was conducted with LVN 2 on March 27, 2012 at 2:30 p.m., and she stated the nurses should know how to position the catheter and drainage tubing.	F 315		
F 323 SS=E	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, interview, and record review, the facility's maintenance staff failed to ensure hot water, from the bathroom sinks, was below 120 degrees Fahrenheit (F) according to facility policy and procedure for the three residents living in Room 26, the three residents living in Room 28, the two residents living in Room 30, the three residents living in Room 42,	F 323	Water heaters designated to rooms 26, 28, 30, 42 and 44 were adjusted to their appropriate temperature settings in an effort to prevent any potential accidents related to high water temperature for residents, staff and visitors. Maintenance staff has been in serviced regarding the appropriate temperature settings for water in resident's rooms.	3/30/12

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F 323	Continued From page 10 the three residents living in Room 44, the three residents living in Room 46, and one resident living in Room 48. Failure to maintain safe water temperature level places residents and staff at risk for burns. Findings: On March 22, 2012 at 8:55 a.m., during the facility's room-to-room initial tour, the water temperature from the bathroom sinks in Rooms 26, 28, 30, 42, 44, 46, and 48 felt hotter than normal. On March 22, 20120 at 9:45 a.m., during an observation, the maintenance supervisor measured the water temperature in Rooms 26, 28, 30, and 42 with a thermometer to be 128 degrees F, in Room 44 to be 126 degrees F, in Room 46 to be 122 degrees F, and in Room 48 to be 124 degrees F. On March 22, 2012 at 9:55 a.m., during an interview, the maintenance supervisor stated sink water temperatures ought to be 105-120 degrees F. The undated facility policy and procedure titled, "Water Supply, Plumbing, and Water Heating System" indicated hot water temperatures be maintained at not less than 105 degrees F and not more than 120 degrees F for all hot water used by residents.	F 323	The Maintenance staff will monitor the water temperature settings on a weekly basis. Any reports of temperature fluctuation will be corrected immediately. Patterns of deficient practices will be brought to the safety committee on a monthly basis and reported to the QA committee for further recommendation as needed.	
F 328 SS=E	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following	F 328	Podiatry care has been provided for Resident's 2, 3 and 10.	3/30/12

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F 328	Continued From page 11 special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility's nursing staff failed to provide podiatry care for three of 16 sampled residents (2, 3, and 10), which had the potential to result in an infection of the toe nails. Findings: a. During an observation on March 23, 2012 at 9:45 a.m., of Resident 3's shower, the resident was noted with long discolored curled toe nails on her feet. During an interview with Certified Nursing Assistant 4 (CNA 4) on March 23, 2012 at 9:45 a.m., she said she reported the long toe nails to the charge nurse. During an interview and record review with social service designee (SSD) on March 26, 2012 at 8 a.m., she was not able to provide documented evidence of podiatry care. The clinical record for Resident 3 was reviewed on March 23, 2012 at 10 a.m. The resident was	F 328	All in house resident charts have been reviewed to ensure that podiatry care is being provided as per physician's orders. Those residents found to be without orders for podiatry care have had their orders updated and clarified to include podiatry care as needed per physician's orders. When a physician's order for podiatry care is received by nursing on behalf of a resident, social services will be notified to schedule the podiatrist visit for the resident. The Social Services Director will maintain a log to track resident's podiatry visits to ensure that podiatry care is provided as ordered. Social Services will report any deficient practices such as delinquent podiatrist visits to the QA committee on a quarterly basis for recommendations as deemed necessary by the committee.	

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F 328	Continued From page 12 admitted to the facility on October 28, 2009, with diagnoses that included dementia (a loss of brain function) and diabetes mellitus (high blood sugar). The Minimum Data Set (MDS), an assessment and care screening tool, dated February 6, 2012, identified the resident as being severely impaired in cognitive skills, requiring total assistance with activities of daily living, and personal hygiene. b. On March 26, 2012 at 12:10 p.m., during Resident 2's range of motion (ROM) exercises to all extremities by the restorative nurse aide (RNA), the resident's feet was observed with long discolored toe nails. During an interview with Resident 2 on March 26, 2012 at 12:10 p.m., she stated she did not remember when her toe nails were last trimmed. During an interview and record review with social service designee on March 26, 2012 at 9:30 a.m., she was not able to provide documented evidence of a podiatrist consultation. The clinical record for Resident 2 was reviewed on March 22, 2012 at 2:45 p.m. The resident was admitted to the facility on November 3, 2008, with diagnoses that included congestive heart failure (the inability of the heart to supply sufficient blood flow to meet the body needs), peripheral neuropathy (a result of nerve damage, often causes numbness and pain in hands and feet), and chronic leg edema (excess fluid trapped in body's tissues). The MDS assessment, dated February 8, 2012,	F 328		

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F 328	Continued From page 13 identified the resident as being alert with a cognitive score of 15 (cognitively intact), requiring extensive assistance with activities of daily living, and personal hygiene. The facility policy and procedure titled, "Podiatry Care" dated 1997 indicated in the event a resident needs podiatry care, social services will notify the podiatrist and family/responsible party. c. During an observation on March 27, 2012 at 10:45 a.m., Resident 10's toe nails were long and unkempt. A review of the resident's Admission Face Sheet indicated the resident was admitted to the facility on October 18, 2012 with a diagnosis of psychosis (loss of contact with reality). According to the MDS assessment, dated January 3, 2012, indicated the resident's cognitive status was severely impaired, and for activities of daily living, the resident was totally dependent on staff to do personal hygiene. On March 29, 2012 at 9:35 a.m., during an interview, the SSD was asked to provide documentation of podiatry visits for the resident. The SSD provided only the initial podiatry note, dated October 22, 2007. A review of the physician's order, dated June 4, 2009, indicated the resident to have podiatry care for hypertrophic mycotic toenails and keratotic lesions every two months.	F 328		
F 367 SS=D	483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN	F 367		

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F 367	Continued From page 14 Therapeutic diets must be prescribed by the attending physician. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility's dietary staff failed to provide fortified diet according to physician's orders for one of 16 sampled residents (2), which placed the resident at risk for nutritional deficiencies. Findings: The clinical record for Resident 2 was reviewed on March 22, 2012 at 2:45 p.m. The resident was admitted to the facility on November 3, 2008, with diagnoses that included decubitus ulcer (bed sore), peripheral neuropathy (a result of nerve damage, often causes numbness and pain in hands and feet), and chronic leg edema (excess fluid trapped in body's tissues). The Minimum Data Set, an assessment and care screening tool, dated February 8, 2012, identified the resident as being alert with a cognitive score of 15 (cognitively intact), requiring extensive assistance with activities of daily living. The physician's order, dated July 13, 2011, indicated to provide fortified regular no added salt (NAS) diet. During observation of the breakfast meal on March 26, 2012 at 7:45 a.m., Resident 2's tray had one stick of butter for the hot cakes. The diet card indicated regular NAS diet.	F 367	Resident 2's medical records were updated to include a fortified diet. The Registered Dietitian conducted a review of all in house resident's diets to ensure that the appropriate diets were ordered and communicated to the Dietary Supervisor to ensure that the diets were correctly transcribed onto the individual resident's diet cards. Any and all diet changes and or updates will be communicated between nursing and dietary by means of a diet requisition slip. All diet requisition slips will be reviewed by the Registered Dietitian on a weekly basis to ensure appropriateness and complete transcription to resident's diet card.	3/29/12

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F 367	Continued From page 16 During an interview with Resident 2 on March 26, 2012 at 7:45 a.m., she said she had spoken with the dietary staff regarding her diet but was not sure if they understood her. During another observation of the breakfast meal on March 28, 2012 at 7:30 a.m., Resident 2's tray had one stick of butter with two wafers. During an interview, review of the resident's diet order, and the diet card with the dietary supervisor on March 28, 2012 at 8:45 a.m., she was not able to explain why the diet card did not reflect the diet list which indicated fortified. She stated to fortify the diet, they provide two sticks of extra butter.	F 367	Any trends of deficient practice will be reported to the QA Committee on a monthly basis for recommendations as needed.	
F 387 SS=E	483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure physician visits were conducted every 60 days for one of 16 sampled residents (Resident 10) and 2 randomly selected residents (RS 1 and 2). All three residents were not seen by the primary physician for a period of eight months. This deficient practice had the potential	F 387	Residents 1, 2 and 10 have been visited by the Medical Director. Physician's orders and progress notes have been updated to reflect any changes resulting from the physician visits with any new orders carried out as noted in the physician's orders.	3/27/12

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F 387	Continued From page 16 for lack of follow up and proper care of the residents' needs and to not update other caregivers on the treatment plan. Findings: a. The clinical record for Resident 10 was reviewed on March 23, 2012. The Physician's Progress Record indicated the primary physician's latest entry was written on July 31, 2011 (eight months ago). A review of the resident's Admission Face Sheet indicated the resident was admitted to the facility on October 18, 2010, with diagnoses including hypertension (high blood pressure), cardiac dysrhythmias (abnormal heart rhythm or beats) and pacemaker (a small device to help control abnormal heart rhythms) insertion. On March 27, 2012 at 11 a.m., during an interview, the director of nursing (DON) reviewed the physician's progress record and was unable to find a progress notes written by the primary physician after July 31, 2011. There was no documented evidence of a physician's visit for duration of eight months. On March 27, 2012 at 11:06 a.m., during a telephone interview, the primary physician assigned to Resident 10's care stated whichever date is written in the progress record ought to be considered the last note written by him. On March 27, 2012 at 11:30 a.m., in a subsequent interview, the DON stated plans are being made to have the medical director come to the facility to visit the residents assigned to the	F 387	Medical Records has conducted a review of all in house resident's medical records to ensure timely physician visits. Any residents with delinquent physician visits were visited by the Medical Director and new orders carried out as noted. The Director of Nurses has in serviced the Medical Records staff and the Licensed Nursing staff in regard to the importance of timely physician's visits and the protocol in place for reporting delinquent physicians. Medical Records staff will conduct monthly medical record chart audits to ensure timely physician's visit. All delinquent physicians will be reported to the DON and brought to the QA Committee for intervention and/or recommendations.	

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F 387	Continued From page 17 primary physician. b. The clinical record for RS 1 was reviewed on March 28, 2012. The Physician's Progress Record indicated the primary physician's latest entry was written on July 31, 2011 (eight months ago). There was an entry written by the medical director on March 27, 2012, eight months after. A review of RS 1's Admission Face Sheet indicated the resident was admitted to the facility on April 20, 2011 with a diagnosis of diabetes mellitus (insulin producing cells are destroyed which leads to increase blood and urine glucose or sugar). c. The clinical record for RS 2 was reviewed on March 28, 2012. The Physician's Progress Record indicated the primary physician's latest entry was written on July 31, 2011 (eight months ago). There was an entry written by the medical director on March 27, 2012, eight months after. A review of RS 2's Admission Face Sheet indicated the resident was admitted to the facility on November 14, 2005, with diagnoses including hypertension, arthritis, and edema (tissue swelling due to fluid accumulation in the tissues) of lower extremities. The facility policy and procedure titled, "Physician Visits" dated February 28, 2012, indicated the schedule of visits may not exceed every sixty days.	F 387		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an	F 441		

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F 441	Continued From page 18 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. (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:	F 441	Resident 5's room was disinfected with the appropriate bleach solution containing a dilution of 1:10 (one part bleach to 10 parts water). All resident rooms under contact isolation for Clostridium difficile (C-diff) were disinfected with the appropriate bleach solution containing a dilution of 1:10 (one part bleach to 10 parts water). Housekeeping staff have been in serviced by the Staff Developer in regard to the infection control policy for disinfecting resident rooms under contact isolation for C-diff.	3/29/12

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F 441	Continued From page 19 Based on observation, interview, and record review, the facility's housekeeping staff failed to ensure they followed infection control policies and procedures (P&P) for one of 16 sampled residents (5), who was on isolation for Clostridium difficile (C-diff) (bacteria that causes diarrhea and more serious intestinal conditions). The housekeeping staff was observed cleaning the resident's room with a disinfectant solution that did not contain bleach. However, the facility's P&P indicated to use bleach solution with a dilution of 1:10 (one part bleach to 10 parts water). Failure to follow infection control P&P places residents at risk for contracting hospital acquired infections. Findings: On March 22, 23, 26, 27 and 28, 2012, at various times throughout the survey, Housekeeper 1was observed cleaning Resident 5's room, an isolation room for C-diff, without using bleach. A review of the clinical record disclosed Resident 5 was admitted to the facility February 23, 2012, with diagnoses that included urinary tract infection and Clostridium difficile. The Minimum Data Set, a standardized assessment and screening care tool, dated March 12, 2012, indicated Resident 5 had no cognitive impairments and was able to make her needs known. An interview was conducted with Housekeeper 1 on March 28, 2012 at 11 a.m. Housekeeper 1 stated she used the facility's disinfectant solution that did not contain bleach.	F 441	The Maintenance supervisor will make daily rounds in an effort to monitor the housekeeping staff's adherence to the infection control policy for C-diff which includes the bleach solution containing 1:10 (one part bleach to 10 parts water). Any deficient practices will be corrected immediately with additional in service training provided to staff as needed. Any trends of non-compliance will be reported to the Infection Control nurse and brought to the QA committee on a quarterly basis for recommendations as deemed necessary by the committee.	

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F 441	Continued From page 20 The facility's policy and procedure titled, "Infection Control - Clostridium Difficile" (no date) indicated the disinfectant recommended for cleaning the environment of this resident is a bleach solution with a dilution of 1:10. During an interview with Housekeeping Supervisor 1 on March 28, 2012 at 2:50 p.m., he stated there should be bleach in the solution.	F 441		
F 507 SS=D	483.75(l)(2)(iv) LAB REPORTS IN RECORD - LAB NAME/ADDRESS The facility must file in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to obtain and have available in the clinical record laboratory results of blood tests (BMP/Basal Metabolic Panel) and (CBC/Complete Blood Count) as ordered by the physician for one of 16 sampled residents (Resident 5), which had the potential to cause complications if blood levels were too high or too low. Findings: On March 23, 2012 at 9:50 a.m., during a clinical record review for Resident 5, it was revealed there was a physician's order, dated February 29, 2012, for the resident to have blood tests done (BMP and CBC). Further review revealed there	F 507	Lab work was performed as ordered by the physician for Resident 5 and results reported to the physician and documented in the medical chart. A complete audit of all laboratory tests for all in house residents has been conducted to ensure the completion of all lab tests as ordered by the physician.	3/28/12

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F 607	Continued From page 21 was no documentation that the blood tests had been done and there were no laboratory results in the clinical record. A review of the clinical record disclosed Resident 5 was admitted to the facility on February 23, 2012, with diagnoses that included urinary tract infection and Clostridium difficile (bacteria that causes diarrhea and more serious intestinal conditions). The Minimum Data Set, a standardized assessment and screening care tool, dated March 12, 2012, indicated Resident 5 had no cognitive impairments and was able to make her needs known. When interviewed on March 27, 2012 at 2:55 p.m., Registered Nurse (RN) 2 stated he did not know why or if the laboratory work had been done.	F 607	The 7-3 shift RN supervisor will complete a daily audit review of lab orders to ensure that lab work has been completed. Any outstanding lab work will be completed as soon as identified and will be reported to the DON. In addition, the Medical Records staff, during routine chart audits will monitor for completion of lab work and report missed and/or incomplete lab work to the DON for necessary corrective action. The laboratory consultant will complete a monthly audit of all lab work for comparison to facility audit to ensure that the facility is meeting professional standards of quality. All licensed staff will be in serviced by the DON on appropriate implementation and follow through of physician orders including completion of lab requisitions.	
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.			

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F 514	Continued From page 22 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility's nursing staff failed to ensure three of 16 sampled residents (2, 6, and 15) records were complete. Resident 2's physician's order did not contain dosage for beneprotein, a high protein supplement. Resident 6, who was on hospice (care services that focuses on improving quality of life at end of life), had hospice forms that were blank, there was no calendar for hospice visits, and no documented visits by the physician, chaplain, or social services. Resident 15's hospice care plans and physician's orders were not signed and the physician's order for limited fluids was not carried over to the present order sheet. These deficient practices had the potential to result in an incorrect dosage of high protein supplement, lack of coordination of care and consultation for spiritual and social needs, and a possible fluid overload. Findings: a. During the medication observation on March 26, 2012 at 8:30 a.m., Licensed Vocational Nurse (LVN) 1 administered one scoop of beneprotein to Resident 2. During an interview and record review with LVN 1 on March 26, 2012 at 8:45 a.m., he said the usual dose of beneprotein is one scoop, however he was not able to explain why there was no dosage		The RN supervisor will be responsible for monitoring the laboratory audits and for communicating with the lab on a daily and ongoing basis. Trends will be identified and reported to the QA Committee monthly. The committee will monitor the effectiveness of the audit system. This will continue for 3 months and re-evaluated at the end of the 3 month timeframe.	

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(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 514	Continued From page 23 Indicated on the physician's order. The clinical record for Resident 2 was reviewed on March 22, 2012 at 2:45 p.m. The resident was admitted to the facility on November 3, 2008, with diagnoses that included congestive heart failure (the inability of the heart to supply sufficient blood flow to meet the body needs), peripheral neuropathy (a result of nerve damage, often causes numbness and pain in hands and feet), and chronic leg edema (excess fluid trapped in body's tissues). A review of the physician's orders revealed an order dated October 31, 2011, for beneprotein in eight ounces of juice for B (breakfast), L (lunch), and D (dinner). There was no dosage indicated. A review of the consultant pharmacist's Medication Regimen Review for November and December 2011, January and February 2012, failed to identify any irregularity on Resident 2's medication regimen or make recommendations. b. During an interview and record review with Registered Nurse (RN) 1, on March 28, 2012 at 2:30 p.m., he was not able to explain why the care plans/ physician's orders were not signed. Further record review revealed on January 30, 2012, the physician ordered to limit the resident's fluid intake to 1500 cubic centimeters daily. This order was not carried over to the current orders and RN 1 did not give an answer to why. The clinical record for Resident 15 was reviewed on March 26, 2012 at 9 a.m. The resident was admitted to the facility on November 11, 2010, with diagnosis of end stage liver disease (an	F 514	Resident 2's physician orders were clarified to include the dosage for beneprotein. Resident 6 was visited by the hospice agency's physician, chaplain and social services staff. The hospice representatives completed all forms and provided a completed calendar specifying hospice staff visits. Resident 15 was visited by the hospice agency's physician. All care plans and physician orders were signed and clarified to include orders for limited fluids.	3/29/12

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555340	A. BUILDING _____ B. WING _____	03/29/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARINA CARE CENTER	6240 SEPULVEDA BLVD CULVER CITY, CA 90230

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F 514	Continued From page 24 irreversible condition of the liver). The resident was recertified for hospice from February 29, 2012 to April 29, 2012. The plan of care and physician's orders were not signed by the physician and the licensed nurse. A review of the Medication Records (MR) for January and February 2012 revealed limited fluids were written and the licensed nurses were documenting the resident's fluid intake each shift. However, the MR for March 2012 failed to indicate limited fluids and there were no documented evidence the licensed nurses were monitoring fluid intake. c. On March 23, 2012 at 10:30 a.m., during a clinical record review, it was revealed Resident 6 was receiving hospice care. The List of Hospice Personnel form was blank and there was no calendar worksheet since March 10 with no year indicated. Resident 6 was placed on hospice care on October 24, 2011. A review of the clinical record disclosed Resident 6 was readmitted to the facility on September 18, 2012, with diagnoses that included diabetes mellitus and renal failure. The Minimum Data Set, a standardized assessment and screening care tool, dated January 20, 2012, indicated the resident's cognition was severely impaired, decisions were poor and was totally dependent on staff for her care needs. The facility's undated policy and procedures titled, "Hospice Admission Procedure" indicated the Admission Process would include but is not	F 514	Medical Records has conducted a review of all in house resident's medical records to ensure timely hospice visits as well as appropriate hospice forms and visitation calendars. Any residents with delinquent hospice visits were visited by the hospice physician and new orders carried out as noted. The Director of Nurses has in serviced the Medical Records staff and the Licensed Nursing staff in regard to the importance of timely hospice visits and the protocol in place for reporting delinquent visits.	

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F 514	Continued From page 26 limited to the disclosure and written information regarding the following information including the organization's mission and scope of care or services provided to the patient directly or through contractual arrangement and the hours that care and services are available and the methods in which the patient can obtain care or services, after hours. On March 28, 2012 at 2 p.m., the director of staff development (DSD) stated the hospice papers should have been completed.	F 514	Medical Records staff will conduct monthly medical record chart audits to ensure timely hospice visits. All delinquent hospice agencies will be reported to the DON and brought to the QA Committee for intervention and/or recommendations and deemed necessary by the committee.	