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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555677	A. BUILDING ______ B. WING ______	R 04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAWTHORNE HEALTHCARE & WELLNESS CENTRE, LP	11630 SOUTH GREVILLEA AVE. HAWTHORNE, CA 90250

RECEIVED
16 MAY [illegible] PM 4:33
[illegible] INSPECTION DIVISION

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{F 000}	INITIAL COMMENTS The following reflects the findings of the Department of Public Health during first revisit survey. Representing the Department of Public Health: Surveyor ID: 36356, RN, HFEN Surveyor ID: 36385, RN, HFEN Surveyor ID: 36331, RN, HFEN Total population: 77 Sample size: 6 Random Selected Resident: 1 Highest Severity and Scope: E	{F 000}	Preparation and/or execution of this Plan of Correction does not constitute admission by the Provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because it's required by the provision of Health and Safety Code Section 1280 and 42 C.F.R. 483. Please accept this POC as our credible allegation of compliance.	
{F 371} SS=E	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 that staff members practiced sanitary conditions when distributing ice cubes from the ice chest. The improper handling of ice cubes placed 77 residents at risk for the spread and growth of	{F 371}	I. Corrective Action/s: 1. The surveyor at the time of inspection did not share the information on the CNA involved. However, the Director of Staff Development at the time it was reported by the surveyor immediately discarded all the ice from the ice cooler and the ice cooler was cleaned. Fresh ice was provided. Nursing staff was given an in service on 4/28/2016 in regards to ice machine and ice storage chest with emphasis on not handling ice directly by hand.	5/13/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] IDN — DON
TITLE
(X6) DATE: 5/13/16

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	555877	A. BUILDING _____ B. WING _____	R 04/28/2016

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HAWTHORNE HEALTHCARE & WELLNESS CENTRE, LP	11630 SOUTH GREVILLEA AVE. HAWTHORNE, CA 90250

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{F 371}	Continued From page 1 bacteria. Findings: On April 27, 2016 at 1:30 p.m., certified nurse assistant (CNA 1) was observed removing ice cubes from the ice chest and placing them into two residents' water pitchers. CNA 1 was observed using her bare hands and not using the ice cube scooper. The CNA's fingernails were polished and designed with two to three crystal studs on each fingernail. During an interview on April 27, 2016 at 3:20 p.m., CNA 1 stated that her nails were not artificial and she had them done the previous day. During an interview on April 28, 2016 at 12:00 p.m., the director of staff development (DSD) stated that the CNAs would wash their hands and use the ice scooper when refilling the residents' water pitchers with ice cubes. The DSD stated that if the ice scooper touches the resident's water pitcher, the ice scooper should be replaced with a clean one. The DSD also stated that the practice was unacceptable for CNAs to use their bare hands as this would cause contamination of the ice cubes and ice chest. According to October 1, 2014 facility's policy and procedures titled ice machines and ice storage sheets indicated to help prevent contamination of ice machines, ice storage/containers or ice, that the facility staff will take the following precautions: Do not handle ice directly by hand and use a smooth-surface ice scoop to obtain and dispense ice.	{F 371}	II. How to Identify Other Residents: An in-service was conducted on 4/28/2016 by the Director of Staff Development with the nursing staff on the facility policy on Ice Machines and Ice Storage. III. Systemic Changes: The Director of Staff Development will include discussion of policy on Ice Machines and Ice Storage with newly hired employees. IV. Monitoring: This process will be monitored by the Administrator and or designee by completing the following: 1. Review orientation checklist that would include the discussion of policy on Ice Machines and Ice Storage. 2. Will randomly observe staff during her routine rounds of proper handling of ice machine and ice storage. 3. Pattern or concerns observed will be shared with the QAA Committee for further suggestions and resolution.	
{F 466}	483.70(h)	{F 466}		

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{F 465} SS=D	Continued From page 2 SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain a clean and safe environment for one of six sampled residents (Resident 21). This deficient practice placed the residents at risk for injury such as skin tear. Findings: On April 27, 2016 at 8:00 a.m., during room observation, Resident 21's overbed table had edges with exposed porous wood, cracked with sharp edges. During an interview on April 27, 2016 at 10:30 a.m. with licensed vocational nurse (LVN 1), LVN 1 stated the exposed sharp edges could hurt the resident. During an interview on April 27, 2016 at 10:32 a.m., with the maintenance supervisor, he stated that he does rounds every morning to check on broken equipment. He stated that he was not aware the table was cracked and needed to be replaced. Review of Maintenance Service policy and procedures dated January 1, 2012 indicated that the function of the maintenance department	{F 466}	I. Corrective Action/s: The overbed table for Resident 21 has been replaced immediately by the maintenance supervisor on 4/28/2016. 1:1 in service with maintenance supervisor by the Assistant Administrator was done on 4/28/2016 in regards to providing and maintaining a safe, functional and comfortable environment for residents. II. How to Identify Other Residents: Overbed table in other resident rooms were inspected by the maintenance department and found no other overbed table with the same or similar concern was found. III. Systemic Changes: A monthly inspection of the overbed tables will be completed by the maintenance director and or designee. Replacement and or repair will be completed as deemed necessary.	5/13/16

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{F 465}	Continued From page 3 Includes maintaining the building in good repair and free from hazards.	{F 465}	IV. Monitoring: This process will be monitored by the Administrator by obtaining a copy of the monthly inspection of overbed table report from the maintenance supervisor. Any trend and or patterns of concerns identified will be shared with the QA committee for further recommendations.	
{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. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure narcotic control record, and medication administration record had no documentation discrepancy for one of six sampled residents (Resident 4), and the indwelling catheter (A flexible plastic tube (a catheter) inserted into the bladder that remains ("dwells") there to provide continuous urinary drainage) care provided for one of one random selected resident (RSR 22) was documented in the resident's clinical record. These deficient practices created a potential for poor continuity of care, and inaccurate treatment. Findings:	{F 514}	I. Corrective Action/s: Licensed Nurses have been in-serviced by the Director of Nurses on 4/27/16 on the importance of drug transcription and reconciliation. II. How to Identify Other Residents: A facility wide MAR and Narcotic Audit was conducted on 4/27/16 by the Medical Records Director. No other resident is affected by this practice.	5/13/16

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{F 514}	Continued From page 4 a. On April 27, 2016 at 9:15 a.m., RSR 22 was observed in his room getting ready for physical therapy. He stated his current pain was 6/10 (moderate pain), and he took his pain medication earlier that morning. Review of RSR 22's admission record indicated the resident was admitted to the facility on March 17, 2016 with the diagnoses that included polymyalgia rheumatic (an inflammatory disorder that causes muscle pain and stiffness), ulcerative colitis (bowel disease that causes long-lasting inflammation and sores of the large intestine and rectum), muscle weakness and acquired absence of the right knee. A review of physician's orders dated March 17, 2016 indicated Percocet (a drug used to control moderate to severe pain) a combination of oxycodone 10 milligram (mg) and acetaminophen 325 mg one tablet by mouth every six hours as needed (PRN) for moderate pain and two tablets by mouth every six hours as needed (PRN) for severe pain. The Narcotic and Hypnotic (medication to induce sleep) Record from April 23 to April 27, 2016 indicated that Percocet 10-325 mg was signed out (taken from the medication bubble pack) for the following dates and times: 1. April 23, 2016 at 6 a.m. two tablets 2. April 23, 2016 at 12 p.m. one tablet 3. April 23, 2016 at 9 p.m. two tablets 4. April 24, 2016 at 6 a.m. one tablet 5. April 24, 2016 at 2 p.m. one tablet 6. April 24, 2016 at 9 p.m. two tablets 7. April 25, 2016 at 5 a.m. two tablets 8. April 25, 2016 at 12 p.m. one tablet	{F 514}	III. Systemic Changes: Medical Records Director and designee will conduct audit 5x a week during business days of the medication and narcotic transcription. Concerns identified will be shared by the Medical Records Director and or her designee with the Director of Nurses for necessary follow-up, re training and or 1:1 counseling of staff involved. IV. Monitoring: This process will be monitored by completing the following: 1. The administrator will be provided a copy of the Medical Records audit and will validate follow-up made by the Director of Nurses and or designee. 2. Trend and or pattern of concerns identified will be shared with the QA committee for further recommendations.	

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{F 514}	Continued From page 5 9. April 25, 2016 at 8 p.m. one tablet 10. April 26, 2016 at 5 a.m. two tablets 11. April 26, 2016 at 11:30 a.m. one tablet 12. April 26, 2016 at 10 p.m. one tablet A review of the pain/MAR assessment flow sheet for same time period above (April 23 to April 26, 2016) indicated the there was no documentation for the following dates and times: 1. April 23, 2016 2. April 24, 2016 at 6 a.m. and 2 p.m. 2. April 25, 2016 at 12 p.m. 3. April 26, 2016 at 10 p.m. During an interview with the director of nursing (DON) on April 27, 2016 at 10:50 a.m. the DON stated she has been in-servicing the staff regarding the narcotic count sheet not always matching the signature on the MAR. She stated the licensed staffs are supposed to write down the drug administered in the MAR. Review of controlled medications policy and procedures dated February 23, 2015 indicated when a controlled medication is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record and the medication administration record (MAR). 1. Date and time of administration 2. Amount administered. 3. Signature of the nurse administering the dose, completed after the medication is actually administered. b. According to admission record indicated that	{F 514}	I. Corrective Action/s: Licensed Nurses have been in-serviced by the Director of Nurses on 4/27/16 on the importance of documenting timely and accurately on the Medication and Treatment Administration Record. II. How to Identify Other Residents: A facility wide TAR Audit was Conducted on 4/28/16 by the Medical Records Director. No other resident is affected by this practice. III. Systemic Changes: Medical Records Director and designee will conduct weekly audit of the Medication and Treatment Administration Records.	5/13/16

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(F 514)	Continued From page 6 Resident 4 was initially admitted on June 24, 2013 and readmitted on March 14, 2016 with diagnoses that included heart failure, anemia (low blood count), and diabetes mellitus (high blood sugar). The Minimum Data Set (MDS, a standardized assessment and care screening tool), dated January 28, 2016, indicated that Resident 4's cognitively skills for daily decision- making were moderately impaired. A record review of Treatment Administration Record (TAR) for indwelling catheter dated April 1, 4, and 10, 2016 indicated no documentation that the indwelling catheter cares was provided. During an interview on April 27, 2016 at 11:15 a.m., the assistant administrator confirmed that the TAR for indwelling catheter care was not signed indicating that the care was provided. The assistant administrator stated that documentation should be done as soon as task is completed. The facility did not have a policy and procedure on documentation time frame.	(F 514)	Concerns identified will be shared by the Medical Records Director and or her designee with the Director of Nurses for necessary follow-up, re training and or 1:1 counseling of staff involved. IV. Monitoring: This process will be monitored by completing the following: 1. The Administrator will be provided a copy of the Medical Records audit and will validate follow-up made by the Director of Nurses and or designee. 2. Trend and or pattern of concerns identified will be shared with the QA committee for further recommendations.	

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