STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056253	A. BUILDING _____ B. WING _____	12/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKLEY VALLEY CONV HOSPITAL	6600 SEPULVEDA BLVD. VAN NUYS, CA 91411

(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: 103 Sample Size: 21 Highest S/S = F	F 000	This plan of Correction shall constitute our credible allegation of compliance. The facility will be in compliance by 01-30-12. The responses contained herein do not represent an admission of guilt on behalf of the facility.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that the care and services provided to a hospice resident were based on a coordinated plan of care and designated responsibilities that included scheduled visits for the hospice agency and the care to be provided for two out of 21 sample residents (12, 14). Findings:	F 309	F309: The facility shall ensure that the care and services provided to a hospice resident is based on a coordinated plan of care developed between the hospice agency and the nursing home, including the hospice staff schedules visits related with the resident care plan. The licensed nurse will ensure that a residents' under hospice care program shall have an integrated care plan developed including an schedule of hospice visiting personnel and shall monitor the attendance consistency with proper documentation recording.	

BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

[signature] Administrator 01-30-12

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 s 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.

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F 309	Continued From page 1 a. According to the admission record, Resident 14 was admitted to the facility on June 20, 2008, with diagnoses that included history of breast cancer, progressive [redacted], [redacted], congestive heart failure, and pacemaker placement. The Minimum Data Set (MDS) assessment dated October 6, 2011, indicated the resident was moderately impaired with cognitive skills for daily decision making, was totally dependent on staff in activities of daily living except in eating. The resident had a physicians order dated October 16, 2008, for hospice admission. There was a hospice calendar for the month of December 2011 with check marks Monday through Thursday and Registered Nurses (RN) initials twice per week throughout the month of December 2011. There was no explanation for the check marks and the calendar did not include scheduled visit for the chaplain and the medical social worker. The calendar did not indicate when the chaplain or medical social worker would visit, these fields were left blank on the calendar. The hospice staff documentation was incomplete with minimal and repetitive information. On December 16, 2011 at 11:30 a.m. during a record review, the calendar for the month of December 2011, indicated an RN was to visit on December 13, and 15, 2011. However, there was no documentation in the medical record to indicate a hospice staff nurse had visited the resident on these dates.	F 309	(F: 309 coming from previous page) a) Resident 14, hospice calendar for the chaplain and the medical social worker visits schedules were reviewed with the hospice agency and the licensed nurse will monitor the attendance and recording consistency. b) Resident 12 was discharged from hospice program on 12/12/11. The Director of Nurses to give in-service to the licensed nurses in regards "Hospice Care Program ". The Director of Nurses will monitor during routine licensed nurses staff meetings for continuance compliance. The facility will be in compliance by 01-30-12.	1/30/12

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F 309	Continued From page 2 On December 16, 2011 at 11:40 a.m., during an interview, Registered Nurse 2 (RN 2), was unable to provide documented evidence from the medical record to indicate that the licensed nurse had visited the resident on December 13, 15, 2011, although there was an RN initial on the calendar on those dates. RN 2 was also unable to explain the significance of the RN initials on those dates because there were also the same RN initials on the calendar on future dates in December 2011. b. According to the face sheet Resident 12, a 67 year old male, was re-admitted to the facility on November 23, 2011, with diagnoses that included end-stage renal disease. Review of MDS assessment, dated December 6, 2011, indicated the resident is totally dependent on staff for all activities of daily living. Review of physician's order, dated December 7, 2011, indicated the resident was determined to have a terminal diagnosis and was entered in Hospice due to end stage congestive heart failure. The Integrated Plan of Care, dated December 7, 2011, indicated the Hospice provider determined a plan of care for Resident 12. However, review of the last page, failed to indicate the facility representative signature. The care plan, titled Anticipatory Grieving Related to the Diagnosis of End-Stage Terminal Illness of Coronary Artery Disease, Congestive Heart Failure and the resident is under Hospice Care, dated December 7, 2011, failed to record any of the Hospice team had reviewed the facility's care plan.	F 309		

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F 309	Continued From page 3 On December 16, 2011, at approximately 10:35 p.m., in an interview with LVN 2 who was in charge of Resident 12, he said he does not review the Hospice notes and or their care plans. Review of facility's policy titled Core Services, revealed the Hospice will develop the care plan, the facility staff will modify the care plan and they both jointly will hold care conferences and develop integrated plan of care.	F 309		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the licensed nurse failed to ensure that excessive air would not enter the resident's stomach during the procedure of medication pass through a gastrostomy tube (GT) to prevent the potential for complications for one random sample resident (22). Findings: On December 14, 2011 at 10 a.m., during the medication pass observation, Resident 22 was	F 322	F322: The facility shall ensure that air would not enter the resident's stomach fed by a naso-gastric or gastrostomy tube during the procedure of medication pass through the gastrostomy tube to prevent the potential for complications The licensed nurses shall ensure when administering medications through a resident's gastrostomy tube using a syringe, to pinch the feeding tube or close the stop-cock valve (valve for regulating the flow of a fluid) between the medication administrations or water flushes to prevent air from entering the resident's stomach.	

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F 322	Continued From page 4 observed in bed with a GT in place. Licensed Vocational Nurse 4 (LVN 4) was observed administering the morning medications to the resident through a GT using a syringe. LVN 4 did not pinch the feeding tube or close the stop-cock valve (valve for regulating the flow of a fluid) between administration of medications or water flushes to prevent air from entering the resident's stomach. The end of the feeding tube is to be pinched-off when a catheter-tip syringe is used and the plunger of the syringe is removed to administer medications or fluids. Pinching the feeding tube will prevent excess air from entering the stomach and causing distention (The Lippincott Manual of Nursing Practice 5th Edition, Page 450). During an interview with LVN 4 on December 14, 2011 at 10 a.m. he stated he should have pinched the feeding tube when administering medications to prevent excess air from entering the resident's stomach.	F 322	(F: 322 coming from previous page) Resident 22, feeding tube is pinched or water flushed when medication is administered through the gastrostomy tube. The Director of Nurses to in-service the licensed nurses in regards "gastrostomy tube proper medication administration technique". The Director of Nurses will monitor during routine rounds for continuance compliance. The facility will be in compliance by 01-30-12	1/30/12
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	F 323		

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F 323	Continued From page 5 review, the facility failed to monitor a resident assessed at risk for falls for one out of 21 sample residents (6), failed to maintain the resident's environment free of potential hazards by not maintaining water temperature at a safe range of 105 degrees Fahrenheit (F) to 120 degrees F in according to regulations in the residents' hand washing basins, and by not securing a television sets that could cause the potential for accidents in the event of an earthquake. Findings: a. According to the clinical record, Resident 6 was readmitted to the facility on May 17, 2011, with diagnoses that included hypertension, anemia, morbid obesity, [redacted]. A review of the Fall Risk Assessment dated May 17, 2011 indicated the resident had a total score of 6 out of 10, a score of ten indicates the resident is at high risk for falls. This record also indicated the resident's ambulatory status was normal, and did not have a history of falls in the past 3 months. The Minimum Data Set (MDS) assessment dated May 30, 2011, indicated the resident had independent cognitive skills for daily decision-making, required a one-person physical assist for transfers, dressing, ambulating, and toilet use, was occasionally incontinent of bladder, and had a history of falls within the last 2-6 months prior to admission. The plan of care dated May 30, 2011, indicated the resident was at risk for falls manifested by a fall in the 31-180 days and unsteady gait. The	F 323	F323: The facility shall ensure that the resident environment remains as free of accidents hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. The Interdisciplinary Team shall include falls preventive measures when developing a resident care plan with high risk of fall, and document when the resident refused for assistance to discuss care assessment. The maintenance supervisor shall maintain the hot water heater automatic thermostat temperature level to not exceed 120 degrees F water temperature in the hand washing sinks resident rooms. The maintenance staff shall maintain resident's television set properly secure to prevent accidents in a case of an earthquake.	

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F 323	Continued From page 6 goal in the care plan stated the resident would have no incidence of falls or injuries every shift. The approaches in the plan of care included to assess degree of orientation and safety awareness of resident to determine safety needs, assist with transfer/mobility as needed and encourage resident to ask for assistance if resident is able, review medications for side effects that causes falls/dizziness and report to the physician if side effects are noted, physical therapy and occupational therapy will evaluate for safety precautions and training as indicated. The resident had a physician's order June 15, 2011 for Losartan 50 milligrams (mg) to be administered every hour of sleep. Losartan is an antihypertensive medication with a central nervous system side effect of dizziness and syncope [fainting Lippincott's Nursing Drug Guide 2010, Pages. 712, 713] According to the Nurse's Notes on July 11, 2011 at 11:20 a.m., a loud crash sound was heard inside the bathroom and the resident was found in a sitting position on the floor and the resident stated she felt dizzy after toileting and fell on the floor and hit the left side of her head and body on the trash can. According to the same Nurse's Notes the resident sustained an abrasion on the left side of the forehead and left scapular area and a bruise on the left elbow that measured 7.0 centimeters (cm) by 1.5 cm. The resident's physician was notified of the fall and gave the following orders dated July 11, 2011: to do neurological checks (a neurologic examination involving an assessment of the patient's mental status, speech, and physical	F 323	(F: 323 coming from previous page) a) Resident 6, care plan fall assessment will be revise, review and implemented. b) The water temperature at the hand-washing basing in the resident rooms 109, 139, 142 and 141 are below 120 degrees F. c) The television set at room 104-C, 105-A, 107-A and 118-C will be properly secure. The Director of Nurses to in-service the licensed nurses in regards "care plan fall prevention assessment", The Maintenance Director to in-service the maintenance staff in regards "water heater thermostat setting in relation with the water temperature state regulations and proper monitoring" and " television sets placed on a nightstand safety installation". (To continue next page)	

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F 323	Continued From page 7 examination) for 72 hours and to cleanse abrasion on left side of forehead and left scapular area with normal saline and pat dry, apply bacitracin and to leave open to air for three days. According to the Neuro Flow Sheet dated July 11, 2011 at 11:20 a.m. to July 14, 2011 at 11:20 a.m. the resident did not have any neurological deficits On December 16, 2011 at 1:50 p.m. during an interview with the resident in the presence of RN 2, the resident stated she had two falls in the bathroom on July 11, 2011, one in the morning at approximately 7:30 a.m. and another one out door on the side walk by the parking lot of the facility. According to the resident she felt a "blackness come over" and fell forward off her wheelchair and stated she sustained a bruise on her right knee. A light discolored area was observed on the resident's inner part of her right knee approximately five to six inches in length, also verified by RN 2. The resident stated she did report the first fall to Licensed Vocational Nurse 5 (LVN 5) after LVN 5 found her in the bathroom after her fall on July 11, 2011. The resident also reported that she had not been assisted to the bathroom by anyone, even though a Certified Nursing Assistant (resident doesn't remember her name) and LVN 5 were in the room. During an interview with RN 2 on December 16, 2011 at approximately 2:30 p.m., she stated the resident does not call for assistance because she wants to do things on her own. During this interview she indicated there was no documented evidence in the medical record that a care plan had been developed to address the issue of the	F 323	(F: 323 coming from previous page) The Director of Nurses will monitor during routine staff meetings for continuance compliance. The Director of Maintenance will monitor during routine rounds for continuance compliance. The facility shall be in compliance by 01-30-12	1/30/12

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F 323	Continued From page 8 resident not asking for assistance. A review of the Resident Care Conference Review dated May 30, 2011, there is no indication fall prevention issues were discussed; the subsection for Areas Reviewed such as physician's orders, MDS Assessments, and Care Plan were left blank; the Resident Care Conference Review dated August 30, 2011 indicates that nursing will continue to monitor for safety and comfort, however, it does not indicate how and who will be doing the monitoring; the subsection for Areas Reviewed such as physician's orders, MDS Assessments, and Care Plan were left blank. According to the facility's Fall Prevention Policy, with no date, the Interdisciplinary Team will be informed of high risk for falls residents, based on the Fall Risk Assessment and will be discussing appropriate measures to impose the prevention of falls. However, the Fall Risk Assessment did not reflect the information necessary for the IDT team to discuss appropriate measures to prevent falls as indicated in this policy. b. During a general observation of the facility on December 14, 2011, between 1:40 p.m. and 2:15 p.m., the following was observed: The water temperature at the hand-washing basin in the bathrooms measured: 122.3 degrees Fin Room 109, 124.3 degrees F in Room 139, 123 degrees F in Room 142 and 123.9 degrees F in Room 141. After the tour, the maintenance supervisor stated that the water temperatures were out of range	F 323		

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F 323	Continued From page 9 and they would correct the problem immediately. On December 15, 2011, the maintenance supervisor stated that the water temperatures were fixed right away by adjusting the thermostat. According to the Uniform Plumbing Code of California Chapter 6 Section 1011 (e) indicates temperature control valves shall be provided to automatically regulate the temperature of hot water delivered to plumbing fixtures used by patients to a range of 105 degrees F minimum to 120 degrees F maximum. c. On December 12, 2011 between 8:35 a.m. and 10:25 a.m., during the initial tour of the facility television sets were observed unsecured in Rooms:104-C , 105-A, 107-A and 118-C. According to the California Governor's Office of Emergency Services earthquake preparedness should include securing any tabletop objects heavy enough to cause injury if they fall on a person (Memorandum, State of California Governor's Office of Emergency Services). On December 14, 2011 at 1:40 p.m., during an interview and observation tour of the rooms with the Maintenance Supervisor, he stated that the televisions on the nightstands needed to be secured and agreed that this was a potential hazard.	F 323		
F 329 SS=D	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	F 329		

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F 329	Continued From page 10 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 observation, interview and record review, licensed nursing staff failed to ensure that an [redacted] would not be administered without adequate indication for use and in the presence of adverse side effects that included sedation (10), failed to ensure sleeping medications (Ambien) was used for short-term and within the geriatric dose limit and not administered for excessive duration, without adequate monitoring and without attempts for non-pharmacological interventions such as sleep hygiene program with or before the administration of high dose of sleeping medication (11), failed to	F 329	F329: The facility shall 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 records; and residents who use antipsychotic drugs receive gradual dose reduction, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. The licensed nurses shall ensure that an antipsychotic medication would not be administered without adequate indication for use and in the presence of adverse side effects that included sedation, shall ensure sleeping medications are used for short-terms and within the geriatric dose limit and not administered for excessive duration without adequate monitoring and attempts for non-pharmacological interventions, and shall ensure prescribed medications (To continue next page)	

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F 329	Continued From page 11 ensure that a resident (11) was free of duplicate therapy (Ambien 10 mg and Ativan 0.5 mg) for two out of 21 sample residents (10,11). Findings: a. Review of face sheet indicated Resident 10, an 82 year old male was admitted to the facility on July 13, 2005, with diagnoses which included organic brain syndrome, [redacted] and cerebral vascular accident (stroke) with left sided weakness. The Minimum Data Set (MDS) assessment, dated October 26, 2011, indicated the resident has short and long term memory problems and is severely impaired in cognitive daily decision making. The resident had the following physician's orders: 1. [redacted] one milligram (mg), one tablet orally three times a day for agitation manifested by persistent screaming dated April 25, 2011. 2. Monitor side effects of [redacted] for [redacted] status and drooling dated August 29, 2009. The care plan for [redacted] manifested by periods of persistent screaming, dated August 29, 2009, indicated a goal that the resident would not have adverse effects from medication. The approach/plan was to monitor side effects and report to the doctor promptly and to see sticker for adverse reaction of central nervous system, which indicated sedation (reduced excitement) as part of some common side effects.	F 329	(F: 329 coming from previous page) (with same sedative properties) are not administered when side-effects sedative behavior are manifested by the resident unless contra-indicated by the attending psychiatrist. A) Resident 10, attending psychiatrist will be inform about the medication (Haldol) sedative behavior side-effect manifested by the resident to review current prescribed medications and/or dosage. B1) Resident 11, behavior and sleeping patterns will be monitor and documented including the interventions to promote comfort and sleep without drugs. B2) Resident 11, attending psychiatrist will be inform about the medication (Ambien & Altivan) duplicate sedative properties and the non-responsive behavior side-effect manifested by the resident to review current prescribed medications and/or dosage. (To continue next page)	

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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 329	Continued From page 12 On December 14, 2011 at approximately 9:25 a.m., during the medication pass observation, the resident was observed seated in a gerichair with a lap tray and with both eyes closed. Licensed nurse (LVN 1) crushed [redacted] one mg tablet and mixed it with the apple sauce. Then, LVN 1 tried to wake the resident up several times by calling his name. At one point Resident 10 opened his eyes and mouth and LVN 1 administered (placed the crushed medication mixed with apple souse in to the resident's mouth. However, the resident just kept the medications in his mouth. LVN 1 kept calling the residents name telling him to swallow and attempted to assist the resident in swallowing by rubbing his throat. The residents eyes was closed and he was not fully responding. After a approximately ten minute the resident finally swallowed most of his medication. The resident was then observed with his eyes closed and did not respond anymore to LVN 1's commands. While the resident was not responding, and did not exhibit behaviors of agitation manifested by persistent screaming, LVN 1 administered the medication without its indication for use. LVN 1 did not hold the [redacted] and/or notify the physician to obtain instruction. On December 14, 2011 at approximately 2:30 p.m., in an interview with the Director of Nursing (DON), she said LVN 1 should have not administered the [redacted] because the resident was too sleepy. b.1. A review of face sheet indicated Resident 11, an 88 year old female, re-admitted to the facility on March 23, 2009, with diagnoses that included	F 329	(F: 329 coming from previous page) The Director of Nurses and/or pharmacy consultant to give in-service to licensed nurses in regards "drug regimen side-effect and unnecessary drugs administration". The Director of Nurses will monitor during monthly pharmacist consultant audits visits for continuance compliance. The facility will be in compliance by 01-30-12.	1/30/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056253	A. BUILDING _____ B. WING _____	12/16/2011

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F 329	Continued From page 13 history of knee placement and [redacted].	F 329		

According to the MDS assessment, dated April 5, 2011, indicated Resident 11 usually understands and or is understood and has trouble sleeping.

The resident had a physician's order for Ambien 10 mg as needed at night for insomnia (inability to sleep), dated May 30, 2009.

Ambien is a hypnotic/sedative drug for short-term treatment for insomnia and the usual geriatric dose of Ambien is 5 mg and should be limited to a short-term use of 7-10 days. (Geriatric Drug Therapy Handbook, Page 971).

On December 14, 2011 at approximately 7:20 a.m., the resident was observed to be in bed. When the evaluator knocked the resident's door and introduced herself twice, the resident was not responsive and did not open her eyes.

A review of the facility's record titled Use of Psychotropic Drugs as Required by OBRA for Accountability form indicated the initial dose for Ambien dated April 27, 2009, was 5 mg and was increased to 10 mg on May 30, 2009, to be administered as needed every night. However, since the dose was increased to 10 mg approximately thirty-one months ago, there was no documented evidence that indicate the resident was assessed for dose reduction and/or the need for the continued use of the Ambien.

The plan of care for use of hypnotic due to inability to sleep (insomnia) and potential for developing adverse reaction of hypnotic

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	056253	A. BUILDING _____ B. WING _____	12/16/2011

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F 329	Continued From page 14	F 329		

medication, dated April 27, 2009, indicated a goal that the resident would sleep at least 6-8 hours per night and will have no adverse reactions. The interventions were to encourage resident to stay up during the day for sleep at night, monitor causes for insomnia such as, medication, caffeine, over stimulation, [redacted] and or [redacted], discourage naps during the day, offer non-chemical interventions such as reading, watching television, warm milk and relaxation remedies. .

A review of the Nurse's Medication Notes and the Monthly Summary of Effect of Medication for Ambien February 2011, to December 2011, indicated the resident had exhibited insomnia between 19 and 30 occasions and received Ambien 10 mg. However, there was no documented evidence that indicated non-pharmacological interventions were attempted prior to the administration of Ambien 10 mg.

b.2. According to the physician's orders, Resident 11, in addition to Ambien 10 mg ordered to be administered as needed at night for insomnia, dated May 30, 2009, the resident also had a physician's order for Ativan 0.25 mg as needed twice a day dated March 23, 2009. On May 13, 2009, the dosage of the Ativan was increased to 0.5 mg every 6 hours.

Ativan is a drug listed under benzodiazepine (is a psychoactive drug-anxiolytics-sedative /hypnotic) medication classified as a Schedule IV Controlled substance. Ativan has a half-life of 15.9 hours in the elderly and both Ativan and Ambien have sedative properties (Geriatric Drug Therapy

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F 329	Continued From page 15 handbook Pages 539-540). According to State Operations manual (SOM), the concurrent administration of multiple medications of the same pharmacological class/category or any medication therapy that substantially duplicates a particular effect of another medication that the individual is taking is considered duplicate therapy (SOM 2010, Pages 339). A review of the Nurse's Medication Notes and Monthly Summary for Ativan from March 2011, December 2011, indicated the resident had episodes of [redacted] ranging from 12 to 29 occurrences and received Ativan as ordered while the resident also received Ambien 10 mg. On December 14, 2011 at approximately 7:20 a.m., the resident was observed to be in bed. When the evaluator knocked the resident's door and introduced herself twice, the resident was not responsive and did not open her eyes. A review of the facility's record titled Use of Psychotropic Drugs as Required by OBRA for Accountability form indicated Resident 11's Ativan was increased on May 13, 2009 from 0.25 mg as needed twice a day to 0.5 mg as needed every six hours. A plan of care initiated for [redacted] dated March 23, 2009, indicated the resident will have less than (blank) episodes of (blank) per week and will not have any side effects from medication. The approach plan was to assess daily for behaviors manifested and notify doctor if medication can be reduced, monitor behavior and report monthly to	F 329		

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F 329	Continued From page 16 physician to assist to assure lowest possible therapeutic doses given. The [redacted] medication sticker indicated to summarize effectiveness and side effect data monthly for physician per [redacted] policy and the common side effects of the central nervous system were sedation, confusion, [redacted], excitement, restlessness and [redacted]. On December 14, 2011 at approximately 2:15 p.m., in an interview with the DON, she said the facility does not document the less restrictive measures (non-pharmacological interventions) prior to administering as needed [redacted] and or [redacted]. A review of facility's procedures, titled Psychotherapeutic Drug/Chemical Restraint, indicated the licensed nurse's notes require the following: date, time, description of the resident's condition for needing the [redacted] or chemical restraint, a less restrictive measures attempted and the results.	F 329		
F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review of the 9 a.m. medication pass on December 14, 2011, the facility failed to ensure that it was free of a medication error rate of 5 percent or greater, as evidenced by the	F 332		

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F 332	Continued From page 17 identification of 3 medication errors out of 40 opportunities for errors, to yield a facility medication error rate of 7.5 percent. Findings: a. On December 14, 2011, at 8 a.m., and 10 a.m. during a medication pass observation the following medication errors were identified: 1. Licensed Vocational Nurse 1 (LVN 1) was observed to crush Resident 3's four solid medications and placed all the crushed medications in one cup. Then she mixed the crushed medications with water, poured the medications into the barrel of a syringe attached to a gastrostomy tube (GT) and administered the medications to the resident through the GT. The licensed nurse failed to administer each medication separately and flush the GT following the administration of each medication. According to the guidelines for administering medication through an enteral feeding tube (GT), each medication should be crushed separately and administered separately through the appropriate access site. Crushing medications results in improved dissolution when mixing with a solvent such as water and decreases the likelihood of tube obstruction (American Journal of Nursing, October 2009, Vol 109, No 10, pages . 34, 35, 39). On the same day at 8:05 a.m. during an interview with LVN 1, she stated, " I know I should separate them but that's the way I've been doing them here."	F 332	F332: The facility shall ensure that it is free of medication error rates of five percent or greater. The licensed nurses shall crush and administer each medication separately through the appropriate access site when administering medication through and enteral feeding tube (GT), shall shake the bottle prior to pouring liquid vitamin solution before administering and shall flush the gastrostomy tube (GT) with at least 30ml. of water after the last medication was administered through the gastrostomy tube. 1) Resident 3, medications are crushed and administered separate by the licensed nurse through the resident gastrostomy tube. 2) Resident 22, multi-vitamin solution prior to pour is shake by the licensed nurse before is administered to the resident. 3) Resident 9, gastrostomy tube is flushed with at least 30 ml. of water by the licensed nurse after the last medication is administered through the resident gastrostomy tube. (To continue next page)	

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F 332	Continued From page 18 2. Licensed LVN 4 was observed to poured 5 cc of liquid Multi-Delyn (multivitamin) from a 16 ounce container and was about to administered it to Resident 22. The evaluator intervened and asked LVN 4 why she did not shake the bottle prior to pouring the medication. According to the manufacturer's instructions the bottle that contained the vitamin solution should be shacked before pouring. On the same day at 8:50 a.m. during an interview, LVN 4, stated he stated he should have shaked the bottle before pouring the vitamin solution and at this time he re-poured the vitamins. 3. On December 14, 2011, during the 9 a.m. medication pass observation, the following Licensed LVN 2 prepared and administered medications for Resident 9 through a gastrostomy tube (GT). LVN 2 did not flush the GT with at least 30 ml of water after the last medication was administered in order to maintain the patency of the GT.	F 332	(F: 332 coming from previous page) The Director of Nurses and/or the pharmacist consultant to give in-service to the licensed nurses in regards "Free of medication error rates of five percent or greater". The Director of Nurses will monitor during monthly pharmacy consultant meetings for continuance compliance. The facility will be in compliance by 01-30-12	1/30/12
F 367 SS=D	483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN 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 staff failed to carry a physician's order for a puree diet with no added salt for one out of 21 sampled residents (13).	F 367		

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F 367	Continued From page 19 Findings: A review of the face sheet indicated Resident 13, was re-admitted to the facility on November 21, 2011 with diagnoses which included dysphagia. The Minimum Data Set (MDS) assessment dated November 19, 2011 indicated short term memory problem, with some/all natural teeth lost and does not use dentures. The physician's order dated October 24, 2011, indicated the resident had an order for for a puree diet with no added salt. The nutritional status as manifested by therapeutic diet care plan, dated November 6, 2011, indicated the approach/plan was to provide diet or nutritional support as ordered and to explain rationale of diet/nutrition for better compliance. The oral/dental care related to some/all natural teeth lost, dated November 6, 2011, indicated the approach/plan was to provide resident with diet/nutrition as ordered and record intake and to monitor for diet texture tolerance. A review of Dysphagia Evaluation form, dated November 30, 2011, indicated Resident 13 was evaluated by the speech therapist because the resident wanted to upgrade her puree, no added salt diet with thickened liquids to mechanical soft diet. According to the evaluation the resident was given a mechanical soft textured diet (tuna sandwich and chopped vegetables), however, the resident stated several times that she felt like she was 'choking' on the tuna sandwich and that it felt	F 367	F367: The facility shall ensure therapeutic diet prescribed by the attending physician is carried out as indicated. The certified nurse shall inform the licensed nurses when a family member brings food to a resident contradicting the therapeutic diet prescribed by the attending physician. The licensed nurses shall ensure that the issue is care planned and discussed with the resident and family members. Resident 13, care plan was reviewed and the therapeutic diet monitored. Additionally, the resident's family member was explained about the importance of the therapeutic diet ordered by the attending physician and compliance. The staff developer to give in-service to the certified nurses in regards "Therapeutic diet ordered by the attending physician". (To continue next page)	

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	056253	A. BUILDING _____ B. WING _____	12/16/2011

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F 367	Continued From page 20 like it was stuck in her throat. The recommendations from the speech therapist was for the resident to remain on puree diet as is the safest least restrictive texture. On December 12, 2011 at approximately 11:45 a.m., Resident 13 was observed lying in bed, next to her on the bedside table, there was 2 Styrofoam food containers. One contained fries and half eaten hamburger patties and the other contained fries and half eaten cooked chicken breast and thigh. At the same time Resident 13 was asked if the food belonged to her. She said it was hers and she had eaten. On December 12, 2011 at approximately the same time, in an interview with CNA 1 he said the food belongs to the resident and is brought in by her family. On December 12, 2011 at approximately 2:15 p.m., in an interview with the DON, she said the facility was not aware of the food being brought in by the family, the staff should not have been giving the resident a regular textured diet and the facility staff should have care planned this problem.	F 367	(F 367: coming from previous page) The staff developer will monitor during weekly rounds for continuance compliance. The facility will be in compliance by 01-30-12	1/30/12
F 371 SS=F	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	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056253	A. BUILDING _____ B. WING _____	12/16/2011

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F 371	Continued From page 21 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the dietary staff failed to ensure the low temperature dishwasher provided 50 parts per million (ppm) hypochlorite (chlorine) on dish surface in the final rinse. The facility staff also failed to ensure that sweeping and mopping of the kitchen floor did not occur at the same time the food was being dished from the steam table on to the plates. The small can opener blade had brown and black particles, the juice dispenser spout had yellowish/black substance and the ice cream freezer had brown sticky substance on the bottom part of the freezer. Findings: On December 16, 2011 at approximately 11:45 a.m., accompanied by the director of dietary, the following was observed: 1. The dietary staff members were observed serving the food from the steam table on to the plates. At the same time a dietary/dishwasher staff member was observed to be sweeping, then mopping the floor approximately 4 feet away from the steam table. 2. The blade of the small can opener had brown and black particles. According to the director of dietary the can opener needed to be thoroughly cleaned. 3. The juice fountain beverage dispensing wand,	F 371	F371: The facility shall ensure that the low temperature dishwasher provides 50 parts per million (ppm) hypochlorite (chlorine) on dish surface in the final rinse, sweeping and mopping shall not occur at the same time the food is dish from the steam table on to the plates, the can opener blade doesn't have brown and black particles, the juice dispenser spout doesn't have yellowish/black substance and the ice cream freezer doesn't have brown sticky substance on the bottom part of the freezer. The dietary supervisor shall monitor the low temperature dishwasher sanitize level provides 50 parts per million (ppm) hypochlorite (chlorine) on the dish surface in the final rinse, shall ensure that sweeping and mopping shall not occur when the food is dish from the steam table on to the plates, replace the can opener blade as need and shall ensure the juice dispenser spout and bottom part of the freezer is clean. (To continue next page)	

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F 371	Continued From page 22 which was equipped with a rubber spout, had yellowish/black substance inside of the spout. The director of dietary said in order to clean the dispenser and spout, the rubber spout should have been taken apart from the spout which then can be soaked in hot water for better cleaning. 4. According to the director of dietary, the facility uses a low temperature dishwasher. The dietary/dishwasher staff member proceeded to check the chemical sanitizer in the final rinse by sticking a precision chloride test strip on the small can opener. However, the precision chloride test strip did not change colors to indicate hypochlorite was in the final rinse. The director of dietary then ran the machine one more time by placing a cup in the dishwasher. She then proceeded to stick the precision chloride test strip in the cup, the test strip again did not change color. On the third attempt, the test strip was still colorless, indicating there was no hypochlorite in the final rinse. On the same day at approximately 12:09 p.m., the director of dietary called the Maintenance Director in order to diagnose the problem. He said he is not responsible for the dishwasher. The facility then notified the maintenance company that services the dishwasher. On the same day at approximately 1:45 p.m., the director of dietary said the problem with the dishwasher not dispensing hypochlorite was due to a plug in the tubing leading from the sanitizer to the dishwasher, which was corrected. Review of the facilities policy for Sanitation and Infection Control under Dishwashing Procedures	F 371	(F 371: coming from previous page) 1) The dietary staff member was counseled and encouraged regarding sweeping and mopping shall not occur when the food is dish from the steam table on to the plates after observation was made during the survey conduction. 2) The can opener blade was replaced for a new one. 3) The juice dispenser spout and bottom part of the freezer was cleaned. 4) The dishwasher machine was serviced and repaired by the contractor right after the surveyor and dietary supervisor findings were made during the survey conduction.. The Dietary supervisor and/or dishwasher contractor representative to give in-service to all the dietary staff in regards _" _monitoring of the low temperature dishwasher machine proper sanitizing monitoring control", and the Dietary supervisor and/or Dietitian consultant to give in-service to all the dietary staff in regards "Sanitary food serving procedures". (To continue next page)	

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F 371	Continued From page 23 (Dishmachine) revealed that a low temperature dishmachines must use a chemical sanitizing rinse to achieve and maintain 50-100 ppm of chlorine at the dish surface.	F 371	(F 371: coming from previous page) The dietary supervisor will monitor during daily rounds for continuance compliance. The facility will be in compliance by 01-30-12	1/30/12
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431	F431: The facility shall ensure that open multi-dose vials of insulin are labeled with the date opened and that multi-dose Humalog insulin vials would not be stored and/or used beyond 28 days after the date opened. The licensed nurse shall ensure that a multi-dose vial of insulin are labeled with the date when opened and shall not store /or use multi-dose Humalog insulin vials beyond 28 days after the opened date. (To continue next page)	

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F 431	Continued From page 24 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that open multi-dose vials of insulin were labeled with the date opened, and ensure that multi-dose Humalog Insulin vials would not be stored and/or used beyond 28 days after the date opened.. Findings: On December 12, 2011, at 8 a.m., during the medication room inspection on Station I, this was observed: 1. There was an opened multi-dose vials of Humalog Lispro Insulin 100 units/ milliliter (ml) which was opened on November 6, 2011 still inside the refrigerator. On that same day on Station II Medication room the following were observed: 2. There was one bottle of Novolin Regular Insulin 100 units/milliter opened with no date of opening still in the refrigerator. 3. Two bottles of Humalog Insulin was opened on November 8, 2011, still in the refrigerator. During an interview with the LVN 1 on the same date at approximately 10:50 a.m. she stated opened multi-dose insulin is considered expired	F 431	(F: 431 coming from previous page) 1) The multi-dose vials found on Station I of Humalog Lispro insulin 100 units/ml opened on November 6 was disposed. 2) The bottle of Novolin regular found on Station II of insulin 100 units/ml with no date indicated when opened was disposed. 3) The two bottles of Humalog insulin opened on November 8 were disposed as well. The Director of Nurses and/or pharmacist consultant to give in-service to the licensed nurses in regards "Insulin Storage Recommendations". The Director of Nurses will monitor during monthly meeting with the pharmacist consultant for continuance compliance. The facility will be in compliance by 01-30-12	1/30/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056253	A. BUILDING _____ B. WING _____	12/16/2011

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F 431	Continued From page 25 30 days after open date of the vials. A review of the facility's guideline titled "Insulin Storage Recommendations" dated October 6, 2011, indicated all insulins required an opening date which would be dated immediately upon opening and Humalog Insulin is used for 28 days after date opened.	F 431		
F 441 SS=E	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. (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	F 441		

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	056253	A. BUILDING _____ B. WING _____	12/16/2011

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F 441	Continued From page 26 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 observe infection control procedures by not using isolation gowns when in isolation room (15), failed to maintain a sanitary environment by not ensuring that laundry staff follow the facility's policy when processing soiled linens in the laundry, failed to ensure that the housekeeping personnel knew the proper cleaning and disinfection of a room occupied by a resident with C-difficile, failed to observe hand washing procedures and to sanitize health care equipment in order to prevent the potential for the spread of infection for three out of 21 sampled residents (9,10,15). Findings: a. On December 12, 2011 during the initial tour of the facility in the presence of Licensed Vocational Nurse 1 (LVN 1), it was noted that Resident 15 was in contact isolation for ESBL [Extended Spectrum Beta-Lactamase organisms are bacteria that are found in the bowel, urine, blood, skin wounds or sputum and can be spread directly by person-to-person contact and indirectly from contaminated surfaces to a person of the	F 441	441: The facility shall establish and maintain an Infection Control designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. The licensed nurses shall ensure isolation precaution are maintained by monitoring the persons entering a room posted with "contact isolation precautions" are wearing an isolation gowns and gloves when assisting a resident directly person-to-person diagnosed with a contagious disease which requires contact isolation measuring precautions, including exposure with indirectly contact with contaminated surfaces such as bed side rails, bed linens and/or cubicle curtains. Additionally, they shall ensure the medication tray is sanitized when is brought from a resident room back to the medication cart and shall washed his/her hands after lifting the trash can beside the medication cart before proceeding with the medication administration procedure as part of infection control in the facility. (To continue next page)	

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F 441	Continued From page 27 urine]. LVN 1 when asked stated that a gown and gloves would be needed to be used by persons entering the resident's room. There was a three drawer cart containing isolation supplies such as gowns and gloves outside the resident's room. In the middle of the room were two containers one for soiled linen and the other for used protective personal equipment such as gowns. The resident had a physician's order dated December 4, 2011 for contact isolation secondary to ESBL in the urine. According to the admission record the resident was readmitted to the facility on June 20, 2011, with diagnoses that included Parkinson's disease, [redacted], weakness of the left arm and hand and urinary tract infection. The Minimum Data Set (MDS) assessment dated December 8, 2011, indicate the resident was [redacted] for daily decision making, needed total assistance from the staff for the activities of daily living, was incontinent of bowel and bladder and did not have any type of urinary catheter. On December 13, 2011 at 7:45 a.m., Certified Nursing Assistant 2 (CNA 2) was observed in the room at the resident's roommate bedside without a protective gown as per the facility's policy. On the same date and time during an interview CNA 2 stated he didn't think he needed to wear a gown since he was assisting the resident in Bed-A and it was the resident in Bed-C who was on isolation. On December 13, 2011 at approximately 11:30 a.m., a Spanish language speaking family	F 441	(F: 441 coming from previous page) The Laundry/Housekeeping supervisor shall ensure the laundry staffs when sorting soil linen wears gowns and gloves as part of infection control in the facility. Also shall ensure that soiled linen, personal cloth and mops are sort and place on separate containers and load washed and dried separated as well. Also shall ensure that the housekeeping staffs are trained and possess knowledge of proper disinfection procedures of an isolation room with C-diff as part of infection control in the facility. Resident 15, contact isolation precaution was clear on 12/19/11. The Director of Nurses and/or staff developer to in-service the nursing personnel in regards "contact isolation precaution policy and procedures". The laundry/housekeeping supervisor will in-service the laundry personnel in regards "sorting the soiled linen related with infection control" and "Proper C-diff disinfection related with infection control". (To continue next page)	

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	056253	A. BUILDING _____ B. WING _____	12/16/2011

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BERKLEY VALLEY CONV HOSPITAL	6600 SEPULVEDA BLVD. VAN NUYS, CA 91411

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F 441	Continued From page 28 member was observed in the room wearing gloves and assisting the resident with repositioning her pillow and adjusting the covers for the resident. The family member was in contact with the resident, bed linens and resident's furniture. On the same date and time during an interview, the family member, stated she was instructed by the facility staff to wear a gown only when she was assisting the resident with her meals. A review of the a Resident Care Plan dated December 24, 2011 for contact isolation related to ESBL in the urine had as a goal to monitor isolation precautions every shift and an intervention to maintain isolation precautions per the facility's policy and procedure. A review of the facility's policy of infection control of antibiotic resistant microorganisms such as ESBL, indicated to wear gowns when contact with soiled surfaces such as side rails or bed linens of an infected resident is anticipated. The facility's policy did not address when visitors should use protective personal equipment. During an interview with the Director of Nursing (DON) on December 16, 2011 at 12:45 p.m., she stated that it is the facility's responsibility that contact isolation procedures be followed. b. On December 14, 2011 between 3:20 p.m. and 3:35 p.m., during inspection of the laundry room, in the presence of the Maintenance Supervisor the following was observed: Laundry Service Staff 1 demonstrated how he sorts soiled laundry, puts the soiled laundry into	F 441	(F: 441 coming from previous page) The Director of Nurses will monitor during weekly rounds for continuance compliance. The Laundry/Housekeeping supervisor will monitor during weekly rounds for continuance compliance. The facility will be in compliance by 01-30-12.	1/30/12

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKLEY VALLEY CONV HOSPITAL	5600 SEPULVEDA BLVD. VAN NUYS, CA 91411

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F 441	Continued From page 29 the washing machines, takes off his gloves and washes his hand and forearms, takes the laundry out of the washing machines, puts the laundry into the driers, and takes the clean dry laundry into the clean laundry area to be folded. Laundry Service Staff 1 stated he wears gloves when he sort soiled laundry to protect his clothing from the soiled laundry. According to Laundry Service Staff 1 the only time he wears gowns is when he is sorting infectious soiled laundry to protect his clothing. The Maintenance Supervisor stated he was not aware the laundry staff should wear a gown at all times while sorting soiled laundry. The facility's Laundry Department policy and procedure does not address the issue of wearing a gown while sorting soiled laundry. At this same time Laundry Service Staff 1 was observed unloading a washing machine of washed laundry which included sheets, towels, blue chux pads, several items of residents' personal clothing, and a mop head. The Maintenance Supervisor stated that the laundry should have been sorted and washed as indicated in the facility's policy. A review of the facility's Laundry Department policy and procedures, indicated laundry staff is to wash and dry residents' clothing separately from facility's linen. The policy and procedure also indicated the laundry staff is to sort and wash laundry in the following manner: a) Sheets and pillow cases b) Diapers and draw sheet c) Towel and washcloths d) Residents' personal clothing	F 441		

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F 441	Continued From page 30 e) Mop heads, cleaning cloths f) Kitchen linens, aprons, rags During an interview on December 14, 2011 at approximately 3:40 p.m. with the Maintenance Supervisor stated different sorted categories of laundry should not be mixed together in the washer or drier. c. On December 14, 2011, at approximately 4:10 p.m., during a telephone interview with Housekeeping Staff 1 who performs the cleaning, she stated she uses the commercially premixed bleach spray to clean rooms with "strong infections". The Maintenance Supervisor confirmed that Housekeeping Staff 1 was referring to the Clorox Commercial Solutions Germicidal Spray. The label on the bottle does not list C.dif. as an organism it is effective against. During an interview with the Maintenance Supervisor on December 14, 2011, at approximately 4:15 p.m., he was asked about the proper disinfection of an isolation room for C.dif. The Maintenance Supervisor stated the housekeeping staff should use a solution of bleach and water in a 1:10 ratio. According to Transmittal 55 dated December 2, 2009, sent by the Center for Medicaid and Medicare Services (CMS), C. diff. 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. diff. spores, and can help prevent transmission of the organism. Cleaning equipment used for residents with C. diff. with a 1:10 dilution of	F 441		

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F 441	Continued From page 31 sodium hypochlorite (bleach) and water will also reduce the spread of the organism. Once mixed, the solution is effective for 24 hours. d. On December 14, 2011 at approximately 8:45 a.m., during the observation of medication administration for Resident 9, LVN 2 was observed bringing the medication tray back to his medication cart, without sanitizing it first. On the same day at approximately 9:25 a.m., LVN 3 was observed bringing the medication tray back to her medication cart from Resident 10's room, without sanitizing it first. She was then observed lifting the trash can beside her medication cart and proceeded with medication administration, without first washing her hands On December 14, 2011 at approximately 3 p.m., RN supervisor during an interview stated they [LVN 2 and 3] should have sanitized their trays with the bleach wipes and LVN 3 should have washed her hands prior to medication administration.	F 441		
F 465 SS=E	483.70(h) 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 and interview with the Maintenance Supervisor (MS), the facility failed to maintain the environment in a clean and orderly manner.	F 465	F465: The facility shall provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. The maintenance supervisor shall ensure to maintain the environment in a clean and orderly manner. (To continue next page)	

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F 465	Continued From page 32 Findings: During a general observation tour of the facility on December 14, 2011, the following was observed: 1. The closet next to Room 107 did not have a ceiling vent cover and had accumulated dust. 2. The ceiling in Room 122 had water damage in an area approximately 1.5 feet by 2 feet. The wall next to the closet had paint peeling off in an area approximately 11 feet by 2.5 feet. 3. The Infectious Waste closet had trash on the floor and dust clumps on the floor and walls. 4. The toilet bowl in the bathroom of room 132 had rust streaks all around the inside of the bowl. 5. Shower room III had an unpainted concrete panel on the ceiling over one shower stall and on the wall over a second shower stall. 6. In room 139 the wall next to the closet had chipped paint and black markings in an area approximately 11 feet by 4 feet. 7. In room 142 a wall had the paint chipped off in an area approximately 11.0 feet by 2.0 feet. 8. In room 141 the trap pipe of the hand-washing basin in the bathroom was leaking water and there was puddle of water on the floor at the bathroom door entry way; on a wall there was an area that measured approximately 11.0 feet by 4.0 feet that had the paint chipped off and blackened.	F 465	(F: 465 coming from previous page) 1) Room 107, ceiling vent cover was installed and dust was cleaned. 2) Room 122, ceiling water damage will be repaired and wall paint fixed. 3) The infectious waste closed trash was cleaned and dust on the floor and wall too. 4) Room 132, toilet bowl in the bathroom was replaced. 5) Shower III, unpainted concrete panel on the ceiling and wall will be paint fixed. 6) Room 139, wall chipped paint and black marking will be patched and paint fixed. 7) Room 142, wall paint chipped will be patched and paint fixed. 8) Room 141, hand washing basin trap water leakage was repaired; wall paint chipped and blackened will be patched and paint fixed 9) Laundry room, accumulated dirt on the base boards and dust on the floor was cleaned. (To continue next page)	

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F 465	Continued From page 33 9. In the clean clothes area of the laundry room, there was accumulated dirt on the base boards and dust on the floor. The MS stated that the housekeepers were responsible for the cleaning that should have been done and the maintenance crew was responsible for the plumbing repairs that should have been done. However he was responsible to ensure they completed the job.	F 465	(F: 465 coming from previous page) The Maintenance Director to in-service maintenance personnel in regards "environment maintenance routines". The Maintenance Director will monitor during weekly rounds for continuance compliance. The facility will be in compliance by 01-30-12	1/30/12
F 517 SS=F	483.75(m)(1) WRITTEN PLANS TO MEET EMERGENCIES/DISASTERS The facility must have detailed written plans and procedures to meet all potential emergencies and disasters, such as fire, severe weather, and missing residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility staff failed to keep a detailed written plan and procedures that included inventory of all the disaster food supplies as indicated in its policy that would match the facility's disaster menu, in order to determine how much food is on hand, how many people it will serve and for how long. Findings: On November 16, 2011 at approximately 12:15 p.m., accompanied by the director of dietary, the facility's disaster food, which is stored in the kitchen, was inspected.	F 517	F517: The facility shall keep a detailed written plan and procedures that included inventory of disaster food supplies that would match the facility disaster menu, in order to determinate inventory on-hand, how many people it will serve and for how long. The Dietary supervisor shall maintain a detailed emergency food supplies on-hand inventory that will match the facility disaster menu including how many peoples and days it will serve. (To continue next page)	

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	056253	A. BUILDING _____ B. WING _____	12/16/2011

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F 517	Continued From page 34 A review of the disaster menus indicated the facility is to have supplies of the following items to last the facility for up to 7 days: canned tuna, peanut butter, beef stew, macaroni & cheese, chili con carne, mashed potatoes, rice, orange juice, apple juice, apple juice base, applesauce, peaches, pears, sliced beets, green beans, green peas, puree meat, puree vegetables, vanilla pudding, dry cereal, vanilla wafers, crackers, nonfat dry milk, coffee and tea bags. However, the director of dietary was not able to verbalize how much supply was on hand, how many people it would serve, and for how long. According to the facility's Emergency And Disaster Procedures, the facility is to maintain an emergency food supply on the premises to last for a three day period. On November 16, 2011 at approximately 1 p.m., the director of dietary said she should be counting her supplies on hand and comparing it to the facility's disaster menu in order to determine if the facility has enough food in case of an emergency, for all the residents, staff and visitors.	F 517	(F: 517 coming from previous page) Current emergency food supplies inventory on-hand will be revised, reviewed and implemented to match with the facility disaster menu. The Dietary supervisor and/or Dietician consultant to give in-service to the cooks staff members in regards "emergency food supplies on-hand inventory control". The Dietary supervisor will monitor during weekly food supplies inventory purchasing orders procedures for continuance compliance. The facility will be in compliance by 01-30-12.	1/30/12