STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555892	A. BUILDING _____ B. WING _____	R 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SELMA CONVALESCENT HOSPITAL	2108 STILLMAN SELMA, CA 93662

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health- Licensing and Certification during a REVISIT survey following a survey with exit date 11/16/18 where the facility was in substantial non-compliance with scope and severity of F and substandard Quality of Care at F tags F584 and F684 Representing the California Department of Public Health - Licensing and Certification: Federal ID: 39603, RN, HFEN and 40360 RN, HFEN. Capacity: 34 Census: 34 Sample: 21 No sub-standard quality of care remains. The following Complaint was investigated during the REVISIT Survey: Complaint CA 00628620: Unsubstantiated with no deficiency.	{F 000}		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure services provided met professional standards of quality for one of 34 sampled residents (Resident 21) when the insulin (a medication used to treat high blood	F 658	F 658 1. How corrective actions will be accomplished for those residents affected by the deficient practice.	3/18/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 03/27/2019

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F 658	Continued From page 1 sugar) pen (a device shaped like a pen and designed to deliver insulin for one resident) was not labeled in accordance with professional standards of practice. This deficient practice had the potential for insulin administration error which could result in adverse effects for Resident 21. Findings: During an observation on 3/14/19, at 10:23 a.m., in the medication room, an unlabeled plastic bag was found with Resident 21's insulin pen. The insulin pen did not have a pharmacy prescription label to identify the pen belonged to Resident 21. The insulin pen had Resident 21's hand written label which indicated, "Resident 21 [room] [redacted] opened 3/13/19. During an interview with Licensed Nurse (LN 10), on 3/14/19, at 10:30 a.m., she stated resident medications required a pharmacy label with complete directions of how to administer the medication. LN 10 stated Resident 21's insulin pen should have been in a plastic bag with the pharmacy label attached. LN 10 stated, Resident 21 could get the wrong dose of insulin if there were no specific directions on how to administer the medication. During an interview with LN 9, on 3/14/19, at 10:40 a.m., she stated Resident 21's insulin pen should have had a proper pharmacy label to ensure Resident 21 received insulin per physician's order. During an interview with the Director of Nursing (DON), on 3/15/19, at 5:10 p.m., she stated	F 658	The insulin pen for Resident 21 was discarded immediately by the charge, and replacement insulin pen was obtained from pharmacy on 3/14/19. Resident 21 did not miss any insulin doses and has exhibited no adverse signs or symptoms due to the alleged deficient practice. 2. How the facility will identify other residents having the potential to be affect by the same deficient practice and what corrective actions will be taken. 11 other residents receiving insulin had potential to be affected however, no other residents were affected by this finding. An audit was completed to ensure all residents receiving insulin had correctly prescribed and labeled insulin being administered on 3/14/2019. DON inspected all other insulins in Med-carts and all other insulins were found correctly labelled on 3/14/19. 3. What Measures will be put in place or what systemic changes will the facility make to ensure the deficient practice does not recur. DON conducted re-education with all licensed nurses on auditing and inspecting insulin for appropriate labeling 03/15/19. Licensed nurses will conduct daily	

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F 658	Continued From page 2 nurses were expected to check and make sure all the medications contained appropriate pharmacy labels. The facility policy and procedure titled, "Labeling of Medication Containers" dated 4/17, indicated, 1. Medication label must be legible at all times. 2. Any medication packaging or containers that are inadequately or improperly labeled shall be returned to the issuing pharmacy... 3. Labels for individual drug containers shall include all necessary information i. Directions for use." The facility policy and procedure titled, "Administering Medications" dated 12/12 indicated " ... 7. The individual administering the medication must check the label THREE (3) times to verify the right resident, right medication, right dose, right time and right method (route) of administration before giving the medication... 14. Insulin pens will be clearly labeled with resident's name or other identifying information. Prior to administering insulin with an insulin pen, the Nurse will verify that the correct pen is used for that resident." Review of ISMP (Institute for Safe Medication Practices) Professional Reference titled, "ISMP Guidelines for Optimizing Safe Subcutaneous Insulin Use in Adults" dated 2017, (found at www.ismp.org) indicated, "... 3. Administration and Monitoring of Subcutaneous Insulin, 3.1 Patient-specific insulin pens are stored on clinical units in a manner that prevents their inadvertent use on more than one patient. If an institution chooses to use insulin pen devices, each should contain a patient-specific label and be stored in a patient-specific bin/drawer on the clinical unit to prevent contamination from inadvertent misuse	F 658	inspection of the insulin labels and maintain log. 4. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. DON or Designee will conduct weekly med-cart inspection and report any findings from the inspections to the QAPI committee meeting on monthly basis until the QAPI committee determines it□s no longer necessary. 5. 3/18/2019	

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F 658	Continued From page 3 on another patient... Insulin as a High- Alert Medication. Medications that are associated with the highest risk of injury when used in error are known as high-alert medications... The survey findings suggest a consensus among pharmacists and nurses that hospitalized patients are vulnerable to errors with subcutaneous insulin, and that more must be done to prevent patient harm with this high alert medication..."	F 658		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide a safe environment when a laundry chute (vertical shaft in a building down which dirty clothes and linens can be dropped, to land in a laundry area on a lower floor) hatch inside an unlocked laundry room closet was accessible to all of the residents. This failure had the potential for residents to access an unsafe room. Findings: During an observation on 3/14/19, at 10:05 a.m., the laundry room closet was unlocked and accessible to anyone who opened the laundry	F 689	F 689 1. How corrective actions will be accomplished for those residents affected by the deficient practice. Maintenance Director installed an automatic lock (lock that locks automatically as the door closes and does not need to be manually locked) on the laundry chute room door on 3/14/19. 2. How the facility will identify other residents having the potential to be affect by the same deficient practice and what	3/18/19

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F 689	Continued From page 4 room closet door. A laundry chute with an unlocked hatch was inside the unlocked laundry room closet. The hatch was a metal door which measured 12 inches long by 13.5 inches wide. During an interview with the Housekeeping Supervisor (HSKPS), on 3/14/19, at 10:30 a.m., she stated she did not know why the laundry room closet was left unlocked. The HSKPS stated, "It should be locked after every time it is used." The HSKPS stated the residents could injure their hands if the laundry chute hatch fell on their hands. During an interview with the Director of Nursing (DON 1), on 3/14/19, at 12:00 p.m., she stated the laundry room closet was accessible to the residents and should have been locked. The DON stated staff should have locked the laundry room closet after every use. During a concurrent observation and interview with the Administrator (ADM), on 3/14/19, at 12:10 p.m., the ADM verified the measurements of the unlocked laundry chute and stated the laundry room closet needed to be locked.	F 689	corrective actions will be taken. All 31 residents in-house had potential to be affected by this finding, but no residents were affected by this finding. 3. What Measures will be put in place or what systemic changes will the facility make to ensure the deficient practice does not recur. Maintenance Director inspected all other supply closet doors and no other door were needing locks, the remainder of the facility was also inspected for similar hazards with none found on 3/14/19. 4. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. Maintenance Director will inspect all supply closet door locks and other similar areas of the facility on monthly basis for function and report findings to monthly QAPI meeting until QAPI committee determines it□s no longer necessary. 5. 3/18/2019	
F 912 SS=C	Bedrooms Measure at Least 80 Sq Ft/Resident CFR(s): 483.90(e)(1)(ii)	F 912		3/18/19

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F 912	Continued From page 5 §483.90(e)(1)(ii) Measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms; This REQUIREMENT is not met as evidenced by: Based on observation during the recertification revisit survey period of 3/14/19 through 3/15/19, the facility failed to provide the minimum square footage for each resident in a multi-resident room. Findings: On 3/15/19, the residents had a reasonable amount of privacy and storage space were adequate. Bedside stands were available. There was sufficient room for nursing care and resident to ambulate. Wheelchairs and toilet facilities were accessible. The health and safety of the residents will not be adversely affected by this waiver.	F 912	Waiver Approved on 3/15/19.	

Room number	Square Foot	Residents
1	118.61	2
2	118.48	2
3	119.58	2
4	119.58	2
5	96.88	1
6	176.47	3
7	96.88	1
8	117.64	2
9	119.58	2
10	118.61	2
11	120.44	2
12	120.44	2
14	112.77	2
16	119.58	2

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F 912	Continued From page 6	F 912		

18	129.31	2
19	96.88	1
20	96.88	1

We recommend continuance of the room waiver.

_____

Health Facility Evaluator Supervisor Date

Request for a continuance of the room waiver.

_____

Facility Administrator Date