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

POC accepted 8/1/13 Abigail D Ramirez

PRINTED: 07/16/2013
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
	05A137	A. BUILDING _____ B. WING _____	06/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL PARK A CENTER OF EFFECTIVE LIVING	1425 LAUREL AVENUE POMONA, CA 91767

(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 and Entity Reported Incident (ERI) Investigations. Intake Number: (Total 15) 1. CA00358062 - Substantiated with no regulatory deficiencies Category: Patient to Patient Abuse 2. CA00355315 - Substantiated with no regulatory deficiencies Category: Patient to Patient Abuse 3. CA00357883 - Substantiated with no regulatory deficiencies Category: Patient to Patient Abuse 4. CA00355335 - Substantiated with no regulatory deficiencies Category: Patient to Patient Abuse 5. CA00357891 - Substantiated with no regulatory deficiencies Category: Patient to Patient Abuse 6. CA00355030 - Substantiated with no regulatory deficiencies Category: Patient to Patient Abuse 7. CA00357170 - Substantiated with no regulatory deficiencies Category: Resident Safety/Falls 8. CA00355132 - Substantiated with no regulatory deficiencies	F 000	**"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Laurel Park does not admit that the deficiency listed on this form exist, nor does Laurel Park admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. Laurel Park reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."** Robert B. Barton **Robert B. Barton** **F 165; SS=E; 483.10(f)(1)** **RIGHT TO VOICE GRIEVANCES WITHOUT REPRISAL** **A. What and how corrective action(s) will be accomplished, both temporarily and permanently, for those patients, employees, and/or facility operations identified/found to have been affected by the deficient practice:** **Starting 06.18.13: Social Service Designee interviewed resident 15 and resident 16 regarding the identified missing items. Social Service Designee initiated a customer first concern/grievance form for both residents and confirmed through a review of both inventory logs in the residents' charts that both residents initially came into the facility with the items both resident 15 and 16 stated were missing. Social Service Designee under the coordination of the Administrator, replaced identified missing items for both residents on 6.18.13. Social Service Designee implemented the customer first concern/grievance log on 6.18.13. Administrator coordinated and completed**	F 165 SS E 483.10 (f)(1) pages: 03-04	**E. Dates when corrective action will be completed:** JUL 26 2013 LOS ANGELES COUNTY HEALTH FACILITIES DIVISION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Robert B. Barton — TITLE: Administrator — (X6) DATE: 7/26/2013

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A137	A. BUILDING _____ B. WING _____	06/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL PARK A CENTER OF EFFECTIVE LIVING	1425 LAUREL AVENUE POMONA, CA 91767

(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	Continued From page 1 Category: Patient to Patient Abuse 9. CA00355434 - Substantiated with no regulatory deficiencies Category: Patient to Patient Abuse 10. CA00354642 - Substantiated with no regulatory deficiencies Category: Resident Safety 11. CA00355298 - Substantiated with no regulatory deficiencies Category: Patient to Patient Abuse 12. CA00352858 - Substantiated with no regulatory deficiencies Category: Patient to Patient Abuse 13. CA00355309 - Substantiated with no regulatory deficiencies Category: Patient to Patient Abuse 14. CA00352860 - Substantiated with no regulatory deficiencies Category: Patient to Patient Abuse 15. CA 00355520 - Substantiated with no regulatory deficiencies Category: Patient to Patient Abuse Representing the Department of Public Health: Surveyor ID #27680 Surveyor ID #28074 Surveyor ID #16279 Total Resident Population: 43	F 000	**an in-service with Social Service Designee on 6.18.13 on the policies and procedures regarding the implementation, review and resolution of all grievances on the customer first concern/grievance log, discussing resident concerns/grievances including but not limited to theft/loss during monthly resident government meetings and documenting accordingly on the resident government meeting minutes. This in-service provides personnel with education on assuring the deficient practice is corrected and does not reoccur.** **B. How the facility will identify other patients, employees, and/or facility operations having the potential to be affected by the same deficient practice and what corrective action(s), both temporarily and permanently, will be taken:** **Starting 06.18.13: Social Service Designee and Program Director coordinated and completed an in-service with facility personnel on 6.24.13 on the policies and procedures regarding issuing and reporting all resident concerns/grievances including but not limited theft/loss. Social Services Designee completed an in-service with all residents during the following resident government meeting on 07.05.13 regarding reporting concerns/grievances including theft/loss – no further resident concerns/grievances identified. These in-services provides personnel and residents with education on assuring the deficient practice is corrected and does not reoccur.** **C. What immediate measures will be put into place and/or what systematic changes the facility will make to ensure the deficient practice does not recur:** **Starting 06.18.13: Social Service Designee will continue to discuss resident**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A137	A. BUILDING _____ B. WING _____	06/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL PARK A CENTER OF EFFECTIVE LIVING	1425 LAUREL AVENUE POMONA, CA 91767

(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	Continued From page 2 Total Resident Sample Size: 11 Highest Severity and Scope: E	F 000	**concerns/grievances during monthly resident government meetings and Social Service Designee will document accordingly on the resident government meeting minutes. Staff will continue to encourage residents to communicate to administrative and supervisory personnel their concerns/grievances and/or assist residents with obtaining and completing the customer first concern/grievance form. Upon identification of issues, administrative and supervisory staff counsel and educate personnel. As needed, Administrator will conduct in-services with Social Service Designee on the policies and procedures regarding the implementation, review and resolution of all grievances on the customer first concern/grievance log, discussing resident concerns/grievances including but not limited to theft/loss during the monthly resident government meeting and documenting accordingly on the resident government meeting minutes. This in-service will continue to provide personnel with education on assuring the deficient practice is corrected and does not reoccur.**	
F 165 SS=E	483.10(f)(1) RIGHT TO VOICE GRIEVANCES WITHOUT REPRISAL A resident has a right to voice grievances without discrimination or reprisal. Such grievances include those with respect to treatment which has been furnished as well as that which has not been furnished. This REQUIREMENT is not met as evidenced by: Based on group interviews and record reviews, the facility did not ensure that resident's grievances were promptly resolved. Specifically, during the Group Meeting, 2 Randomly Selected Resident (RSR 15 and 16) complained that some of their personal items were missing. The residents stated that they did not know what happened after they reported the incidents to the nursing staff. Findings: A Resident Group Meeting was conducted on June 7, 2013, at 10 a.m. During the meeting, 2 of eight residents complained of the following: 1. Resident 15 stated that some pieces of his Chinese chess set pieces disappeared from his closet for more than 3 months 2. Resident 16 stated that a set of ear buds also disappeared for about 2 weeks from her closet. The residents stated that they had reported the incidents to the attention of the Nursing Staff numerous times without improvement. The residents stated that they do not remember who they reported the missing items to anymore and they were sure the	F 165	**D. How the facility plans to monitor its performance to make sure that solutions are sustained (description of the monitoring process and positions responsible for monitoring). 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:** **Starting 06.18.13 and Daily: During the weekday Clinical At Risk Evaluation/Facility Rounds and Stand-Up Meetings and during monthly facility**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A137	A. BUILDING _____ B. WING _____	06/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL PARK A CENTER OF EFFECTIVE LIVING	1425 LAUREL AVENUE POMONA, CA 91767

(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 165	Continued From page 3 staff would not do anything about it. The Social Service Designee (SSD) was interviewed on June 7, 2013, at 12 p.m. The SSD stated that she was unaware of the missing personal items. A review of the Monthly Resident Council Meetings from February 2013 through May 2013, revealed no documented evidence that reporting of missing personal items was reviewed with the residents or documented evidence of the residents being educated regarding the missing items through grievance procedure. A facility policy titled "Customer Concerns/Grievances" dated December 2009, indicated "concerns and/grievances may be presented verbally or in writing and may include concerns about treatment, care,management of funds, lost personal items, or violation or rights." The undated facility policy titled "Resident Personal Property", indicated that ". . . a log of all resident personal property items reported missing will be maintained in the facility." There was no evidence that the facility had a log to include RSR 15 and 16's missing items.	F 165	**resident council meetings, Social Services Designee, as a member of the Performance Improvement Committee, continues to address facility resident concerns/grievances with facility residents and will continue to implement, review and resolve weekly. Performance Improvement Committee continues with necessary follow through to address identified issues. All above stated weekly Performance Improvement actions are reviewed, at least quarterly, by the Performance Improvement Committee for success, areas of improvement, and necessary future action. As needed, Administrator will conduct an in-services with Social Service Designee on the policies and procedures regarding the implementation, review and resolution of all grievances on the customer first concern/grievance log, discussing resident concerns/grievances including but not limited to theft/loss during the monthly resident government meeting and documenting accordingly on the resident government meeting minutes.**	7.03.13
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.	F 167 SS C 483.10 (g)(1) pages: 04-06	**F 167; SS=C; 483.10(g)(1)** **RIGHT TO SURVEY RESULTS – READILY ACCESSIBLE** **A. What and how corrective action(s) will be accomplished, both temporarily and permanently, for those patients, employees, and/or facility operations identified/found to have been affected by the deficient practice:** **Starting 06.18.13: Plant Operations Supervisor under the coordination of the Administrator posted and secured survey binder on 6.18.13 containing previous year's survey results on the interior wall of the program trailer accessible to residents and visitors without having to ask staff. Facility**	**E. Dates when corrective action will be completed:**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A137	A. BUILDING _____ B. WING _____	06/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL PARK A CENTER OF EFFECTIVE LIVING	1425 LAUREL AVENUE POMONA, CA 91767

(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 167	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to make the most recent survey results available for examination in a place readily accessible to the residents. The facility had a sign that indicated the survey results were located inside the nursing station. Findings: On June 12, 2013, between 7:30 a.m. and 8:45 a.m., the evaluator conducted an initial tour of the facility. At 7:40 a.m., the evaluator observed that the last survey report was not posted at the consumer board or in a common area for the residents. At 7:45 a.m., the evaluator noticed a sign was posted that indicated, "The most recent annual recertification survey binder is located at the nurses' station for review by all staff, residents and visitors." On June 13, 2013, at 10:15 a.m., during the group interview, seven of seven alert and oriented residents indicated that they did not know where the survey results were located and that they would like to review the report. On June 18, 2013, at 1:05 p.m., the evaluator conducted an interview with the administrator regarding posting of the survey results for the residents. The administrator stated the facility had posted a copy of the last survey results accessible to the residents, outside of the nursing station. But the residents would constantly tear it	F 167	**will continue to provide an additional survey binder containing previous years survey results in the nursing station accessible to staff, residents and visitors upon request. Regional Director of Programing in-serviced Administrator on 6.18.13 regarding the policies and procedures of assuring survey results are readily available to residents and visitors.** **B. How the facility will identify other patients, employees, and/or facility operations having the potential to be affected by the same deficient practice and what corrective action(s), both temporarily and permanently, will be taken:** **Starting 06.18.13: Social Service Designee completed an in-service with all residents on 6.18.13 regarding the two survey binder locations (nursing station and program trailer office) that are accessible to all staff, residents and visitors.** **C. What immediate measures will be put into place and/or what systematic changes the facility will make to ensure the deficient practice does not recur:** **Starting 06.18.13: Social Service Designee will continue to discuss with and in-service all residents regarding the two survey binder locations (nursing station and program trailer office) during the monthly resident government meetings. Plant Operations Supervisor will continue to conduct weekly facility visual audits including but not limited to ensuring survey binders are properly secured and in good condition. Plant Operation Supervisor to repair issues as necessary. As needed, Regional Director of Programing in-services Administrator regarding the policies and procedures of assuring survey results are readily available to residents and visitors.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A137	A. BUILDING _____ B. WING _____	06/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL PARK A CENTER OF EFFECTIVE LIVING	1425 LAUREL AVENUE POMONA, CA 91767

(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 167	Continued From page 5 down. The evaluator pointed out that the survey results should be readily accessible and residents should not have to ask staff for the survey results. The administrator stated the survey results would be accessible to the residents, and that it would be secured, to prevent it from being removed.	F 167	**D. How the facility plans to monitor its performance to make sure that solutions are sustained (description of the monitoring process and positions responsible for monitoring). 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:** **Starting 06.18.13 and Monthly: During the weekday Clinical At Risk Evaluation/Facility Rounds and Stand-Up Meetings, Administrator, as a member of the Performance Improvement Committee, continues to address facility accessibility to survey results. Performance Improvement Committee continues with necessary follow through to address identified issues. All above stated weekly Performance Improvement actions are reviewed, at least quarterly, by the Performance Improvement Committee for success, areas of improvement, and necessary future action. As needed, Administrator coordinate and completes in-services with Social Service Designee on the policies and procedures regarding the accessibility of survey results to resident and visitors. As needed, Regional Director of Programing coordinates in-services with Administrator regarding the policy and procedures of assuring survey results are readily accessible to residents and visitors.**	7.03.13
F 278 SS=B	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement.	F 278	**F 278; SS=B; 483.20(g) – (j) ASSESSMENT ACCURACY/COORDINATION/ CERTIFIED** **A. What and how corrective action(s) will**	**E. Dates when correc-tive**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A137	A. BUILDING _____ B. WING _____	06/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL PARK A CENTER OF EFFECTIVE LIVING	1425 LAUREL AVENUE POMONA, CA 91767

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that the Minimum Data Set (MDS), a standardized assessment and care planning tool, was accurate for one of 11 sampled residents (1). This resulted in an inaccurate assessment of the resident's fall history. Findings: A review of the Admission Record of Resident 1 indicated that the resident was admitted to the facility on February 25, 2013, with diagnoses that included schizoaffective disorder (a mental illness), hypertension (high blood pressure), and osteoarthritis (joint disorder causing pain, stiffness, and inflammation of one or more joints caused by wear and tear). A review of a Change of Condition (COC) documentation dated May 20, 2013, at 8:15 a.m., indicated that the resident fell while walking through the corridor, landing on his buttock. The COC documentation further indicated that the resident sustained no injuries. According to the documentation, the physician was notified and ordered to draw a Lithium (antimanic medication) level and comprehensive metabolic panel (CMP- a blood test that measures your sugar level, electrolyte and fluid balance, kidney function, and liver function) immediately and change Trazodone (antidepressant) from routine to as needed (PRN) for problematic sleep. Another COC documentation dated May 20, 2013, at 11:30 a.m., disclosed that the resident	F 278 483.20 (g) – (j) pages: 06-09	**be accomplished, both temporarily and permanently, for those patients, employees, and/or facility operations identified/found to have been affected by the deficient practice:** **Starting 06.18.13: Director of Nursing Services/MDS Coordinator completed an MDS quarterly modification regarding resident 1's fall on 7.4.13. Administrator completed in-service with the Director of Nursing Services/MDS Coordinator on 6.18.13 regarding accurate recording and timely completion of initial, quarterly and annual MDS assessments related but not limited to resident falls. This in-service provides personnel with education on assuring the deficient practice is corrected and does not reoccur.** **B. How the facility will identify other patients, employees, and/or facility operations having the potential to be affected by the same deficient practice and what corrective action(s), both temporarily and permanently, will be taken:** **Starting 06.18.13: Director of Nursing Services and the Health Information Management Coordinator completed an MDS audit on all resident charts regarding accurate recording and timely completion including but not limited to resident falls – no other issues identified.** **Administrator completed in-service with the Director of Nursing Services/MDS Coordinator on 6.18.13 regarding accurate recording and timely completion of initial, quarterly and annual MDS assessments related but not limited to resident falls. This in-service provides personnel with education on assuring the deficient practice is corrected and does not reoccur.** **C. What immediate measures will be put into place and/or what systematic changes**	**action will be completed:**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A137	A. BUILDING _____ B. WING _____	06/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL PARK A CENTER OF EFFECTIVE LIVING	1425 LAUREL AVENUE POMONA, CA 91767

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 7 was found lying face first on the floor inside his room. The COC documentation further indicated that the resident sustained a laceration on the bridge of his noise and was observed with weakness and twitching. According to the documentation, the physician was notified and ordered to send the resident to the acute care hospital for evaluation. A short term care plan dated May 20, 2013, indicated that the resident fell on his buttocks in the corridor. The short term care plan goal indicated that the resident will not incur additional falls and his personal safety will be assured. The listed nursing interventions included to arrange for labs as ordered by the physician and report abnormals promptly, monitor the resident for possible side effects of medications, balance, gait, involuntary movements, weakness, body control, cognitive status PRN and report abnormals to the physician promptly, and complete a pain assessment PRN. The MDS dated June 3, 2013, indicated that the resident was highly impaired in his hearing with unclear speech, but was able to complete the brief interview for mental status, able to understand others and make himself understood, and independent in activities of daily living. The MDS further indicated that the resident had hallucinations, delusions, trouble concentrating on things, felt down, depressed or hopeless for several days, and was on antipsychotic and antianxiety medications during the last seven days. According to the MDS, the resident had no falls since admission/entry or reentry or the prior assessment.	F 278	**the facility will make to ensure the deficient practice does not recur:** **Starting 06.18.13 and Weekly: During weekly reviews of MDS assessments, Director of Nursing Services assures accurate recording and completion of MDS assessments. Health Information Manager continues to audit MDS assessments to ensure accurate completion. As needed, Administrator coordinates and completes in-services on the policies and procedures with the Director of Nursing Service, Program Director, Social Service Designee and the Activity Director regarding the accurate recording and timely completion of MDS assessments. This in-service provides personnel with education on assuring the deficient practice is corrected and does not reoccur.** **D. How the facility plans to monitor its performance to make sure that solutions are sustained (description of the monitoring process and positions responsible for monitoring). 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:** **Starting 06.18.13 and Daily: During the weekday Clinical At Risk Evaluation/Facility Rounds and Stand-Up Meeting, Director of Nursing Services and Health Information Manager, as members of the Performance Improvement Committee, will bring forward identified issues (through their completed audits and reviews of resident health records) related to the accurate recording and timely completion of MDS assessments. Performance**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A137	A. BUILDING _____ B. WING _____	06/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL PARK A CENTER OF EFFECTIVE LIVING	1425 LAUREL AVENUE POMONA, CA 91767

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 8 During an interview on June 18, 2013, at 2:10 p.m., the director of nursing (DON) who is also the MDS nurse, reviewed the MDS and stated that the resident's falls and injury should have been coded on the MDS. The DON further stated that she will double check the MDS of all residents with falls and make the necessary corrections. The facility's policy and procedure titled "Assessment" dated January 2008, indicated that the MDS nurse coordinates the interdisciplinary team in completing the resident's comprehensive assessment according to the RAI process guidelines. The MDS nurse utilizes the RAI guidelines to prioritize resident problems/concerns and to determine appropriate care plan interventions. The Interdisciplinary Team assesses each resident quarterly, annually, or if there has been a significant change of condition. According to the Resident Assessment Instrument (RAI) Manual Version 3.0, identification of residents who are at high risk of falling is a top priority for care planning. A previous fall is the most important predictor of risk for future falls. A fall should stimulate evaluation of the resident's need for rehabilitation, ambulation aids, modification of the physical environment, or additional monitoring. The RAI Manual further indicated to code 1 (yes) under section J1800, if the resident has fallen since the last assessment then determine the number of falls that occurred since admission or prior assessment and code the level of fall-related injury for each, under section J1900.	F 278	**Improvement Committee continues with necessary follow through to address identified issues. During monthly facility visits, Manager of Clinical Operations, as a member of the Performance Improvement Committee, completes monthly reviews of the facility's clinical practices including, but not limited to, accurate recording and timely completion of MDS assessments. This includes providing nursing department, operation recommendations and assuring nursing department follows up on such recommendations. All above stated weekly and monthly Performance Improvement actions are reviewed, at least quarterly, by the Performance Improvement Committee for success, areas of improvement, and necessary future action. As needed, Administrator coordinates and completes in-services with the Director of Nursing Service, Program Director, Social Service Designee and the Activity Director on the policies and procedures regarding accurate recording and timely completion of MDS assessments.**	7.04.13
F 309	483.25 PROVIDE CARE/SERVICES FOR	F 309	**F 309; SS=D; 483.25** **PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING** **A. What and how corrective action(s) will be accomplished, both temporarily and permanently, for those patients, employees, and/or facility operations identified/found to have been affected by the deficient practice:** **Started 06.18.13: Director of Nursing Services reviewed resident 8's chart, weekly summaries, identified physician order, and identified care plan. Determined licensed nursing personnel did not carry out identified physician order by scheduling EKG test every six months. Director of**	**Dates when corrective action will be completed:**

F309
SS
D
483.25
pages: 09-12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A137	A. BUILDING _____ B. WING _____	06/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL PARK A CENTER OF EFFECTIVE LIVING	1425 LAUREL AVENUE POMONA, CA 91767

(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 309 SS=D	Continued From page 9 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 observation, interview, and record review, the facility staff failed to follow the physician's order to complete an electrocardiogram (EKG- a test that records the electrical activity of the heart) every six months for one of 11 sampled residents (8). This had the potential to cause a delay in providing the necessary care and treatment in an event of an abnormal test. Findings: A review of the Admission Record of Resident 8 indicated that the resident was admitted to the facility on July 8, 2009, with diagnoses that included chronic schizoaffective disorder (a mental condition that causes both a loss of contact with reality (psychosis) and mood problems), borderline personality disorder, and hypertension (high blood pressure). A review of a physician's order dated April 17, 2012, indicated to complete an EKG test every six months, on July and January (indication for the test not specified).	F 309	**Nursing Services assessed resident 8 – no adverse effects. Director of Nursing Services contacted ordering physician and received orders to discontinue identified EKG order. Director of Nurses with Staff Development Coordinator completed an in-service on 6.24.13 with nursing personnel on the policies and procedures regarding physician orders and ancillary services.** **B. How the facility will identify other patients, employees, and/or facility operations having the potential to be affected by the same deficient practice and what corrective action(s), both temporarily and permanently, will be taken:** **Started 06.18.13: Director of Nursing Services with the Health Information Management Coordinator completed a diagnostic lab audit on 6.18.13 on all resident charts – no physician order or laboratory issues identified. Director of Nursing Services with Staff Development Coordinator completed an in-service on 6.24.13 with licensed nursing personnel on the accurate receiving and carrying out of physician orders including, but not limited to laboratory tests in order to provide care and services for residents' highest well being. This in-service provided personnel with education on assuring the deficient practice is corrected and does not reoccur.** **C. What immediate measures will be put into place and/or what systematic changes the facility will make to ensure the deficient practice does not recur:** **Started 06.18.13 and Daily/Weekly/Monthly: During weekday reviews of physician orders, Director of Nursing Services assures that physician orders are necessary, complete, and being appropriately carried out. During weekday reviews of laboratory tests,**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A137	A. BUILDING _____ B. WING _____	06/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL PARK A CENTER OF EFFECTIVE LIVING	1425 LAUREL AVENUE POMONA, CA 91767

(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 309	Continued From page 10 The Minimum Data Set (MDS), a standardized assessment and care planning tool, dated April 13, 2013, indicated that the resident was highly impaired in her hearing and had no speech, but was able to complete the brief interview for mental status, able to understand others and make himself understood, and independent in activities of daily living. The MDS further indicated that the resident had hallucinations, delusions, and physical and verbal behavioral symptoms directed toward others and other behavioral symptoms not directed toward others occurring one to three days a week. According to the MDS, the resident received antipsychotic medications during the last seven days. During an interview on June 14, 2013, at 3 p.m., the medical records designee reviewed the clinical record and was unable to find documented evidence that the EKG test was completed in July of 2012 or January of 2013 as ordered by the physician. On June 18, 2013, at 7:20 a.m., during an interview, the director of nursing (DON) stated that the EKG test was a one time order and the staff entered the order in the computer incorrectly. The DON further stated that there was no documentation in the physician's progress notes indicating the need to perform the test every six months. However, the DON was unable to find documented evidence that the resident's physician was called to clarify the EKG order since April 2012. The facility's policy and procedure titled "Medically Related Contract/Agreement Services"	F 309	**Director of Nursing Services assures that physician ordered laboratory tests are completed. Identified issues are promptly corrected with necessary counseling and education of licensed nursing personnel. As needed, Director of Nursing Services with the Staff Development Coordinator coordinates and completes in-services with licensed nursing personnel on accurate receiving and carrying out of physician orders including but not limited to laboratory tests in order to provide care and services for residents' highest well being.** **D. How the facility plans to monitor its performance to make sure that solutions are sustained (description of the monitoring process and positions responsible for monitoring). 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:** **Starting 06.18.13 and Weekly: During the weekly Clinical At Risk Evaluation/Facility Rounds and Stand-Up Meeting, Director of Nursing Services and Health Information Management Coordinator, as members of the Performance Improvement Committee, bring forward identified issues (through their completed audits and reviews of resident health records) related to the provisions of care and services to meet residents' highest well being including, but not limited to, physician orders and laboratory tests. Performance Improvement Committee continues with necessary follow through to address identified issues. During monthly facility visits, Manager of Clinical Operation, as a member of the Performance**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A137	A. BUILDING _____ B. WING _____	06/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL PARK A CENTER OF EFFECTIVE LIVING	1425 LAUREL AVENUE POMONA, CA 91767

(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 309	Continued From page 11 dated January 2009, indicated that the facility will provide contracted/agreement services which are not routinely provided by the facility to meet the needs of each resident. The licensed nurse/designee will obtain the services as ordered by the physician and will notify the physician of any findings related to medication and treatment orders, laboratory tests, radiological procedures and hospice services conducted as part of the resident's overall plan of care.	F 309	**Improvement Committee, completes monthly reviews of the facility's clinical practices including, but not limited to, carrying out of physician orders. This includes providing the nursing department operation recommendations and assuring the nursing department follows up on such recommendations. All above stated weekly and monthly Performance Improvement actions are reviewed, at least quarterly, by the Performance Improvement Committee for success, areas of improvement, and necessary future action. As needed, the Director of Nursing Services with the Staff Development Coordinator coordinates and completes in-services with licensed personnel on the accurate receiving and carrying out of physician orders including, but not limited to, laboratory tests in order to provide care and services for residents' highest well being.**	
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, the facility failed to ensure that it was free of a medication error rate of five percent or greater. During the medication pass observation, four medication errors were observed out of 46 opportunities for errors, to yield a facility medication error rate of 8.6 percent. Findings: a. During a medication pass observation on June 13, 2013, at 11:10 a.m., licensed vocational nurse (LVN) 1 was observed as she pre-poured the medications of multiple residents in the medication room. Another staff was observed pre-pouring juice and water in multiple five ounces plastic cups for residents to drink during	F 332 F 332 SS E 483.25 (m)(1) pages: 12-15	**F 332; SS=E; 483.25(m)(1)** **FREE OF MEDICATION ERROR RATES OF 5% OR MORE** **A. What and how corrective action(s) will be accomplished, both temporarily and permanently, for those patients, employees, and/or facility operations identified/found to have been affected by the deficient practice;** **a.1) Starting 06.18.13: Director of Nursing Services reviewed resident 3's medical record, identified physician order (medication), and identified medication administration record. Determined licensed nursing personnel did not mix Metamucil powder with at least 8 ounces of water or other fluid as ordered. Director of Nursing Services assessed resident 3 – no adverse effects. Director of Nursing contacted prescribing physician – no new orders**	**7.03.13** **E. Dates when corrective action will be completed:**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A137	A. BUILDING _____ B. WING _____	06/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL PARK A CENTER OF EFFECTIVE LIVING	1425 LAUREL AVENUE POMONA, CA 91767

(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 332	Continued From page 12 the medication pass. At 11:30 a.m., during further observation, multiple residents were observed lining up in the corridor outside of the nursing station dutch door, waiting to receive their medications. As LVN 1 administered the medications, she asked each resident if he/she preferred water or juice with his/her medications. On June 13, 2013, at 11:55 a.m., during the medication pass, LVN 1 was observed mixing one teaspoon (tsp) of Metamucil in one of the pre-poured cups with five ounces (oz) of water and administering it to Resident 3. At 12:04 p.m., LVN 1 was also observed mixing one tablespoon (tbsp) of Metamucil in one of the pre-poured cups with five oz of juice and administering it to Resident 4. During further observation of the medication pass on June 13, 2013, at 12 p.m. a randomly selected resident (RSR 13), asked LVN 1 for her inhaler. According to LVN 1, RSR 13 gets Combivent Inhaler two puffs as needed. LVN 1 was then observed shaking the Combivent canister and handing it to RSR 13. RSR 13 administered 2 puffs into her mouth, one puff after the other, in the presence of LVN 1. The medication label on the Combivent canister indicated to wait two minutes in between puffs. However, LVN 1 failed to stop and instruct RSR 13 to hold and wait two minutes before taking the second puff. On June 13, 2013, at 12 p.m., during another medication pass observation, LVN 1 shook and handed the ProAir inhaler to RSR 12. In the presence of LVN 1, RSR 12 administered 2 puffs into her mouth, without waiting one minute in between puffs. The medication label on the	F 332	**provided. Director of Nursing Services ordered and supplied required 8-ounce cups to licensed nursing personnel for future use of mixing Metamucil powder.** **a.2) Starting 06.18.13: Director of Nursing Services reviewed resident 4's chart, identified physician order (medication), and identified medication administration record. Determined that licensed nursing personnel did not mix Metamucil powder with at least 8 ounces of water or other fluid as ordered. Director of Nursing Services assessed resident 4 – no adverse effects. Director of Nursing contacted prescribing physician – no new orders provided. Director of Nursing Services ordered and supplied required 8-ounce cups to licensed nursing personnel for future use of mixing Metamucil powder.** **a.3) Starting 06.18.13: Director of Nursing Services reviewed resident 13's chart, identified physician order (medication), and identified medication administration record. Determined that licensed personnel did not wait approximately two minutes between puffs as ordered. Director of Nursing Services assessed resident 13 – no adverse effects. Director of Nursing contacted prescribing physician – no new orders provided. Director of Nursing Services and the Staff Development Coordinator completed in-service on 6.24.13 with all licensed nursing personnel regarding following physician orders and proper medication administration.** **a.4) Starting 06.18.13: Director of Nursing Services reviewed resident 12's chart, identified physician order (medication), and identified medication administration record. Determined that licensed personnel did not wait approximately one minute between**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A137	A. BUILDING _____ B. WING _____	06/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL PARK A CENTER OF EFFECTIVE LIVING	1425 LAUREL AVENUE POMONA, CA 91767

(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 332	Continued From page 13 ProAir canister indicated to wait one minute in between puffs. However, LVN 1 failed to stop and instruct RSR 12 to hold and wait one minute before taking the second puff. Upon reconciliation with the physician's orders, the orders revealed the following: 1. For Resident 3, a physician's order dated September 30, 2011, indicated to administer Metamucil powder one tsp by mouth three times a day with eight oz of water for colonic atony. 2. For Resident 4, a physician's order dated May 15, 2011, indicated to administer Metamucil powder one tbsp by mouth three times a day with eight oz of water for colonic atony (an intestinal condition). 3. For RSR 13, a physician's order dated June 3, 2013, indicated to administer Combivent 18-103 mcg/act aerosol inhalation two puffs every four hours as needed (PRN) for chronic airway obstruction. 4. For RSR 12, a physician's order dated December 1, 2011, indicated to administer Albuterol inhalation two puffs three times a day for chronic airway obstruction. During an interview on June 14, 2013, at 8:55 a.m., LVN 1 stated that she usually only gives five oz of water or juice with medication administration, unless a resident asks for more fluids. LVN 1 further stated that she did not know she had to give at least eight ounces of water with the Metamucil powder. Additionally, during the same interview, LVN 1 stated that she did not know she had to wait two minutes in between puffs of the Combivent and one minute in between puffs of the ProAir.	F 332	**puffs as ordered. Director of Nursing Services assessed resident 12 – no adverse effects. Director of Nursing contacted prescribing physician – no new orders provided. Director of Nursing Services and the Staff Development Coordinator completed in-service on 6.18.13 with all licensed nursing personnel regarding following physician orders and proper medication administration.** **B. How the facility will identify other patients, employees, and/or facility operations having the potential to be affected by the same deficient practice and what corrective action(s), both temporarily and permanently, will be taken:** **a.1-4) Starting 06.18.13: Director of Nursing Services completed 5 random medication pass reviews to ensure physician orders were followed and proper medication administration occurred – no issues identified. Director of Nursing Services and the Staff Development Coordinator completed an in-service on 6.18.13 with licensed nursing personnel regarding following physician orders and proper medication administration. This in-service provided personnel with education on assuring the deficient practice is corrected and does not reoccur.** **C. What immediate measures will be put into place and/or what systematic changes the facility will make to ensure the deficient practice does not recur:** **a.1-3) Starting 06.18.13 and weekly/monthly: During monthly reviews of medication administration record, Director of Nursing Services continues to assure licensed personnel carry out physician orders accurately and follow proper medication administration through the completion of**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A137	A. BUILDING _____ B. WING _____	06/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL PARK A CENTER OF EFFECTIVE LIVING	1425 LAUREL AVENUE POMONA, CA 91767

(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 332	Continued From page 14 During an interview on June 14, 2013, at 1:05 p.m., the director of nursing (DON) stated that the staff uses five oz cups during medication pass because that is the only supply of cups available in the facility. The DON further stated that the facility is already ordering 8 oz cups. A review of the manufacturer's instructions for use revealed the following: 1. For Metamucil, put one dose into an empty glass. Mix this product with at least 8 ounces (a full glass) of water or other fluid. Taking this product without enough liquid may cause choking. Stir briskly and drink promptly. If mixture thickens, add more liquid and stir. (Retrieved from http://dailymed.nlm.nih.gov/dailymed/lookup.cfm?setid=7fb350de-624d-4765-a777-6c7efebd2b28#nlm34068-7) 2. For Combivent Inhalation Aerosol, if the physician ordered to use more than one spray, wait approximately two minutes and shake the inhaler vigorously again for at least 10 seconds... (Retrieved from http://dailymed.nlm.nih.gov/dailymed/lookup.cfm?setid=504e0426-1f75-4007-a596-66628227c275#section-15.1) 3. For ProAir Inhalation Aerosol, if the physician ordered to use more than one spray, wait 1 minute and shake the inhaler again... (Retrieved from http://www.proairhfa.com/library/docs/ProAirDosecounter-Prescribing-Information-PA0512G-PE2557.pdf)	F 332	**medication administration competency validations of all licensed nursing personnel. As Needed, the Director of Nursing Services will coordinate the completion of medication administration competency validations with licensed nursing personnel to assure licensed nursing personnel carry out physician orders accurately and follow proper medication administration. Information Manager continues to complete medication administration record audits along with physician orders, in order to ensure physician orders are properly carried out. Director of Nursing Services and Staff Development Coordinator completed an in-service on 6.24.13 with licensed nursing personnel regarding following physician orders and proper medication administration.** **D. How the facility plans to monitor its performance to make sure that solutions are sustained (description of the monitoring process and positions responsible for monitoring). 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:** **a.1-3) Starting 06.18.13 and weekly: During the weekday Clinical At Risk Evaluation/Facility Rounds and Stand-Up Meeting, Director of Nursing Services and Health Information Manager, as members of the Performance Improvement Committee, bring forward identified issues (through their completed audits and reviews of resident health records) related to the provisions of care and services to meet residents' highest well-being including, but**	
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain	F 425		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A137	A. BUILDING _____ B. WING _____	06/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL PARK A CENTER OF EFFECTIVE LIVING	1425 LAUREL AVENUE POMONA, CA 91767

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 15 them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure accurate dispensing of all drugs by failing to clarify a medication label on the Lithium Carbonate bubble pack with the facility pharmacist and/or resident's physician for one randomly selected resident (RSR 14). The medication label on RSR 14's Lithium bubble pack indicated "take this med after a meal" and "take with food." This had the potential to cause a medication error. Findings: During a medication pass observation on June 13, 2013, at 11:10 a.m., licensed vocational nurse (LVN) 1 was observed as she pre-poured the	F 425 F 425 SS D 483.60 (a),(b) pages: 15-17	**not limited to, physician orders and medication administration. Performance Improvement Committee continues with necessary follow through to address identified issues. During monthly facility visits, Manager of Clinical Operations, as a member of the Performance Improvement Committee, completes monthly reviews of the facility's clinical practices including, but not limited to, physician orders and medication administration records. This includes providing the nursing department operation recommendations and assuring the nursing department follows up on such recommendations. All above stated weekly and monthly Performance Improvement actions are reviewed, at least quarterly, by the Performance Improvement Committee for success, areas of improvement, and necessary future action. As needed, Director of Nursing Services and the Staff Development Coordinator coordinates and completes in-services with licensed nursing personnel regarding following physician orders and proper medication administration.** **F 425; SS=D; 483.60(a),(b)** **PHARMACEUTICAL SVC – ACCURATE PROCEDURES, RPH** **A. What and how corrective action(s) will be accomplished, both temporarily and permanently, for those patients, employees, and/or facility operations identified/found to have been affected by the deficient practice:** **Starting 06.18.13: Director of Nursing Services reviewed resident 14's medical record, identified physician order (medication), and identified medication administration record. Determined licensed nursing personnel did not give identified**	7.03.13 **E. Dates when corrective action will be completed:**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A137	A. BUILDING _____ B. WING _____	06/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL PARK A CENTER OF EFFECTIVE LIVING	1425 LAUREL AVENUE POMONA, CA 91767

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 16 medications of multiple residents in the medication room. At 11:19 a.m., LVN 1 was observed as she poured one tablet of Lithium Carbonate 300 milligrams (mg) into a medication cup for RSR 14. The Lithium Carbonate bubble pack was observed with a label indicating "take this med after a meal" and "take with food." During further observation on June 13, 2013, at 11:30 a.m., multiple residents were observed lining up in the corridor outside of the nursing station dutch door, waiting to receive their medications. At 12:06 p.m., LVN 1 was observed as she administered the medications of RSR 14, including the Lithium Carbonate. Upon reconciliation with the physician's order, there was an order dated April 14, 2013, indicating to administer Lithium Carbonate 300 mg by mouth three times a day for schizoaffective disorder. However, the physician's order did not include that the Lithium Carbonate was to be taken after a meal and/or taken with food. On June 14, 2013, at 8:55 a.m., during an interview, LVN 1 reviewed the Lithium Carbonate medication label and stated that she will clarify the label and the timing of the medication with the resident's physician. According to LVN 1, the residents usually have their lunch meal around 12:15 p.m. During an interview on June 14, 2013, at 1:05 p.m., the director of nursing (DON) reviewed the medication label and stated she will clarify it with the pharmacist and will have the label corrected.	F 425	**medication as directed. Director of Nursing Services assessed resident 14 – no adverse effects. Director of Nursing contacted prescribing physician –new orders received on 6.14.13 to take identified medication "with food". Director of Nursing Services and the Staff Development Coordinator completed in-service on 6.24.13 with all licensed nursing personnel regarding following physician orders and proper medication administration.** **B. How the facility will identify other patients, employees, and/or facility operations having the potential to be affected by the same deficient practice and what corrective action(s), both temporarily and permanently, will be taken:** **Starting 06.18.13: Director of Nursing Services completed 5 random medication pass review to ensure physician orders were followed and proper medication administration occurred – no issues identified. Director of Nursing Services and the Staff Development Coordinator completed an in-service on 6.24.13 with licensed nursing personnel regarding following physician orders and proper medication administration. This in-service provided personnel with education on assuring the deficient practice is corrected and does not reoccur.** **C. What immediate measures will be put into place and/or what systematic changes the facility will make to ensure the deficient practice does not recur:** **Starting 06.18.13 and weekly/monthly: During monthly reviews of medication administration record, Director of Nursing Services continues to assure licensed personnel carry out physician orders accurately and follow proper medication**	
F 458	483.70(d)(1)(ii) BEDROOMS MEASURE AT	F 458		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A137	A. BUILDING _____ B. WING _____	06/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL PARK A CENTER OF EFFECTIVE LIVING	1425 LAUREL AVENUE POMONA, CA 91767

(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 458 SS=B	Continued From page 17 LEAST 80 SQ FT/RESIDENT Bedrooms must 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, interview and record review, the facility failed to ensure that 14 of 19 resident rooms met the 80 square feet (sq. ft.) per residents in multiple resident rooms. These 14 rooms consisted of nine 2-bed rooms and six 3-bed rooms. Findings: On June 12, 2013, between 7:30 a.m. and 8:45 a.m., during a general observation, the evaluator observed that 14 of the 19 resident rooms did not meet the requirement of 80 sq. ft. per residents in multiple resident rooms. These rooms were Rooms 3, 4, 5, 6, 7, 8, 9, 10, 12, 14, 16, 20, 21, 22, and 23. The evaluator noticed that the residents in these 14 resident rooms were able to move freely in their rooms, nursing staff had enough space to provide care to these residents, and there was space for the beds, chairs, and dressers. On June 12, 2013, at 8:55 a.m., the evaluator conducted an interview with the administrator regarding the 14 resident rooms that did not meet the requirement of 80 sq. ft. per residents in multiple resident rooms. The administrator stated that a room wavier would be submitted for these 14 resident rooms.	F 458	**administration through the completion of medication administration competency validations of all licensed nursing personnel. Health Information Manager continues to complete medication administration record audits along with physician orders, in order to ensure physician orders are properly carried out. As Needed, the Director of Nursing Services will coordinate the completion of medication administration competency validations with licensed nursing personnel to assure licensed nursing personnel carry out physician orders accurately and follow proper medication administration.** **D. How the facility plans to monitor its performance to make sure that solutions are sustained (description of the monitoring process and positions responsible for monitoring). 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:** **Starting 06.18.13 and weekly: During the weekday Clinical At Risk Evaluation/Facility Rounds and Stand-Up Meeting, Director of Nursing Services and Health Information Manager, as members of the Performance Improvement Committee, bring forward identified issues (through their completed audits and reviews of resident health records) related to the provisions of care and services to meet residents' highest well-being including, but not limited to, physician orders and medication administration. Performance Improvement Committee continues with necessary follow through to address**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A137	A. BUILDING _____ B. WING _____	06/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL PARK A CENTER OF EFFECTIVE LIVING	1425 LAUREL AVENUE POMONA, CA 91767

(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 458	Continued From page 18 On June 12, 2013, at 9:45 a.m., the evaluator reviewed the room waiver letter (dated June 12, 2013) for the 14 resident rooms. The room waiver letter indicated that these rooms had enough space for each resident's care, dignity and privacy. The waiver letter also indicated that these rooms were in accordance with the special needs of the residents, and would not have an adverse effect on the residents' health and safety or impedes the ability of any resident in the rooms to attain his or her highest practicable well-being. The room waiver showed the following: Rm # # of Beds Sq. Ft. 3 2 152 4 2 156 5 2 158 6 2 152 7 3 209 9 2 146 10 3 226 12 3 227 14 3 214 16 3 235 20 2 150 21 2 155 22 2 153 23 2 156 The minimum square footage for a 2-bed room is 160 sq. ft., and a 3-bed room is 240 sq. ft.	F 458	**identified issues. During monthly facility visits, Manager of Clinical Operations, as a member of the Performance Improvement Committee, completes monthly reviews of the facility's clinical practices including, but not limited to, physician orders and medication administration records. This includes providing the nursing department operation recommendations and assuring the nursing department follows up on such recommendations. All above stated weekly and monthly Performance Improvement actions are reviewed, at least quarterly, by the Performance Improvement Committee for success, areas of improvement, and necessary future action. As needed, Director of Nursing Services and the Staff Development Coordinator coordinates and completes in-services with licensed nursing personnel regarding following physician orders and proper medication administration.** **F 458; SS=B; 483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT** **A. What and how corrective action(s) will be accomplished, both temporarily and permanently, for those patients, employees, and/or facility operations identified/found to have been affected by the deficient practice:** **Administrator submitted and the Department accepted the annual "Program Flexibility Waiver regarding F 458 – 483.70(d)(1)(ii) Resident Rooms" letter to the Department for rooms #3, #4, #5, #6, #7, #9, #10, #12, #14, #16, #20, #21, #22, and #23.** **Starting 6/18/13 and daily: Facility personnel assure that the needs of residents in rooms #3, #4, #5, #6, #7, #9, #10, #12, #14, #16, #20, #21, #22, and #23 are fully met and**	**7.03.13** **E. Dates when corrective action will be completed:**
F 458		**F 458** **SS B** **483.70 (d)(1) (ii)** **pages: 17-19**		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional,	F 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A137	A. BUILDING _____ B. WING _____	06/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL PARK A CENTER OF EFFECTIVE LIVING	1425 LAUREL AVENUE POMONA, CA 91767

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 19 sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide a safe environment for the residents, visitors and staff, regarding hot water heaters. Two of eight hot water heaters which were unsecured and could be unsafe for residents, visitors and staff. Findings: On June 18, 2013, between 9:25 a.m. and 10:55 a.m., the evaluator and the maintenance supervisor conducted a general observation of the facility. There were a total of eight hot water heaters throughout the facility. At 9:50 a.m., the evaluator observed a 40-gallon hot water heater inside the hot water heater closet, at the doctor's office. Closer observation revealed that this hot water heater did not have wall straps, to secure it. At 10:45 a.m., the evaluator observed a 50-gallon hot water heater inside the laundry room. Closer observation revealed that this hot water heater did not have wall straps, to secure it. On June 18, 2013, at 11:10 a.m., the evaluator conducted an interview with the maintenance supervisor regarding these two hot water heaters. The evaluator mentioned that these two hot water heaters did not have wall straps to secure them, and could be accident hazards, in the event of an	F 465	**that no adverse effects to health, safety, or welfare exist for the residents occupying the rooms.** **B. How the facility will identify other patients, employees, and/or facility operations having the potential to be affected by the same deficient practice and what corrective action(s), both temporarily and permanently, will be taken:** **Rooms #8, #15, #17, #18, and #19 met the minimum square footage requirement.** **Facility personnel assure that the needs of residents in rooms are fully met and that no adverse effects to health, safety, or welfare exist for the residents occupying the identified rooms.** **C. What immediate measures will be put into place and/or what systematic changes the facility will make to ensure the deficient practice does not recur:** **Per the request of the Department, Administrator submits the annual "Program Flexibility Waiver regarding F 458 – 483.70(d)(1)(ii) Resident Rooms" letter to the Department for rooms #3, #4, #5, #6, #7, #9, #10, #12, #14, #16, #20, #21, #22, and #23.** **Facility personnel assure that the needs of residents in rooms are fully met and that no adverse effects to health, safety, or welfare exist for the residents occupying the identified rooms.** **D. How the facility plans to monitor its performance to make sure that solutions are sustained (description of the monitoring process and positions responsible for monitoring). 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**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A137	A. BUILDING _____ B. WING _____	06/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL PARK A CENTER OF EFFECTIVE LIVING	1425 LAUREL AVENUE POMONA, CA 91767

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 20 earthquake. The maintenance supervisor stated he would make sure that wall straps would be applied to these hot water heaters, as soon as possible.	F 465	assurance system: During weekday Clinical at Risk Evaluation/Facility Rounds and Stand-Up Meetings, Administrator, as a member of the Performance Improvement Committee, reviews that corrective actions are and achieved and sustained for resident rooms. Performance Improvement Committee develops and implements necessary corrections for identified issues related to the meeting of residents' needs. All above stated weekly Performance Improvement actions are reviewed, at least quarterly, by the Performance Improvement Committee for success, areas of improvement, and necessary future action. F 465; SS=E; 483.70(in-service) SAFE/FUNCTIONAL/SANITARY/ COMFORTABLE ENVIRONMENT A. What and how corrective action(s) will be accomplished, both temporarily and permanently, for those patients, employees, and/or facility operations identified/found to have been affected by the deficient practice: Starting 06.18.13: Plant Operations Supervisor coordinated the installation of wall straps and securing of the water heaters in both the doctor's office closet and the laundry room on 6.18.13. Administrator coordinated and completed an in-service with Plant Operations Supervisor on 6.18.13 on the identification and correction of necessary plant maintenance including, but not limited to, ensuring all water heaters are properly secured with wall strap. This in-service provided personnel with education on assuring the deficient practice is corrected and does not reoccur. B. How the facility will identify other patients, employees, and/or facility	7.03.13 E. Dates when corrective action will be completed: