DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 05A137 B. WING

NTE**O**: 07/16/2013 **FORM APPROVED** OMB NO. 0938-0391

(X3) DATE SURVEY COMPLETED 06/18/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1425 LAUREL AVENUE LAUREL PARK A CENTER OF EFFECTIVE LIVING **POMONA, CA 91767** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID. (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE CATE TAG TAG **DEFICIENCY**) F 000 INITIAL COMMENTS F 000 "This Plan of Correction is prepared and submitted as required by law, The following reflects the findings of the submitting this Plan of Correction, Laurel Department of Public Health during a Park does not admit that the deficiency RECERTIFICATION Survey and Entity Reported listed on this form exist, nor does Laurel Incident (ERI) Investigations. Park admit to any statements, findings, facts, or conclusions that form the basis for Intake Number: (Total 15) the alleged deficiency. Laurel Park reserves the right to challenge in legal and/or 1. CA00358062 - Substantiated with no regulatory regulatory or administrative proceedings the deficiency, statements, facts, and conclusions deficiencies that form the basis for the deficiency." Category: Patient to Patient Abuse Robert B. Barton 2. CA00355315 - Substantiated with no regulatory deficiencies Robert B. Barton Category: Patient to Patient Abuse F 165; SS=E; 483.10(f)(1) 3. CA00357883 - Substantiated with no regulatory 165 TO VOICE RIGHT GRIEVANCES Dates deficiencies WITHOUT REPRISAL when SS A. What and how corrective action(s) will Category: Patient to Patient Abuse correc-E be accomplished, both temporarily and tive permanently, for those patients, employees, action 4. CA00365335 - Substantiated with no 483.10 and/or facility operations identified/found to will be regulatory deficiencies have been affected by the deficient practice 32 (f)(1)com-Category: Patient to Patient Abuse Starting 06.18.13: Social Service Design interviewed resident 15 and resident 16 5. CA00357891 - Substantiated with no regarding the identified missing item Dages: regulatory deficiencies Social Service Designee initiated a customic 03-04 Category: Patient to Patient Abuse first concern/grievance form for books residents and confirmed through a review of both inventory logs in the residents' chare 6. CA00355030 - Substantiated with no that both residents initially came into the regulatory deficiencies facility with the items both resident 15 and Category: Patient to Patient Abuse 16 stated were missing. Social Service: Designee under the coordination of the 7. CA00357170 - Substantlated with no Administrator, replaced identified missing regulatory deficiencies items for both residents on 6.18.13. Social Category: Resident Safety/Falls Service Designee implemented the customer first concern/grievance log on 6.18.13. 8. CA00355132 - Substantiated with no Administrator coordinated and completed requiatory deficiencies

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Administrator

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 A. BUILDING				(X3) DATE SURVEY COMPLETED	
		05A137	B. WING	······································		06	/18/2013	
	ROVIDER OR SUPPLIER	OF EFFECTIVE LIVING		1425 LAUR	RESS, CITY, STATE, ZIP CODE REL AVENUE I, CA 91767		nonde, , , ,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	× cre	PROVIDER'S PLAN OF CORREI EACH CORRECTIVE ACTION SHO DSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 000	deficiencies Category: Patient 10. CA00354642 regulatory deficie. Category: Reside 11. CA00355298 regulatory deficie. Category: Patient 12. CA00352858 regulatory deficie Category: Patient 13. CA00355309 regulatory deficie Category: Patient 14. CA00352860 regulatory deficie Category: Patient 15. CA 0035552 regulatory deficie Category: Patient 15. CA 0035552 regulatory deficie Category: Patient	to Patient Abuse Substantiated with no regulatory to Patient Abuse - Substantiated with no noises in Safety - Substantiated with no noises to Patient Abuse - Department of Public Health: 80 174 179	F	an in-se 6.18.13 regardi resoluti first resident not lin resident docume governi provide assurin and doc B. H patient operati by the correcti perman Startin and P complet person procedi all resident governi reporti theft/loc concert services with e practice C. Wi into pli the faci practice Startin startin services startin services services startin services startin services services startin services services services services services services startin services	enting accordingly on the ment meeting minutes. This is personnel with educing the deficient practice is it is not reoccur. The session reoccur, will identify a member of the facility will identify and the potential to be same deficient practice a live action(s), both temportently, will be taken: g 06.18.13: Social Service rogram Director coordinated an in-service with mel on 6.24.13 on the polares regarding issuing and ident concerns/grievances to limited the ft/loss. Social see completed an in-service its during the following ment meeting on 07.05.13 and concerns/grievances	rocedures view and customer discussing ading but monthly gs and resident in-service ation on corrected tify other facility reaffected and what arily and Designee ated and facility licies and reporting including I Services with all resident regarding including resident l'hese in- residents deficient recocur. till be put c changes e deficient		

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		05A137	B WING			06/	18/2013
	ROVIDER OR SUPPLIER PARK A CENTER O	F EFFECTIVE LIVING		14	EET ADORESS, CITY, STATE, ZIP CODE 125 L AUREL AVENUE OMONA, CA 91767		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	8E	COMPLETION DATE
F 000 F 165 SS=E	Highest Severity at 483.10(f)(1) RIGH' WITHOUT REPRISON A resident has a right discrimination or reinclude those with been furnished as furnished. This REQUIREME by: Based on group in the facility did not e grievances were produring the Group A Resident (RSR 15 of their personal ite residents stated the happened after the nursing staff. Findings: A Resident Group June 7, 2013, at 10 eight residents correctly residents set of about 2 weeks fror stated that they ha attention of the Nu without improvements.	Ind Scope: E If TO VOICE GRIEVANCES SAL. Ight to voice grievances without oprisal. Such grievances respect to treatment which has well as that which has not been If I is not met as evidenced Iterviews and record reviews, ensure that resident's romptly resolved. Specifically, Meeting, 2 Randomly Selected and 16) complained that some ensure missing. The at they did not know what ey reported the incidents to the Da.m. During the meeting, 2 of inplained of the following: 1. I that some pieces of his pieces disappeared from his in 3 months 2. Resident 16 fear buds also disappeared for in her closet. The residents of the residents to the ring Staff numerous times ent. The residents stated that		165	concerns/grievances and/or assist resis with obtaining and completing the custifirst concern/grievance form. Identification of issues, administrative supervisory staff counsel and edipersonnel. As needed, Administrator conduct in-services with Social Se Designee on the policies and proced regarding the implementation, review resolution of all grievances on the custifirst concern/grievance log, discursident concerns/grievances including not limited to theft/loss during the moresident government meeting documenting accordingly on the result government meeting minutes. This in-se will continue to provide personnel education on assuring the deficient presis corrected and does not reoccur. D. How the facility plans to monite performance to make sure that solution sustained (description of the monite process and positions responsible monitoring). The facility must devel plan for ensuring that correction is ach and sustained. This plan must implemented, and the corrective a evaluated for its effectiveness. The pl correction is integrated into the quassurance system: Starting 06.18.13 and Daily: During weekday Clinical At Evaluation/Facility Rounds and Stanted.	rvice the Staff s to and their dents poner Upon and ucate will rvice tures sing but nthly and ident rvice with actice ar its stare gring for leved top alieved the crise stare gring for alieved the crise crise stare gring for alieved the crise ar its stare gring for	
	•	ber who they reported the nymore and they were sure the			Meetings and during monthly fa	cility	and the control of th

	FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1 "	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY : COMPLETED	
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	ROVIDER OR SUPPLIER PARK A CENTER OF	EFFECTIVE LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 1425 LAUREL AVENUE POMONA, CA 91767			
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F 167	interviewed on June SSD stated that she personal items. A Resident Council M through May 2013, evidence that repor was reviewed with I evidence of the residence of the concerns/Grievand indicated "concerns about treating to lost personal property", resident personal property", resident personal powill be maintained in There was no evident include RSR 15 at 483.10(g)(1) RIGHT READILY ACCESS A resident has the intermost recent sur Federal or State su correction in effect.	Inything about it. Designee (SSD) was a 7, 2013, at 12 p.m. The e was unaware of the missing review of the Monthly leetings from February 2013 revealed no documented ting of missing personal items the residents or documented idents being educated ing items through grievance. I "Customer es" dated December 2009, ins and/grievances may be or in writing and may include atment, care, management of I items, or violation or rights." I policy titled "Resident indicated that" a log of all roperty items reported missing in the facility." ence that the facility had a log and 16's missing items. I TO SURVEY RESULTS -	F 1 167 F 1 5S C 483.10 (g)(1) pages: 04-06	resident council meetings, Social Designee, as a member of the Performprovement Committee, continuations facility resident concerns/grivith facility residents and will commit implement, review and resolve Performance Improvement Cocontinues with necessary follow the address identified issues. All above weekly Performance Improvement are reviewed, at least quarterly, Performance Improvement Commissuccess, areas of improvement necessary future action. As Administrator will conduct an invite Social Service Designee on the and procedures regarding implementation, review and resoluting rievances on the customer concern/grievance log, discussing concerns/grievances including be limited to theft/loss during the resident government meeting documenting accordingly on the government meeting minutes. F 167; SS=C; 483.10(g)(1) RIGHT TO SURVEY RESUREADILY ACCESSIBLE A. What and how corrective setto be accomplished, both temporar permanently, for those patients, emand/or facility operations identified/have been affected by the deficient p	rmance mes to evances tinue to weekly. mmittee ough to e stated actions by the tice for t, and needed, services policies the on of all first resident ut not monthly and resident LTS — (s) will ily and ployees, found to ractice; erations of the survey is year's I of the ents and	7.03.13 E. Dates when correc- tive action will be com- pleted;	

PRINTED: 07/16/2013 FORM APPROVED OMB NO. 0938-0391

	OF DEPOSITIONS	DENTIFICATION NUMBER:		E GUNSINGATION		E SURVET IPLETED
		05A137	8 WING		06/	18/2013
	PARK A CENTER O	F EFFECTIVE LIVING	1	REET ADDRESS, CITY, STATE, ZIP CODE 425 LAUREL AVENUE POMONA, CA 91767	***************************************	
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F 167	This REQUIREME by: Based on observa review, the facility survey results avai readily accessible had a sign that ind located inside the Findings: On June 12, 2013, a.m., the evaluator facility. At 7:40 a.m., the evai posted that indicat recertification surv nurses' station for and visitors." On June 13, 2013, group interview, se residents indicated the survey results would like to review On June 18, 2013 conducted an inter regarding posting residents. The adr posted a copy of the accessible to the re-	ation, interview and record failed to make the most recent lable for examination in a place to the residents. The facility icated the survey results were nursing station. between 7:30 a.m. and 8:45 conducted an initial tour of the valuator observed that the last not posted at the consumer non area for the residents. At it is most recent annual ey binder is located at the review by all staff, residents at 10:15 a.m., during the even of seven alert and oriented it that they did not know where were located and that they	F 167	will continue to provide an additional binder containing previous years results in the nursing station access staff, residents and visitors upon Regional Director of Programing in-Administrator on 6.18.13 regardit policies and procedures of assuring results are readily available to reside visitors. B. How the facility will identify patients, employees, and/or operations having the potential to be by the same deficient practice an corrective action(s), both temporar permanently, will be taken: Starting 06.18.13: Social Service I completed an in-service with all residents and visitors. C. What immediate measures will into place and/or what systematic the facility will make to ensure the opractice does not recur: Starting 06.18.13: Social Service I will continue to discuss with and in all residents regarding the two survey locations (nursing station and practice does not recur: Starting 06.18.13: Social Service I will continue to discuss with and in all residents regarding the two survey locations (nursing station and prailer office) during the mouthly government meetings. Plant Op Supervisor will continue to conduct facility visual audits including I limited to ensuring survey bind properly secured and in good corplant Operation Supervisor to repart as necessary. As needed, Regional of Programing in-services Admin regarding the policies and proced assuring survey results are readily at to residents and visitors.	survey sible to request. serviced ing the survey ents and y other facility affected d what illy and designee dents on binder program all staff, be put changes leficient Designee i-service y binder program resident erations is weekly but not ers are andition. ir issues Director nistrator lures of	

Facility ID: CA950000068

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDERSUPPLIERCLA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED
		05A137	8. WING		06/18/2013
	PARK A CENTER O	F EFFECTIVE LIVING		STREET ADDRESS, CITY, STATE, ZIP COD 1425 LAUREL AVENUE POMONA, CA 91767	
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	results should be no should not have to The administrator of the accessible to the be secured, to prevent the secured, to prevent the secured of the secured of the secured of the assessment of the accessment of	per pointed out that the survey readily accessible and residents ask staff for the survey results would be residents, and that it would be resident appropriate of the sign and certify reflect the repleted. The completes a portion of the resident and certify the accuracy of assessment. The Medicaid, an individual who resident assessment is oney penalty of not more than sessment; or an individual who resident assessment in a resident assessment and resident assessment are resident assessment are resident assessment are resident assessment and resident assessment are resident assessment and resident assessment are resident assessment are resident assessment and resident assessment are resident assessment are resident assessment are resident assessment as resident assessment are resident assessment are resident assessment as resident assessment are resident assessment as resident a	F 278 SS B	D. How the facility plans to performance to make sure that sustained (description of the process and positions responentioring). The facility must plan for ensuring that correction and sustained. This plan implemented, and the correevaluated for its effectiveness, correction is integrated into assurance system: Starting 06.18.13 and Monthly: weekday Clinical A Evaluation/Facility Rounds an Meetings, Administrator, as a m Performance Improvement continues to address facility ac survey results. Performance I Committee continues with nece through to address identified	monitoring onsible for if develop a is achieved must be extive action. The plan of the quality During the it Risk of Stand-Up ember of the Committee, cessibility to issues. All Performance wed, at least improvement areas of ature action. In the action or dinate and is service procedures arvey results led, Regional reliance in agarding the aring survey residents and residents a

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA LIDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING		E SURVEY IPLETED
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F 278	by: Based on observar review, the facility of Minimum Data Set assessment and cafor one of 11 samp in an inaccurate as history. Findings: A review of the Adrindicated that the refacility on February included schizoaffa illness), hypertensic osteoarthritis (joint stiffness, and inflancaused by wear and documentation date indicated that the rethrough the corrido COC documentation resident sustained documentation, the ordered to draw a lievel and comprehe a blood test that me electrolyte and fluid liver function) immediated (PRN) for inceded (PRN) for income COC documentation can be a blood test that me electrolyte and fluid liver function) immediated (PRN) for inceded (PRN) for income COC documentation can be a blood test that me electrolyte and fluid liver function) immediated (PRN) for inceded (PRN) for income COC documentation can be a blood test that me electrolyte and fluid liver function) immediated (PRN) for inceded (PRN) for income can be a blood test that me electrolyte and fluid liver function) immediated that the control of the co	NT is not met as evidenced tion, interview, and record ailed to ensure that the (MDS), a standardized are planning tool, was accurate led residents (1). This resulted sessment of the resident's fall esident was admitted to the 25, 2013, with diagnoses that citive disorder (a mental on (high blood pressure), and disorder causing pain, nemation of one or more joints disorder tell while walking r, landing on his buttock. The en further indicated that the no injuries. According to the physician was notified and athium (antimanic medication) ensive metabolic panel (CMP-easures your sugar level, I balance, kidney function, and ediately and change pressant) from routine to as	F 2 483.20 (g) – (J) pages: 06–09	be accomplished, both temporar permanently, for those patients, en and/or facility operations identified/ have been affected by the deficient p Starting #6.18.13: Director of Services/MDS Coordinator complem MDS quarterly modification resident 1's fall on 7.4.13. Admicampleted in-services/MDS Coordinator completed in-services/MDS Coordinated for the Director of timely completion of initial, quart annual MDS assessments related limited to resident falls. This is provides personnel with educa assuring the deficient practice is and does not reoccur. B. How the facility will identify patients, employees, and/or operations having the potential to be by the same deficient practice a corrective action(s), both tempora permanently, will be taken: Starting #6.18.13: Director of Services and the Health Info Management Coordinator complem MDS audit on all resident charts recurrate recording and timely contacting but not limited to resident no other issues identified. Administrator completed in-service	nployees. found to ractice: Nursing leted an egarding nistrator rector of ator on ling and but not n-service tion on corrected fy other facility affected nd what urity and Nursing ormation leted an egarding mpletion nt falls with the lees/MDS accurate of initial, lessments alls. This leducation lettice is	action will be com- pleted:

PRINTED: 07/16/2013 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED A BUILDING 05A137 B. WING 06/18/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1425 LAUREL AVENUE LAUREL PARK A CENTER OF EFFECTIVE LIVING POMONA, CA 91767 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 278 | Continued From page 7 F 278 the facility will make to ensure the deficient was found lying face first on the floor inside his practice does not recur: room. The COC documentation further indicated Starting 96.18.13 and Weekly: that the resident sustained a laceration on the weekly reviews of MDS assessments, bridge of his noise and was observed with Director of Nursing Services assures weakness and twitching. According to the accurate recording and completion of MDS documentation, the physician was notified and assessments. Health Information Manager ordered to send the resident to the acute care continues to audit MDS assessments to hospital for evaluation. ensure accurate completion. As needed, Administrator coordinates and completes in-A short term care plan dated May 20, 2013, services on the policies and procedures with the Director of Nursing Service, Program indicated that the resident fell on his buttocks in Director, Social Service Designee and the the corridor. The short term care plan goal Activity Director regarding the accurate indicated that the resident will not incur additional recording and timely completion of MDS falls and his personal safety will be assured. The assessments. This in-service provides listed nursing interventions included to arrange personnel with education on assuring the for labs as ordered by the physician and report deficient practice is corrected and does not abnormals promptly, monitor the resident for reocent. possible side effects of medications, balance, D. How the facility plans to monitor its gait, involuntary movements, weakness, body performance to make sure that solutions are control, cognitive status PRN and report sustained (description of the monitoring process and positions responsible for abnormals to the physician promptly, and monitoring). The facility must develop a complete a pain assessment PRN. plan for ensuring that correction is achieved This plan must be and sustained. The MDS dated June 3, 2013, indicated that the implemented, and the corrective action resident was highly impaired in his hearing with evaluated for its effectiveness. The plan of unclear speech, but was able to complete the correction is integrated into the quality brief interview for mental status, able to assurance system: understand others and make himself understood. Starting 06.18.13 and Daily: During the and independent in activities of daily living. The Clinical Risk weekday At MDS further indicated that the resident had Evaluation/Facility Rounds and Stand-Up

assessment.

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

MDS

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

assessments.

Performance

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	:	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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F 278	p.m., the director of the MDS nurse, revithat the resident's false occided on the that she will double residents with falls corrections. The facility's policy "Assessment" date the MDS nurse coording assessment according assessment according delines. The MD guidelines to priorit problems/concerns care plan interventi Team assesses ear if there has been condition. According to the Refinstrument (RAI) Midentification of resident's near the re	on June 18, 2013, at 2:10 If nursing (DON) who is also viewed the MDS and stated alls and injury should have MDS. The DON further stated check the MDS of all and make the necessary and procedure titled d January 2008, indicated that ordinates the interdisciplinary the resident's comprehensive ding to the RAI process and to determine appropriate ons. The Interdisciplinary ch resident quarterly, annually, a significant change of esident Assessment lanual Version 3.0, idents who are at high risk of ity for care planning. A most important predictor of risk ill should stimulate evaluation and for rehabilitation, odification of the physical ditional monitoring. The RAI cated to code 1 (yes) under e resident has fallen since the en determine the number of since admission or prior ode the level of fall-related	F309 SS D 483.25 pages: 09-12	Improvement Committee continuecessary follow through to identified issues. During monthly visits, Manager of Clinical Operations of the Performance Imp Committee, completes monthly respectively a completed to, accurate recording a completion of MDS assessments, includes providing nursing desoperation recommendations and nursing department follows up recommendations. All above states and monthly Performance Improvement of for success, areas of improvement of for success, areas of improvement of for success, areas of improvement of services with the Director of Service, Program Director, Social Designee and the Activity Director policies and procedures regarding recording and timely completion assessments. F 309; SS=D; 483.25 PROVIDE CARE/SERVICES HIGHEST WELL BEING A. What and how corrective active accomplished, both temporal permanently, for those patients, eand/or facility operations identified have been affected by the deficient Started 06.18.13; Director of Services reviewed resident 8's charsommaries, identified physician of identified physician order by a EKG test every six months. Director of Services reviewed resident 8's charsommaries, identified physician order by a EKG test every six months.	address facility ons, as a ovement views of ding, but ad timely This artment, assuring on such d weekly ovement terly, by ommittee ent, and needed, pletes in- Nursing Service r on the accurate of MDS FOR m(s) will city and aployees, found to cractice: Nursing t, weekly der, and licensed rry out cheduling	7.04.13 Dates when corrective action will be completed:	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	• 1		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		Q5A137	B. WING			06/	18/2013
	ROVIDER OR SUPPLIER PARK A CENTER OF	EFFECTIVE LIVING		14	REET ADDRESS, CITY, STATE, ZIP CODE 425 LAUREL AVENUE POMONA, CA 91767		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 309 SS=D	Each resident mus provide the necess or maintain the high mental, and psyche accordance with the and plan of care. This REQUIREME by: Based on observativew, the facility of for one of 11 samp potential to cause a necessary care and abnormal test. Findings: A review of the Addindicated that the refacility on July 8, 20 included chronic somental condition the contact with reality problems), borderlichly problems), borderlichly endicated to a physical 2012, indicated to	t receive and the facility must cary care and services to attain thest practicable physical, osocial well-being, in a comprehensive assessment. NT is not met as evidenced tion, interview, and record staff failed to follow the complete an (EKG- a test that records the the heart) every six months led residents (8). This had the adelay in providing the direatment in an event of an existent was admitted to the copy, with diagnoses that chizoaffective disorder (a lat causes both a loss of (psychosis) and mood ine personality disorder, and blood pressure).		309	Nursing Services assessed resident 8 adverse effects. Director of Nursing Secontacted ordering physician and recorders to discontinue identified EKG of Director of Nurses with Staff Develop Coordinator completed an in-service 6.24.13 with nursing personnel or policies and procedures regarding phy orders and ancillary services. B. How the facility will identify patients, employees, and/or for operations having the potential to be affective action(s), both temporarily permanently, will be taken: Started 06.18.13: Director of Nu Services with the Health Inform Management Coordinator complete diagnostic lab audit on 6.18.13 or resident charts — no physician orders including, but not liboratory issues identified. Direct Nursing Services with Staff Develop Coordinator completed an in-service 6.24.13 with licensed nursing personate accurate receiving and carrying ophysician orders including, but not libo laboratory tests in order to provide and services for residents' highest being. This in-service provided perswith education on assuring the depractice is corrected and does not reocc. What immediate measures will into place and/or what systematic charts does not recur: Started 06.18.13 and Daily/Weekly/Moduring weekday reviews of physician of Director of Nursing Services assures physician orders are necessary, con and being appropriately carried out.	rvices reived profer. profer. profer other reility fected what raing nation ed a n all er or or of profer pout of amited e care well reient ear, tel on out of amited care well reient ear, tel put tenses ficient unitaly: rders, that uplete, buring	
		and January (indication for	O. OOLOOMIA MINIS		weekday reviews of laboratory		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		RE SURVEY
		05A137	B. WING	www.	06/	18/2013
	PARK A CENTER OF	EFFECTIVE LIVING	1	REET ADDRESS, CITY, STATE, ZIP GODE 1425 LAUREL AVENUE POMONA, CA 91767		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (FACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(XS) COMPLETION DATE
F 309	The Minimum Data assessment and considered in her heat was able to complemental status, able make himself under activities of daily live that the resident heat and physical and volve directed toward of the symptoms not directed toward of the resident received during the last several during an interview the medical record clinical record and documented evider completed in July cordered by the phy. On June 18, 2013, interview, the directed the physician the physician was called since April 2012. The facility's policy	a Set (MDS), a standardized are planning tool, dated April I that the resident was highly aring and had no speech, but at the brief interview for to understand others and arstood, and independent in ring. The MDS further indicated at hallucinations, delusions, arbal behavioral symptoms are and other behavioral cted toward others occurring a week. According to the MDS, and antipsychotic medications are days. I on June 14, 2013, at 3 p.m., as designee reviewed the was unable to find ince that the EKG test was of 2012 or January of 2013 as		Director of Nursing Services assuphysician ordered laboratory to completed. Identified issues are a corrected with necessary counsel education of licensed nursing person needed, Director of Nursing Servithe Staff Development Coocoordinates and completes in-servilicensed nursing personnel on receiving and carrying out of a porders including but not limitaboratory tests in order to provide services for residents' highest well but how the facility plans to mother performance to make sure that solus austained (description of the material process and positions responsimonatoring). The facility must deplan for ensuring that correction is and sustained. This plan of implemented, and the corrective evaluated for its effectiveness. The correction is integrated into the assurance system: Starting 06.18.13 and Weekly: Duweekly Clinical At Risk Evaluation Rounds and Stand-Up Meeting, Di Nursing Services and Health Info Management Coordinator, as mentise Performance Improvement Cobring forward identified issues their completed audits and recessions of care and services residents' bighest well being included to physician order indicatory tests. Performance Improcessor timited to, physician order indocatory tests. Performance Improcessant throught facility visits, Manager of Operation, as a member of the Performantly facility visits, Manager of Operation, as a member of the Performance Improcessor of the Performance of the Perfo	sts are promptly ing and inel. As ces with relinator ces with accurate physician ited to care and ping. Ited to care and ping. Ited for exclor its tions are politoring ble for exclor of quality ring the plan of quality rector of promation in the ping the ping the ping to the to meet ling, but ers and exement by follow During Clinical	

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A BUILDING			(XS) DATE SURVEY COMPLETED	
		05A137	B. WING		06/	18/2013	
	ROVIDER OR SUPPLIER PARK A CENTER O	F EFFECTIVE LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 1425 LAUREL AVENUE POMONA, CA 91767			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	D PREFI TAG		LO BE	(X6) COMPLETION DATE	
F 309 F 332 S5=E	dated January 200 provide contracted not routinely provide needs of each resinurse/designee will ordered by the phyphysician of any fir and treatment ordered proceducted as part care. 483.25(m)(1) FRE RATES OF 5% OF	IP, indicated that the facility will lagreement services which are led by the facility to meet the ident. The licensed il obtain the services as risician and will notify the indings related to medication ers, laboratory tests, fures and hospice services of the resident's overall plan of		Improvement Committee, comouthly reviews of the facility's practices including, but not limit carrying out of physician orders, includes providing the nursing department follows uperecommendations and athe nursing department follows uperecommendations. All above stated and monthly Performance Improvement Confor success, areas of improvement for success, areas of improvement necessary future action. As need Director of Nursing Services with the Development Coordinator coordinate completes in-services with licensed poon the accurate receiving and carrying physician orders including, but not to, laboratory tests in order to proviand services for residents' higher being.	This This partment assuring on such d weekly ovement terly, by ommittee ent, and ded, the the Staff ates and versonnel ing out of t limited vide care	7.03.13	
	by: Based on observereview, the facility of a medication engreater. During the four medication error redication error redications of mumedication room.	etion, interview, and record failed to ensure that it was free for rate of five percent or emedication pass observation, rors were observed out of 46 frors, to yield a facility ate of 8.6 percent. Attion pass observation on June a.m., licensed vocational nurse rived as she pre-poured the attiple residents in the Another staff was observed and water in multiple five os for residents to drink during	F 332 SS E 483.25 (m)(1) pages: 12-15	F 332; SS=E; 483.25(m)(1) FREE OF MEDICATION ERROR OF 5% OR MORE A. What and how corrective action be accomplished, both temporari permanently, for those patients, em and/or facility operations identified/ have been affected by the deficient pr a.1) Starting 06.18.13: Director of Services reviewed resident 3's record, identified physician (medication), and identified me administration record. Determined nursing personnel did not mix Ma powder with at least 8 ounces of v other fluid as ordered. Director of Services assessed resident 3 – no effects. Director of Nursing of prescribing physician – no new	n(s) will ly and ployees, jound to actice: Norsing medical order dication licensed etamucil vater or Nursing adverse	E. Dates when correc- tive action will be com- pleted:	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		É SURVEY PLETED
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	· · · · · · · · · · · · · · · · · · ·	F EFFECTIVE LIVING	1	REET ADDRESS, CITY, STATE, ZIP CODE 1425 LAUREL AVENUE POMONA, CA 91767	***************************************	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(XS) COMPLETION DATE
F 332	observation, multiplining up in the constation dutch door, medications. As LY medications, she apreferred water or On June 13, 2013, medication pass, Lone teaspoon (tsp) pre-poured cups wand administering LVN 1 was also ob (tbsp) of Metamuc with five oz of juice Resident 4. During further observed shaking than the presence of LVN 1 haler two puffs a observed shaking thanding it to RSR puffs into her mout the presence of LVN the Combivent can minutes in betwee to stop and instruction pass of handed the ProAir presence of LVN 1 into her mouth, with into her mouth, with the presence of LVN 1 into her mouth, with the presence of LVN 2 into her mouth, with the presence of LVN 2 into her mouth, with the presence of LVN 2 into her mouth, with the presence of LVN 2 into her mouth, with the presence of LVN 2 into her mouth, with the presence of LVN 2 into her mouth, with the presence of LVN 2 into her mouth, with the prese	is. At 11:30 a.m., during further ille residents were observed ridor outside of the nursing waiting to receive their /N 1 administered the isked each resident if he/she juice with his/her medications. at 11:55 a.m., during the into line of the interest of the interest of the ith five ounces (oz) of water into Resident 3. At 12:04 p.m., is served mixing one tablespoon ill in one of the pre-poured cups and administering it to revalid of the medication pass at 12 p.m. a randomly selected asked LVN 1 for her inhaler. 1, RSR 13 gets Combivent is needed. LVN 1 was then the Combivent canister and 13. RSR 13 administered 2 th, one puff after the other, in /N 1. The medication label on inster indicated to wait two in puffs. However, LVN 1 failed the RSR 13 to hold and wait two ing the second puff. at 12 p.m., during another been valued on making one minute in medication label on the medi	F 332	provided. Director of Nursing ordered and supplied required 8-out to licensed nursing personnel for further of mixing Metamucil powder. a.2) Starting 96.18.13: Director of Services reviewed resident 4's identified physician order (medication administration Determined that licensed aursing public duot mix Metamucil powder with 8 ounces of water or other fluid as Director of Nursing Services resident 4 no adverse effects. Director of Nursing Services resident 4 no adverse effects. Director of Nursing Services resident 8-ounce cups to licensed personnel for future use of Metamucil powder. a.3) Starting 96.18.13: Director of Services reviewed resident 13's identified physician order (medication identified medication administration Determined that licensed personnel wait approximately two minutes puffs as ordered. Director of Services assessed resident 13 no effects. Director of Nursing eprescribing physician no new provided. Director of Nursing Services to Staff Development Concompleted in-service on 6.24.13	Nursing chart, on), and record. ersonnel at least ordered. assessed rector of supplied nursing mixing Nursing chart, ion), and record. I did not between Nursing adverse contacted return of supplied nursing mixing Nursing adverse contacted return orders vices and ordinator with all regarding proper Nursing s chart, ion), and n record. I did not	

PRINTED: 07/16/2013 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER. COMPLETED A BUILDING 05A137 B. WING 06/18/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1425 LAUREL AVENUE LAUREL PARK A CENTER OF EFFECTIVE LIVING **POMONA, CA 91767** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID Ð (X2) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY F 332 | Continued From page 13 F 332 puffs as ordered. ProAir canister indicated to wait one minute in Director of Nursing Services assessed resident 12 - no adverse between puffs. However, LVN 1 failed to stop and effects. Director of Nursing contacted instruct RSR 12 to hold and wait one minute prescribing physician - no new orders before taking the second puff. provided. Director of Nursing Services and Staff Development Coordinator Upon reconciliation with the physician's orders, completed in-service on 6.18.13 with all the orders revealed the following: licensed nursing personnel regarding 1. For Resident 3, a physician's order dated following physician orders and proper September 30, 2011, indicated to administer medication administration. How the facility will identify other Metamucil powder one top by mouth three times employees, and/or facility patients. a day with eight oz of water for colonic atony. operations having the potential to be affected 2. For Resident 4, a physician's order dated May by the same deficient practice and what 15, 2011, indicated to administer Metamucil corrective action(s), both temporarily and powder one than by mouth three times a day with permanently, will be taken: eight oz of water for colonic atony (an intestinal a.1-4) Starting 06.18.13: Director of Nursing condition). Services completed 5 random medication 3. For RSR 13, a physician's order dated June 3. pass reviews to ensure physician orders were 2013, indicated to administer Combivent 18-103 proper medication followed and mcg/act aerosol inhalation two puffs every four occurred issues administration no hours as needed (PRN) for chronic airway identified. Director of Nursing Services and obstruction. Staff Development Coordinator completed an in-service on 6.18.13 with 4. For RSR 12, a physician's order dated licensed nursing personnel regarding December 1, 2011, indicated to administer following physician orders and proper Albuterol inhalation two puffs three times a day medication administration. This in-service for chronic airway obstruction. provided personnel with education on assuring the deficient practice is corrected During an interview on June 14, 2013, at 8:55 and does not reoccur, a.m., LVN 1 stated that she usually only gives five

az of water or juice with medication

administration, unless a resident asks for more

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.

fluids. LVN 1 further stated that she did not know

she had to give at least eight ounces of water with

C. What immediate measures will be put

into place and/or what systematic changes

the facility will make to ensure the deficient

s.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

practice does not recur:

Facility ID: CA950000068

	F CORRECTION	IDENTIFICATION NUMBER:	1 ' ' ' ' ' ' '		E CONSTRUCTION		E SURVEY PLETED
		05A137	B WING		hadren and the state of the sta	06/	18/2013
	ROVIDER OR SUPPLIER PARK A CENTER O	F EFFECTIVE LIVING	and the second s	14	EET ADDRESS, CITY, STATE, ZIP CODE 125 LAUREL AVENUE DMONA, CA 91767		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRÉCEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(XS) COMPLETION BATE
F 425	p.m., the director of staff uses five oz constaff uses five of the manuser evealed the foliation of the manuser even of the manu	on June 14, 2013, at 1:05 If nursing (DON) stated that the ups during medication pass I only supply of cups available DON further stated that the ordering 8 oz cups. Inufacturer's instructions for following: Out one dose into an empty duct with at least 8 ounces (a or other fluid, Taking this ough liquid may cause or and drink promptly. If mixture or liquid and stir. (Retrieved Inih.gov/dailymed/lookup.cfm? 4d-4765-a777-6c7efebd2b28# Inhalation Aerosol, if the to use more than one spray, two minutes and shake the again for at least 10 seconds Inih.gov/dailymed/lookup.cfm? 75-4007-a596-66628227c275# Interest in the physician ore than one spray, wait 1 Ithe inhaler again (Retrieved to bairhfa.com/library/docs/ r-Prescribing-Information-PA05 IRMACEUTICAL SVC		132	medication administration compervalidations of all licensed nursing personal As Needed, the Director of Nursing Serwill coordinate the completion of medical administration competency validations licensed nursing personnel to assure licensed nursing personnel carry out physorders accurately and follow products are properly carried Director of Nursing Services and Development Coordinator completed a service on 6.24.13 with licensed nupersonnel regarding following physorders and proper medical administration. D. How the facility plans to monitoperformance to make sure that solution sustained (description of the monitoperformance to make sure that solution sustained (description of the monitoperformance to make sure that solution sustained (description). The facility must deverbly plan for ensuring that correction is achand sustained. This plan must implemented, and the corrective sevaluated for its effectiveness. The plan must implemented, and the corrective sevaluated for its effectiveness. The plan for ensuring 06.18.13 and weekly: Description of the monitoperformance system: a.1-3) Starting 06.18.13 and weekly: Description is integrated into the quassurance system: a.1-3) Starting 06.18.13 and weekly: Description is integrated into the quassurance system: a.1-3) Starting 06.18.13 and weekly: Description is integrated into the quassurance system: a.1-3) Starting 06.18.13 and weekly: Description is integrated into the quassurance system: a.1-3) Starting 06.18.13 and weekly: Description is integrated into the quassurance system: a.1-3) Starting 06.18.13 and weekly: Description is integrated into the quassurance system: a.1-3) Starting 06.18.13 and weekly: Description is integrated into the quassurance system:	nnel. vices ation with exsed sician roper ation ation with rsure out. Staff in in- rsing sician extion or its extion for leved Lev	
		als to its residents, or obtain		mour source	residents' highest well-being including	, put	**************************************

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CUA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		05A137	B. WING	·		06/	18/2013
NAME OF PROVIDER OR SUPPLIER LAUREL PARK A CENTER OF EFFECTIVE LIVING (X4) ID SUMMARY STATEMENT OF DEFICIENCIES			STREET ADDRESS, CITY, STATE, ZIP CODE 1425 LAUREL AVENUE POMONA, CA 91767 ID PROVIDER'S PLAN OF CORRECTION (X)			(XS)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPRODEFICIENCY)			HL A19779	
F 425	them under an agri§483.75(h) of this punicensed personal law permits, but on supervision of a lice. A facility must prove (including proceduracquiring, receiving administering of all the needs of each. The facility must erralicensed pharmaton all aspects of the services in the facility dispensing of all driven medication label or pack with the facility physician for one received. The medication label or pack with the facility dispensing of all driven medication label or pack with the facility physician for one received. The medication label or pack with the facility physician for one received. The medication label or pack with the facility physician for one received.	eement described in part. The facility may permit net to administer drugs if State lily under the general ensed nurse. Inde pharmaceutical services res that assure the accurate ly, dispensing, and drugs and biologicals) to meet resident. Imploy or obtain the services of cist who provides consultation a provision of pharmacy lity. In the not met as evidenced failed to ensure accurate rugs by failing to clarify a met the Lithium Carbonate bubble by pharmacist and/or resident's andomly selected resident dication label on RSR 14's ek indicated "take this med after with food." This had the	F 425 SS D 483,60 (a),(b)	425	not limited to, physician orders medication administration. Perform Improvement Committee continues necessary follow through to addidentified issues. During monthly favisits, Manager of Clinical Operations, member of the Performance Improve Committee, completes monthly review the facility's clinical practices including not limited to, physician orders medication administration records. includes providing the nursing depart operation recommendations and assist the oursing department follows up on recommendations. All above stated wand monthly Performance Improve actions are reviewed, at least quarterly the Performance Improvement Commitor success, areas of improvement, necessary future action. As needed, Dirof Nursing Services and the Development Coordinator coordinates completes in-services with licensed nu personnel regarding following physorders and proper medicadministration. F 425; SS=D; 483.60(a),(b) PHARMACEUTICAL SVC - ACCURAPROCEDURES, RPH A. What and how corrective action(s) be accomplished, both temporarily permanently, for those patients, empleand/or facility operations identified/fon have been affected by the deficient prace Starting 06.18.13: Director of Nu Services reviewed resident 14's me	ance with dress cility as a ment s of but and This ment uring such eckly ment y, by uittee and ector Staff and rsing ician ation TE will and evees od to tice: rsing edical	7.03.13 E. Dates when correc- five action will be com- pleted:
	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		15-1 7		record, identified physician (medication), and identified medic administration record. Determined lice nursing personnel did not give iden	ensed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 * '	(2) MULTIPLE CONSTRUCTION BUILDING		(X3) DATÉ SURVEY COMPLETED	
		05A137	05A137 B. WING		06/	18/2013	
	PROVIDER OR SUPPLIE PARK A CENTER (OF EFFECTIVE LIVING		STREET ADDRESS, CITY, STATE, 1425 LAUREL AVENUE POMONA, CA 91767		***************************************	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	D PREFI TAG		ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
F 425	medications of manedication room. observed as she Carbonate 300 m cup for RSR 14. pack was observed this med after a m During further observed as medications, at 1 as she administed including the Lithic there was an orderindicating to admining by mouth three disorder. However include that the Lithic control of the contr	ultiple residents in the At 11:19 a.m., LVN 1 was poured one tablet of Lithium illigrams (mg) into a medication The Lithium Carbonate bubble ed with a label indicating "take nea!" and "take with food." servation on June 13, 2013, at ple residents were observed wridor outside of the nursing r, waiting to receive their 2:06 p.m., LVN 1 was observed red the medications of RSR 14,		prescribing physician —n on 6.14.13 to take ide "with food". Director of and the Staff Develop completed in-service or licensed nursing per following physician or medication administration. B. How the facility patients, employees, operations having the por by the same deficient corrective action(s), but permanently, will be take Starting 06.18.13: Dir Services completed 5 m pass review to ensure ph	nt 14 — no adverse Nursing contacted sew orders received entified medication of Nursing Services oment Coordinator of 6.24.13 with all sonnel regarding ders and proper of and/or facility tential to be affected practice and what h temporarity and entire of Nursing random medication system orders were oper medication system orders were oper medication system orders were oper medication typic and orders orders and ment Coordinator of of 6.24.13 with resonnel regarding		
F 458	interview, LVN 1 medication label the label and the resident's physici residents usually 12:15 p.m. During an interview p.m., the director medication label the pharmacist at	3, at 8:55 a.m., during an reviewed the Lithium Carbonate and stated that she will clarify timing of the medication with the an. According to LVN 1, the have their lunch meal around aw on June 14, 2013, at 1:05 of nursing (DON) reviewed the and stated she will clarify it with a will have the label corrected.		medication administration provided personnel wassuring the deficient pand does not reoccur. C. What immediate minto place and/or what the facility will make to practice does not recur: Starting 06.18.13 and During monthly review administration record, left Services continues to personnel carry out accurately and follow	on. This in-service with education on ractice is corrected easures will be put systematic changes ensure the deficient d weekly/monthly; was of medication Director of Nursing a assure licensed physician orders	The same and the s	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		PARTATOPINA APPANALANTA CARACTA		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		05A137	B. WING		06/	18/2013	
	PROVIDER OR SUPPLIER	EFFECTIVE LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 1425 LAUREL AVENUE POMONA, CA 91767			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPRIDEFICIENCY)	YO BE	(X6) COMPLETION DATE	
ŧ	per resident in multileast 100 square fe This REQUIREMENT by: Based on observative with the facility fresident rooms melper residents in multiple residents in multiple resident rooms. Findings: On June 12, 2013, a.m., during a gene observed that 14 of meet the requirement multiple resident ro Rooms 3, 4, 5, 6, 7 22, and 23. The every residents in these freely in their enough space to prove freely in their enough space to prove the requirement of multiple resident roomultiple r	RESIDENT casure at least 80 square feet diple resident bedrooms, and at let in single resident rooms. NT is not met as evidenced alled to ensure that 14 of 19 the 80 square feet (sq. ft.) diple resident rooms. These do fine 2-bed rooms and six between 7:30 a.m. and 8:45 and observation, the evaluator of the 19 resident rooms did not lent of 80 sq. ft. per residents in looms. These rooms were 1, 8, 9, 10, 12, 14, 16, 20, 21, aluator noticed that the 14 resident rooms were able to rooms, nursing staff had rovide care to these residents, be for the beds, chairs, and at 8:55 a.m., the evaluator view with the administrator sident rooms that did not meet 80 sq. ft. per residents in looms. The administrator stated would be submitted for these	F 4:	administration through the complemedication administration comvalidations of all licensed nursing per Health Information Manager conticomplete medication administration audits along with physician orders, to ensure physician orders are partied out. As Needed, the Dirac Norsing Services will coordinate completion of medication administrations with nursing personnel to assure licensed personnel carry out physician accurately and follow proper meadministration. D. How the facility plans to more performance to make sure that solutions sustained (description of the more process and positions responsimonitoring). The facility must deplan for ensuring that correction is and sustained. This plan mimplemented, and the corrective evaluated for its effectiveness. The correction is integrated into the assurance system: Starting 06.18.13 and weekly: Duweekday Clinical At Evaluation/Facility Rounds and S Meeting, Director of Nursing Serv Health Information Manager, as me the Performance Improvement Cobring forward identified issues their completed audits and revresident health records) related provisions of care and services residents' highest well-being including timited to, physician ords.	recency resonnel. Investo record in order properly ector of the internal properly ectors are relicus and relicus and relicus and relicus of the to meet thing, but ers and formance res with		

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	TIPLE CONSTRUCTION (NG		COMPLETED		
		0 5 A137	B. WING	**************************************	06/	18/2013	
NAME OF PROVIDER OR SUPPLIER LAUREL PARK A CENTER OF EFFECTIVE LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 1425 LAUREL AVENUE POMONA, CA 91767			1 00712010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ULD BE	(X5) COMPLETION DATE	
F 465 SS=E	reviewed the room 2013) for the 14 m waiver letter indicate enough space for and privacy. The wathese rooms were needs of the reside adverse effect on to rimpedes the abit to attain his or her The room waiver state of the	at 9:45 a.m., the evaluator waiver letter (dated June 12, esident rooms. The room leted that these rooms had each resident's care, dignity vaiver letter also indicated that in accordance with the special ents, and would not have an the residents' health and safety lility of any resident in the rooms highest practicable well-being showed the following: Sq. Ft. Sq. Ft. 68 67 74 65 60 67 75 65 66 67 76 77 78 78 78 78 78 78 78 78 78 78 78 78	F 458 SS B 483.70 (d)(1) (ii) pages: 17-19	identified issues. During monthly visits, Manager of Clinical Operation member of the Performance Improduced for the facility's clinical practices included to the facility's clinical practices included to the physician order medication administration recordinctudes providing the nursing depoperation recommendations and the nursing department follows up recommendations. All above state and monthly Performance Impractions are reviewed, at least quarthe Performance Impravement Cofor success, areas of improvement cases and the Development Coordinator coord	ons, as a revement views of ding, but ers and a. This partment assuring on such deckly revement terly, by committee ent, and Director e Staff ates and nursing physician edication OOMS OOMS	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 A. BUILDING			(X3) DATE SURVEY COMPLETED	
05A137		B. WING			06/18/2013		
NAME OF PROVIDER OR SUPPLIER LAUREL PARK A CENTER OF EFFECTIVE LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 1425 LAUREL AVENUE POMONA, CA 91767				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
	This REQUIREMENT by: Based on observatifailed to provide a stresidents, visitors a heaters. Two of eignoresidents, visitors are sidents, visitors are residents, visitors are repervisor conducted the facility. There we heaters throughout the facility. There we heater inscloset, at the doctor revealed that this he wall straps, to secure At 10:45 a.m., the experiment of the evaluator regarding the evaluator mention of the evaluat	ortable environment for the public. NT is not met as evidenced tion and interview, the facility rafe environment for the and staff, regarding hot water that water heaters which discould be unsafe for and staff. between 9:25 a.m. and 10:55 and the maintenance ed a general observation of the facility. raluator observed a 40-gallon side the hot water heater ris office. Closer observation of water heater did not have re it.		55	that no adverse effects to health, safet welfare exist for the residents occupyin rooms. B. How the facility will identify patients, employees, and/or fa operations having the potential to be affiby the same deficient practice and corrective action(s), both temporarily permanently, will be taken: Rooms #8, #15, #17, #18, and #19 me minimum square footage requirement. Facility personnel assure that the nee residents in rooms are fully met and the adverse effects to health, safety, or we exist for the residents occupying identified rooms. C. What immediate measures will be into place and/or what systematic chethe facility will make to ensure the defipractice does not recur: Per the request of the Departe Administrator submits the annual "Proflexibility Waiver regarding F 4: 483.70(d)(1)(ii) Resident Rooms" letter Department for rooms #3, #4, #5, #6, #10, #12, #14, #16, #20, #21, #22, and #2 Facility personnel assure that the nee residents in rooms are fully met and the adverse effects to health, safety, or we exist for the residents occupying identified rooms. D. How the facility plans to monito performance to make sure that solution sustained (description of the monitor performance to make sure that solution sustained (description f the monitor performance to make sure that solution sustained (description f the monitor performance to make sure that solution sustained for ensuring that correction is ache and smealined. This plan musting implemented, and the correction is ache and smealined. This plan musting evaluated for its effectiveness. The plan correction is integrated into the general correction is ache and correction is integrated into the general correction is integrated into the general correction is ache and correction is integrated into the general c	g the other cility exical what and t the ds of at no clifare the anges icient ment, gram 58 — to the 7, #9, 3. ds of at no clifare the exits sare oring for lop a clieved t be action an of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(MESCHELMATION) NI (KROED)		TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		D6A137	E. WING			6/18/2013	
	ROVIDER OR SUPPLIER PARK A CENTER O	F EFFECTIVE LIVING		STREET ADDRESS, CITY, ST. 1425 LAUREL AVENUE POMONA, CA 91767	——————————————————————————————————————	AUUINA M	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG	X (EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE DED TO THE APPROPRIATE EFICIENCY)	COMPLETION DATE	
F 465	he would make su	age 20 naintenance supervisor stated re that wall straps would be of water heaters, as soon as	F 465 SS E 483.79 (in- service) pages: 19-21	assurance system: During weekday Evaluation/Faellity Meetings, Administr Performance Imp reviews that corre achieved and sustai Performance Imp develops and corrections for ident meeting of residents weeldy Performanc are reviewed, at I Performance Impre success, areas o necessary future acti F 465; SS=E; 483.78 SAFE/FUNCTIONA COMFORTABLE F A. What and how be accomplished, permanently, for th and/or facility opers have been affected b Starting 06.18.13 Supervisor coordin wall straps and secu in both the doctor laundry room on 6, coordinated and c with Plant Operatio on the identificati necessary plant mai not limited to, ensur properly secured w service provided po on assuring the corrected and does n	Rounds and Stand-Up rator, as a member of the provement Committee, ective actions are and ined for resident rooms. Provement Committee implements necessary tified issues related to the resease quarterly, by the evenent Committee for improvement, and ion. (in-service) AL/SANITARY/ ENVIRONMENT corrective action(s) will both temporarily and more patients, employees, ations identified/found to by the deficient practice: The installation of tring of the water heaters are office closet and the installation of intenance including, but ring all water heaters are of the wall strap. This intersonnel with education deficient practice is not reoccur. Lity will Identify other	7.03.13 E. Dates when corrective action will be com- pleted;	