| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555492 | A. BUILDING _____ B. WING _____ | C 06/26/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MIRAVILLA CARE CENTER | 9246 AVENIDA MIRAVILLA CHERRY VALLEY, CA 92223 |

| (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<br><br>The following reflects the findings of the California Department of Public Health during the investigation of one complaint.<br><br>Complaint number: CA00342470<br><br>Representing the California Department of Public Health: Surveyor 18821/1722, HFEN<br><br>The inspection was limited to the specific complaint(s) investigated and does not represent the findings of a full inspection of the facility.<br><br>Deficiencies were issued for complaint number CA00342470 | F 000 | This Plan of Correction (POC) constitutes the facility's credible allegation of compliance.<br><br>Miravilla Care Center (MVCC) makes its best efforts to operate in full compliance with both the State and Federal laws. Nothing included in this Plan of Correction is an admission otherwise. Miravilla Care Center (MVCC) has submitted this Plan of Correction as part of its statutory requirements but does not waive any objections to the merits of forms of any allegations contained therein. Please note that MVCC may contest the merits and/or form of all and/or any deficiencies and the findings alleged below | |
| F 224 SS=D | 483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN<br><br>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review the facility failed to prevent the occurrence of a skin tear to Resident 1's hand while attempting to provide personal care to the resident.<br><br>Findings:<br><br>On February 6, 2013, a visit was made to the | F 224 | | |

13 JUL -8 PM 4:05
LICENSING & CERT.
RIVERSIDE COUNTY

CA DEPT OF PUBLIC HEALTH

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 07/08/13

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.

7/16/13 POC acceptable

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555492 | A. BUILDING _____ B. WING _____ | C 06/26/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MIRAVILLA CARE CENTER | 9246 AVENIDA MIRAVILLA CHERRY VALLEY, CA 92223 |

| (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 224 | Continued From page 1<br>facility to investigate a complaint regarding care issues a resident received during October 17, 2012. The resident was a 88-year-old female with a diagnosis of End Stage Chronic Obstructive Pulmonary Disease (a progressive disease characterized by increased scarring of the lung tissues and shortness of breath), and dementia (a progressive organic mental disorder characterized by chronic personality disintegration, confusion, disorientation, stupor,deteriorate of intellectual capacity and function and impairment of control of memory,judgement, and impulses.)<br><br>On February 6, 2013, a review of Resident 1's record, indicated the following:<br><br>"At 2 pm, CNA (certified nursing attendant) called to my attention noted resident c(with) skin tear on r (right) hand c minimal bleeding. Measuring 5X3.5 cm (centimeters). Asked what happened, CNA stated patient was being cleaned in the middle of changing cleaning resident; resident being agitated, & swung the r arm c back scratcher; 2 CNA finished cleaning the resident. As 2 CNA pulling her up, noticed a tear on her r hand resident is alert but confused and disoriented x3. Called Primary MD informed him of incident, gave an order to cleanse skin tear c staff cleanse pat dry, apply steri strips and triple ABT (antibiotic) ointment cover c non adherent dressing qd (every day) x 21 days. Then re-eval. Educate CNA, if resident agitated, Incident could be prevented by leaving pt. (patient) room cont. (continue) to monitor, come back, if resident calm, no behavior". | F 224 | 1. The policy and Procedure for Elder Abuse was reviewed and revised by the IDT Team on 07/01/2013 to ensure that all incidents resulting to an injury will be submitted to the Abuse Investigation Team for review and once the team has established that an abuse has occurred, the incident will be reported to the appropriate agencies within the Elder Abuse Guidelines. The revised Policy and Procedure will be submitted for final approval during the scheduled QA & A Committee Meeting on July 24, 2013.<br><br>2. All residents that display agitated behavior or resistance to care have the potential to be affected by the above deficient practice. The IDT team will update all care plans of resident identified as having an agitated behavior or resistance to care during their regularly scheduled Care Conference Meetings.<br><br>3. An Incident Investigation Team has been established composed of the Administrator, DON, Social Services, DSD and any other appropriate Department Supervisor to promptly review all incident investigations with injuries involving residents with agitated behavior or resistance to care. Once the team establishes that abuse has occurred the appropriate agencies will be informed within the Elder Abuse Prohibition guidelines. | 07/01/13<br><br>07/24/13 |

13 JUL -8 PM 4:05
CA DEPT OF PUBLIC HEALTH
LICENSING & CERT.
RIVERSIDE COUNTY

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555492 | A. BUILDING _____ B. WING _____ | C 06/26/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MIRAVILLA CARE CENTER | 9246 AVENIDA MIRAVILLA CHERRY VALLEY, CA 92223 |

| (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 224 | Continued From page 2<br>On February 6, 2013, in a review of the facility Abuse Prohibition Program indicated the following:<br>"All incidents resulting in an injury must be fully investigated to determine the cause of the incident and how to prevent recurrence in the future. Assessments and care plans should be updated based on an analysis of the information collected.<br><br>Injuries of unknown origin require a more in depth assessment to include the "possible" causes of injury. The investigation or assessment should determine if some form of abuse "could" have been the cause. Although conclusive evidence will be difficult to secure at times, it is imperative that the interdisciplinary team put interventions in place to address the possible cause of the injury.<br><br>The Employee Incident Investigation Report should be completed. If unsure if abuse had occurred, but evidence suggests abuse could have occurred, a report to the state's abuse hotline or or other designated agency should be made".<br><br>The facility failed to report this incident of injury to the Department of Public Health within the time frame as required by the Department of Public Health. In the standard process of abuse training, staff are instructed that when residents/patients are agitated they should allow the resident/patient to calm down and attempt at a later time to follow up with care issues. The CNA's that provided care to Resident 1, did not do this. The CNA's continued there care while the resident was agitated potential causing increased agitation. | F 224 | 4. An in-service was provided on 07/03/13 by the DSD regarding How to Care for Residents with behavior to the nursing staff utilizing specific case studies. A follow-up in-service will be provided by Dr. Houston our resident psychologist on July 9, 2013. The Incident Investigation team will meet as each incident with injury occurs and monthly thereafter to further discuss and review all incidents with injuries. Any noted deficiencies will be corrected for immediate compliance and discussed further in the QA & A Committee for continuous quality improvement.<br><br>5. The facility will be in compliance by July 26, 2013 | 07-03-13<br>07-09-13<br>07-26-13 |

13 JUL -8 PM 4:05
LICENSING & CERT.
RIVERSIDE COUNTY

CA DEPT OF
PUBLIC HEALTH

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555492 | A. BUILDING _____ B. WING _____ | C 06/26/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MIRAVILLA CARE CENTER | 9246 AVENIDA MIRAVILLA CHERRY VALLEY, CA 92223 |

| (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 323 SS=D | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review the facility failed to provide adequate supervision to Resident 1 while care was provided by two CNA's.<br><br>Findings:<br>On February 6, 2013, a visit was made to the facility to investigate a complaint regarding care issues a resident received during October 17, 2012. The resident was a 88-year-old female with a diagnosis of End Stage Chronic Obstructive Pulmonary Disease ( (a progressive disease characterized by increased scarring of the lung tissues and shortness of breath), and dementia (a progressive organic mental disorder characterized by chronic personality disintegration, confusion, disorientation, stupor,deteriorate of intellectual capacity and function and impairment of control of memory,judgement, and impulses.)<br><br>On February 6, 2013, a review of Resident 1's record, progress notes dated october 17, 2012, indicated the following:<br>"At 2 pm, CNA called to my attention noted | F 323 | 1. The two certified nursing assistants involved were counseled in writing by the DSD re-emphasizing to them the importance of allowing a resident to calm down before and during the provision of care on June 30, 2013.<br>A monthly re-evaluation of their skills when providing care to patients will be done by the DSD on the involved C.N.A.'s for the next three months and yearly thereafter. An in-service was provided on 07/03/13 by the DSD regarding on how to care for residents with behaviors to the nursing staff utililizing specific case study.<br><br>2. All residents displaying agitated behavior or resistance to care have the potential to be affected by this deficient practice. All Certified Nursing Assistance assigned to such residents identified with such behaviors will be mandated to attend all special in-service training programs on how to deal or provide care to the residents with behaviors.<br><br>3. DSD and/or RN Supervisor will randomly observe two Certified Nursing Assistants on a weekly basis and observe how they care for residents with behaviors and submit a report monthly to the QA Committee for the first three months and yearly thereafter. A Skills Observation Test will be done to all new hires within their month of hire. A buddy system will be implemented in the provision of care to residents with behaviors and incorporated in their plan of care. | 06 30 13 |



CA DEPT OF PUBLIC HEALTH
JUL -8 PM 4:05
LICENSING & CERT.
RIVERSIDE COUNTY

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555492 | A. BUILDING _____ B. WING _____ | C 06/26/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MIRAVILLA CARE CENTER | 9246 AVENIDA MIRAVILLA CHERRY VALLEY, CA 92223 |

| (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 323 | Continued From page 4<br>resident c(with) skin tear on r (right) hand c minimal bleeding. Measuring 5X3.5 cm (centimeters). Asked what happened, CNA stated patient was being cleaned in the middle of changing cleaning resident; resident being agitated, & swung the r arm c back scratcher; 2 CNA finished cleaning the resident. As 2 CNA pulling her up, noticed a tear on her r hand resident is alert but confused and disoriented x3. Called Primary MD informed him of incident, gave an order to cleanse skin tear c staff cleanse pat dry, apply steri strips and triple ABT (antibiotic) ointment cover c non adherent dressing qd (every day) x 21 days. Then re-eval. Educate CNA, if resident agitated, Incident could be prevented by leaving pt. (patient) room cont. (continue) to monitor, come back, if resident calm, no behavior".<br><br>The facility failed to properly supervise the two CNA's while they change her diaper. Review of the facility nursing notes indicated that the resident was frequently agitated and would strike out at staff.<br>The resident had a care plan to handle gently during care, and good skin care. The resident was at risk for skin discoloration/hematoma/skin tears and skin breakdown.<br><br>The facility failed to follow the abuse training process, as related to when residents are agitated and to leave agitated residents alone until they have had time to calm down. The nurse documents in her charting that the physician said that the Incident could have been avoided had the CNA allowed the resident to calm down. The incident was also not reported to the Department of Public Health timely. This lack of adequate | F 323 | 4. A follow-up in-service will be provided by the Residents Psychologist to the C.N.A.'s on 07/09/13 on How to Provide Care to Residents with Behaviors and quarterly thereafter. An updated report will be submitted to the quarterly QA & A Committee and any noted deficiencies will be discussed for immediate corrective action and for continuous quality improvement.<br><br>5. The facility will be in compliance by July 26, 2013 | 07/26/13 |

13 JUL -8 PM 4:05
LICENSING & CERT.
RIVERSIDE COUNTY

CA DEPT OF
PUBLIC HEALTH

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555492 | A. BUILDING _____ B. WING _____ | C 06/26/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MIRAVILLA CARE CENTER | 9246 AVENIDA MIRAVILLA CHERRY VALLEY, CA 92223 |

| (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 323 | Continued From page 5<br>supervison could potential lead to a breakdown in the resident's skin and continued skin tears or hematomas. | F 323 | | |

13 JUL -8 PM 4:05
LICENSING & CERT.
RIVERSIDE COUNTY
CA DEPT OF
PUBLIC HEALTH