Annie Woods

Digitally signed by Annie Woods
DN: cn=Annie Woods, o=West District Office, ou=HFID, email=awoods@cdph.ca.gov, c=US
Date: 2012.09.12 15:58:38 -07'00'

9/11/12 Accepted

PRINTED: 08/30/2012
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555305	A. BUILDING _____ B. WING _____	08/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH BAY KEIRO NURSING HOME	15115 S VERMONT AVE GARDENA, CA 90247

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the Department of Public Health during a Recertification survey. Representing the Department of Public Health: [redacted], RN, HFEN RN, HFEN RN, HFEN Total Resident Population: 96 Total Sample Size: 20 Highest Severity and Scope: E	F 000	"This Plan of Correction constitutes my written allegation of compliance for deficiencies"	9/8/12
F 154 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.	F 164	F 164 Personal Privacy/Confidentiality of Records (See Page 2 of 31)	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Norma Nagpaul — TITLE: Administrator — (X6) DATE: 9/7/12

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.

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F 164	Continued From page 1 The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility staff failed to ensure the resident was provided with privacy during wound dressing by pulling the privacy curtain completely around resident's bed for one of 20 sample residents (17). This deficient practice resulted to unnecessary exposure of resident's body parts during wound dressing. Findings: On 8/4/12, at 10:40 a.m., during a treatment observation, licensed vocational nurse (LVN 1) provided wound care on Resident 17's buttocks pressure ulcers (skin breakdown from prolonged pressure) assisted by LVN 2. The privacy curtain was not fully closed around the resident's bed and was visible to anyone entered the room toward the resident. The Minimum Data Set (MDS) an assessment and care screening tool dated 7/18/12 indicated Resident 17's cognition was moderately impaired and was totally dependent on staff for activities of daily living. The resident had a Stage IV pressure sore to her sacral area (sitting bone).	F 164	**F 164** Personal Privacy/Confidentiality of Records • As of 8/5/12 forward resident #17's privacy curtain has been completely closed during wound care. The Responsible Treatment Nurse received a 1:1 in-service with the Director of Nurses regarding privacy, on 8/5/12. • The Director of Nurses observed Wound Care week of 8/31/12-9/5/12 with no deficient privacy practices observed. • In-service given by the Director of Nurses to all nursing staff on 9/5/12 regarding protecting the privacy of the residents. Charge Nurses and RN Supervisors to check for compliance during nursing rounds daily. Any incidents of non-compliance will be corrected immediately and reported to the Director of Nurses. • Outcome of the daily rounds will be reported by the Director of Nurses to the Quarterly Quality Assurance and Assessment Committee for any actions as indicated. • Corrective action will be completed by September, 8, 2012.	9/8/12

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F 164	Continued From page 2 On 8/4/12, at 11: 20 a.m., during an interview, LVN 1 and LVN 2 stated the curtain should be fully closed around the resident's bed when providing care. According to facility undated policy and procedure on Wound Care, provide privacy by pulling the curtain all the way to the end of residents bed.	F 164	F166 Right To Prompt Efforts To Resolve Grievances • On 9/5/12, the attentions of residents and resident council members were directed to the signage posted on the consumer bulletin board regarding the facility's Grievance Procedure indicating a resident's rights to contact the Department of Health and/or Ombudsman. Posting provided in conference room • Administration and the Director of Nurses held a meeting with all interested residents on 9/5/12 to discuss the Facility's revised Noise Management Policy and Grievance action plan for noise abatement. • Sound Management Rounds were made by the Administration/Nursing Supervisor week of 8/31-9/6/12 with no new complaints expressed regarding sound levels during this period. • As of 9/6/12 Administration has reviewed and revised the Facility Noise Management Policies and will be presented at the Quality Assurance & Assessment (QA&A) Committee for additional recommendations as necessary. On 9/5/12 In-service was provided to all Staff by the Director of Nurses & Administration regarding the revised (Continued on Page 4 of 31)	
F 166 SS=E	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure prompt efforts to resolve grievances a resident may have for five out of six alert and oriented residents that attended the Group Meeting. The residents express concerns over staff speaking loudly among themselves. As a result, they had restless nights. Findings: During the Group Meeting on August 3, at 7 p.m., five out of six alert and oriented residents stated staff while providing care in their rooms or in the hallways, would speak loudly among themselves. They stated it made them feel hopeless as staff would talk among themselves while in their rooms. Four of the residents stated they felt hopeless, especially when staff would answer their cell phones in their rooms. They further	F 166		

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F 166	Continued From page 3 stated that staff would shout out to each other in the hallways. The residents stated it was worse during the evening shift and at nights when management was gone for the day. They stated they complained about this on many occasions and that management told them they were addressing the situation. During an interview with the assistant director of nursing on August 4, 2012, at 1 p.m., she stated she was aware of the complaints and that staff has been working on resolving the above concern. She further stated she reported this to management. She further stated they frequently give in-services to staff regarding noise level. However, she could not provide any documentation of in-services given to staff nor could she provide any documentation to support that the grievance was addressed. A review of the facility undated policy and procedure on Reducing Noise Level indicates noise level is reduced to promote enough rest and sleep for the residents. Residents are provided during the night with quiet time for resting and sleeping. All staff is instructed to minimize sounds/conversations at night and avoid talking in the hallways. A review of the facility policy and procedure regarding Grievances indicates all resident grievances would be promptly addressed. The facility staff would make prompt efforts to resolve the problems a resident may have. The facility staff failed to implement the above policies for each residents. F 221 483.13(a) RIGHT TO BE FREE FROM	F 166	F166 Right To Prompt Efforts To Resolve Grievances (Continued From Page 3 of 31) Noise Management and the rights of residents to file Grievances. Staff was reminded that cell phone use during working hours is not permitted. Cell phones may be used only during breaks and lunch time. Department managers and nursing supervisors have been instructed to enforce excessive noise management policies during evening shifts and to provide reports of non-compliance and/or resident complaints to the Director of Nurses to • Any new grievances will be provided to Administration, and a written action plan that will be provided to the individual(s) in question. Random resident satisfaction studies will be conducted monthly by Department Heads with grievances reported to Administration for further attention. Social Services and Administration will review the grievance log monthly for any unresolved grievances. • Outcome of random departmental resident satisfaction studies and any unresolved grievances log will be reported by Administration at the monthly QA&A Committee meeting for further recommendations as necessary. • Corrective action will be completed by September 8, 2012.	9/8/12
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F 221 SS=D	Continued From page 4 PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a resident who had a seat belt physical restraint while in wheelchair was removed during meals while supervised by staff for one of 20 residents (7). This deficient practice resulted to resident being restrained during meal times without justification Findings: Resident 7's diagnoses included organic psychotic behavior and dementia. The Minimum Data Set an assessment and care screening tool dated July 9, 2012, revealed the resident was confused and required total assistance on staff with her activities of daily living. She has a physician's order and care plan dated July 5, 2012, to apply self-releasing seat belt while in wheelchair. The plan of care included releasing the restraints for comfort and circulation. On August 2, 2012, at 7:10 p.m., Resident 7 was observed eating and sitting in a wheelchair with a seat belt in place. A staff member was sitting at the same table providing assistance with meals. On August 3, 2012, at 6:45 p.m., the same observation was made.	F 221	F221 Physical Restraints • As of 8/5/12 forward resident #7, restraint was re-assessed by the RN Coordinator, and is being released during meal times. • Director of Staff Development conducted meal observations week of 8/31/12-9/6/12 with release and repositioning of the restraints evident during meals periods. (Continued on Page 6 of 31)	

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F 221	Continued From page 5 During an interview with the certified nursing assistant (CNA 1) on August 3, 2012, at 6:50 p.m., he stated Resident 7 always has the seat belt on when she is up in the wheelchair. He stated he does not release the seat belt, not even at meal times. During an interview with a licensed vocational nurse (LVN 3) on August 3, 2012 at 7:55 p.m., he stated he was not aware the residents should not be restrained during meal times. During a record review of the facility undated policy and procedure, titled "Physical Restraints", indicated it is the policy and procedure for staff to evaluate the need for restraints and to use alternatives for how each resident can attain or maintain the highest level of functioning with the least restrictive measures. Restraints such as seatbelts are removed every 2 hours or more frequently if needed. When under supervision, restraints are removed for better circulation. During an interview with the assistant director of nursing on August 4, 2012, at 1:30 p.m., she concur it is a good practice to release the restraints during meal times, especially when the residents are being supervised in the dining room.	F 221	**F221** Physical Restraints (Continued From Page 5 of 31) • In-service given by the Director of Nurses to all nursing staff on 9/5/12 regarding justification for restraint use, release, and trial reductions. In addition, MDS coordinator/RN Supervisor will re-assess all resident with restraints quarterly in conjunction with the MDS/Care Plan schedule. Charge Nurses to check for supervised release of restraints, especially during meal times. • Non-compliances will be reported to the Director of Nurses and she will report over-all compliance rates to the Quarterly Quality Assurance & Assessment Committee for further follow-up and recommendations. • Corrective action will be completed by September 7, 2012.	9/7/12
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.	F 241	**F241** Dignity and Respect of Individuality (See Page 7 of 31)	

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F 241	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure the residents were treated with respect by not calling them "sweetie" or "mama-son" which the residents disliked for five of six alert and oriented residents that attended the group meeting. This deficient practice resulted to residents being unhappy, upset with staff and had potential to affect the residents' quality of life. Finding: During the group meeting on August 3, 2012, at 7 p.m., five of six alert and oriented residents stated they were upset with staff, especially the certified nursing assistants (CNAs). They stated staff would call them "sweetie" or "mama-son". Two of the residents stated they had American names but staff would say their names were difficult to remember so calling them mama-son was much easier. One of the residents stated she has been a professional all her life and she wanted to be called by her name. Two of the residents stated it was degrading being called "mama-son" by staff members. One of the residents stated she complained to the charge nurses about it and that it has not yet been resolved. During an interview with the charge nurse on August 4, 2012, at 11:25 a.m., she stated the facility staff was aware of this problem and they are working on it. During an interview with the staff developer at the same time, she stated she has given staff in-services to treat the residents with dignity and respect and she was	F 241	F241 Dignity and Respect of Individuality • Promptly on 8/7/12 a mandatory in-service was provided by Administration and the Director of Nursing regarding treating the residents with dignity and respect. Staff was instructed to only use the resident family name when address them. • Care rounds were made week of 8/31/12-9/6/12 by the Director of Staff Development & Administrative staff with residents found to be called by their family name, no deficient practices observed. • In-service given by the Director of Nursing and Administration to all staff on 8/9/12. The topic included dignity & respect, and the use of family name when addressing the resident. Additionally, random Resident Satisfaction Studies will be conducted weekly by the Department Supervisors with a focus on dignity and respect. Outcome of the Resident Satisfaction Studies will be provided to Administration and the Director of Nurses for any further action, which may include disciplinary action being taken. (Continued on Page 8 of 31)	

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F 241	Continued From page 7 disappointed that the issue was not fully resolved. A review of the facility undated policy and procedure regarding Dignity and Respect indicated all resident are treated with dignity, kindness, and respect. Staff shall display respect for residents when speaking, caring, and talking about them, an affirmation of their individuality and dignity as human beings. Staff will address each resident by name and will speak respectively.	F 241	**F241** Dignity and Respect of Individuality (Continued from Page 7 of 31) • Reports of non-compliance and action taken will be discussed at the Monthly Quality assurance and Assessment Committee. The committee will make further recommendations as necessary. • Corrective action will be completed by September 8, 2012.	9/8/12
F 243 SS=E	483.15(c)(1)-(5) RIGHT TO PARTICIPATE IN RESIDENT/FAMILY GROUP A resident has the right to organize and participate in resident groups in the facility; a resident's family has the right to meet in the facility with the families of other residents in the facility; the facility must provide a resident or family group, if one exists, with private space; staff or visitors may attend meetings at the group's invitation; and the facility must provide a designated staff person responsible for providing assistance and responding to written requests that result from group meetings. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure staff or visitors that attend resident group meetings, have been invited by the residents. Five of six alert and oriented residents that attended the Group Meeting stated they did not invite staff to the resident group meeting, and the residents felt useless they attended the group meeting.	F 243	**F243** Right to Participate in Resident/Family Group • During Survey process, the Administration indicated that the copies of the attached signage had been posted on the consumer bulletin board, however information may not have been properly provided to Activity Staff by Administration. All department supervisors have been provided copies of the posting. • On 9/9/12, all department supervisors were provided copies of Resident Council guidelines *Long Term Care Activity Professionals, Social Service Professionals, and Recreational Therapists, 6th Edition.* Author: Elizabeth Best-Martini, et al. Publisher: Idyll Arbor, Inc. 2011 (Continued on Page 9 of 31)	

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F 243	Continued From page 8 Findings: During the Group Meeting on August 3, 2012 at 7 p.m., five of six alert and oriented residents stated they always had staff at their resident council meetings. They stated it was difficult to express their concerns because they did not want to be known as the "big mouth" or "the instigator" . Two of the six residents stated they stopped attending the meetings because they had staff at the meetings and they were not comfortable expressing their complaints. Four of the residents stated there was no use in the resident group meetings because they were not always comfortable in telling the truth about their complaints. They stated it was usually the activity director at the meetings and sometimes other staff members would "drop-in". They stated they did not know they could request for certain staff members to be there and that they had the right to have the meetings without staff. During an interview with the activity director on August 4, 2012, at 10:45 a.m., she stated she did not know she had to get the resident's permission for staff members to attend the meetings or to invite other staff personnel. A review of the resident's council meeting minutes for the month of May 2012, June 2012 and July 2012, could not locate any documented evidence that the activity director obtained permission/invitation from the residents in the group for staff members to attend the resident council meetings. During an interview with the assistant director of nursing on August 4, 2012, at 9 a.m., she stated it	F 243	F243 Right to Participate in Resident/Family Group (Continued from Page 8 of 31) • Activity Staff was instructed to only attend if requested/invited by the residents Council members. • Resident Council Meeting was held on 9/5/12, with no visitors in attendance. Members have been informed that facility can provide an invited staff person to record and assist administration with follow- through with recommendations and grievances. • All residents and resident council members shall be re-instructed and/or reminded of the requirement for staff/outside visitors to the Resident Council Meetings must be by invitation of the committee only. • On 9/6/12, a Revised Policy was approved and presented to the Quality Assurance and Assessment (QA&A) Committee. • Activity supervisor will monitor for compliance on a monthly basis with feedback to Administration. • Compliance will be reviewed at the Monthly QA&A Committee. The committee will make further recommendations as necessary. Corrective action will be completed by September 8, 2012.	9/8/1

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F 243	Continued From page 9 is the protocol at the facility for staff to obtain verbal or written permission from the residents for all staff members who attend the Group Meeting. She stated the residents also had a right to have meetings without staff members. However, she stated she could not locate the facility's policy regarding resident council meetings.	F 243		
F 246 SS=E	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure call lights were within reach and answered in a timely manner for five of six alert and oriented residents that attended the Group Meeting. As a result, the residents expressed stress and anxiety. Findings: During the Group Meeting on August 3, 2012 at 7 p.m., five of six alert and oriented residents that attended the group meeting stated that sometimes staff would leave the call lights far from them and they would have to shout for help. Two of the residents stated it was because staff was in a hurry and would forget to put the call lights back where they can reach it. Four of the	F 246	F246 Reasonable Accommodation of Needs/Preferences • Administration held a meeting with the interested residents on 9/6/12 regarding process improvement plan for timely answering of the call lights. The Assistant Director of Nurses/DSD in-serviced Certified Nurse Assistants on 8/7/12 regarding call light placement and timely answering of call lights. • Nursing Care rounds were made by the DSD/Nursing Supervisor week of 8/31-9/6/12 with call lights found to be in place and answered courteously and in a timely manner. (Continued on Page 11 of 31)	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH BAY KEIRO NURSING HOME	15115 S VERMONT AVE GARDENA, CA 90247

(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 246	Continued From page 10 residents stated that it would take staff up to 30 minutes to answer their call lights, especially on the 3 p.m. to 11 p.m. shift. They stated it was stressful when staff would tell them to be patient because their nurse was not available and they were too busy with their own residents to help. One of the residents stated her anxiety level would increase when she needed to use the restroom and staff would not answer her call light. During an interview with the activity director on August 4, 2012, at 9:45 a.m., she stated she was aware of this and told management about it. A review of the resident council meeting minutes for the month of April, May, June, and July 2012, could not locate any complaints regarding the call lights. Further interview with the activity director on August 4, 2012, at 9:55 a.m., she stated she did not document it on the meeting minutes because the residents told her it was getting better. During an interview with the assistant director of nursing and the administrator on August 4, 2012, at 11:55 a.m., they stated they would immediately in-service all staff to keep the call lights within reach. The administrator stated staffs have been in-serviced many times to answer the lights within minutes. A review of the facility undated policy and procedure on Call Light Use indicated all call lights should be positioned in an area convenient for the resident to use and must be answered promptly. Never make the resident feel you are too busy to give assistance. The facility staff failed to implement this policy for the residents	F 246	**F246** Reasonable Accommodation of Needs/Preferences (Continued From Page 10 of 31) • A Quality Assurance monitoring tool for call lights has been developed by Administration and has been implemented as of 9/6/12. This monitor will be conducted randomly on a weekly basis and will be used to monitor the placement & timeliness of answering call lights. • In-service conducted by the Director of Nurses and Administration on 9/6/12 regarding call lights. Nursing Staff found to have repeat occurrences of call light infractions and/or a pattern of resident complaints shall be subject to disciplinary action. • Outcome of random weekly Call Light QA Study will be provided to the Director of Nurses & Administration for discussion at the monthly Quality Assurance & Assessment Committee for further recommendations as necessary. • Corrective action will be completed by September 7, 2012.	9/7/12

PRINTED: 08/30/2012
FORM APPROVED
OMB NO. 0938-0391

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	556308	A. BUILDING _____ B. WING _____	08/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH BAY KEIRO NURSING HOME	15115 S VERMONT AVE GARDENA, CA 90247

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F 246	Continued From page 11 that attended the group meeting.	F 246		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to develop a care plan for two of 20 sample residents (3, 4) that include measurable objectives and timetables to meet a resident's medical and nursing needs. Resident 2 had orders for a hand roll and there was no written care plan to ensure the resident's skin was being monitored for potential skin irritation or breakdown. Resident 4 was in contact isolation of the urine and there was no written care plan to	F 279	F279 Comprehensive Care Plans (See Page 14 of 31)	

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SOUTH BAY KEIRO NURSING HOME	15115 S VERMONT AVE GARDENA, CA 90247

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F 279	Continued From page 12 specify what types of protective barriers were needed to prevent cross contamination and promote infection control measures. Findings: a.. On 8/2/12, at 7:15 p.m., Resident 3 was observed in bed, eyes closed wearing a left hand roll secured in and around the resident's left palm. A review of the resident's clinical record indicated the resident was re-admitted to the facility on 5/12/09 with diagnoses that included convulsions. A review of the resident's Minimum Data Set dated 4/30/12 indicated the resident was unable to understand or comprehend simple commands and was totally dependent on staff with bed mobility and transferring from bed to chair and personal hygiene and using the bathroom. A review of the physician's orders dated 6/6/12 indicated to apply hand roll to left hand at all times to prevent contracture. On 8/4/12, at 10:45 a.m., a review of the resident's clinical record was conducted with licensed vocational nurse (LVN 2) revealed no evidence that a care plan was written for the resident's left hand roll. LVN 2 stated the purpose of the care plan was to guide the nursing staff on the use of the hand roll and to check and monitor the resident's skin condition such as skin breakdown and or irritation from the use of hand roll. Further review of the clinical record revealed a care plan dated 5/1/12 for impaired physical mobility related to severe generalized weakness and interventions included applying left hand roll	F 279	F279 Develop Comprehensive Care Plans (See Page 14 of 31)	

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F 279	Continued From page 13 daily to prevent contractures, however, this was an intervention for physical mobility and not for the use of left hand roll. b. On 8/2/12, at 7:10 p.m., an observation outside of Resident 4's room revealed a plastic shelf unit with drawers that stored disposal yellow gowns, gloves and masks. Concurrently, an interview was conducted with the rehabilitation nurse who stated Resident 4 was in contact isolation of the urine. A review of Resident 4's clinical record revealed Resident 4 was re-admitted to the facility on 9/1/11 with diagnoses that included stroke, high blood pressure and depressive disorder. A review of Resident 4's physician's orders dated 7/31/12 indicated to give the resident antibiotic treatment Nitrofurantoin 100 milligrams twice a day for 7 days and Cephalexin 500 milligrams twice a day for 7 days orally for extended-spectrum beta lactamase (ESBL [a gram negative bacteria that is multi-drug resistant]) and urinary tract infection and on 8/1/12, an order to move the resident into Resident 2's room for Contact Isolation of ESBL. ESBL's can be spread from person to person by touching body fluids (blood, urine) or items that have been in contact with the resident (stethoscope, blood pressure cuff, etc.) If a resident has an ESBL in the lungs, it can be spread by coughing, sneezing, or suctioning. (Reference Center for Disease Control, 2005) On 8/4/12, at 10:50 a.m., a review of the resident's clinical record was conducted with LVN 2 that revealed there was no care plan written for Contact Isolation to specify what type of	F 279	**F279** Develop Comprehensive Care Plans • The care plans for resident #3 and #4, were reviewed and revised by the MDS coordinator to include a care plan for prevention of skin breakdown & the specific protective barriers for isolation. • The care plans of the other residents on isolation and those utilizing hand rolls have been reviewed and revised to include prevention for skin breakdown & protective barriers for isolation. • In-service given by the Director of Nurses and Health Record Consultant on 9/5/12 to the licensed Nurses regarding Comprehensive Care Planning. MDS Nurse/Restorative Nurse Coordinator to check for care planning of these components as part of admission & the MDS quarterly re-assessments. Director of Nurses to randomly review monthly for compliance. • Outcome of the monthly random audits will be reported by the Director of Nurses or her designee to the Quarterly Quality Assurance & Assessment Committee Meetings for further action as necessary. • Corrective action will be completed by September 8, 2012.	9/8/12

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F 279	Continued From page 14 preventative measures or protective barriers such as gown, gloves or masks are needed for the protection of other residents to prevent cross contamination and appropriate use of infection control. Concurrently, an interview was conducted with LVN 2 who stated a care plan should be written for the contact isolation to alert staff the precautions and necessary protective barriers needed to prevent transmission of infective organism.	F 279		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the resident medication was given as prescribed by the physician for one of 20 residents (16). This deficient practice resulted to resident receiving extra dose of medication. Findings: According to Resident 16's medical record indicated the resident was admitted to the facility on 4/9/11, with diagnoses that included hypertension, cerebrovascular accident (CVA [stroke]), asthma and blindness.	F 309	F309 Provide Care/Services for Highest Well Being • On 8/4/12, Resident #16's Physician was called and notified regarding the extra dose of nasonex spray, with no new orders given. Resident #16 did not experience any negative outcome as a result of this practice. • Licensed Nurses technique and administration of nasal spray was observed by the RN Supervisor week of 8/31-9/8/12 with the correct number of sprays observed to be given to each nostril. • In-service for licensed staff was provided by the Pharmacy Consultant regarding Nasal Spray Administration and technique on 9/9/12. (Continued on Page 16 of 31)	

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F 309	Continued From page 15 The Minimum Data Set (MDS) an assessment and care screening tool dated 7/1/12 indicated the resident was alert, able to make her needs known and required supervision on staff with activities of daily living. On 8/4/12, at 8:35 a.m., during the medication pass observation for Resident 18, the licensed vocational nurse (LVN 1) administered Nasonex nasal spray, two sprays to each nostril. A review of the physician's orders for the month of July and August 2012 indicated the physician's ordered Flonase 0.05 mg/Actuation nasal spray (Fluticasone propionate) one spray to each nostril two times a day for allergic Rhinitis. However, during medication pass observation, LVN 1 administered two sprays to each nostril instead of one spray. On 8/4/12, at 9:30 a.m., during an interview, LVN 1 stated she was aware that she did not follow the physician's order.	F 309	**F309** Provide Care Plan/Services For Highest Well Being (Continued From Page 15 of 31) • Administration of Nasal Spray will be reviewed as part of a random monthly Medication Pass review by the Pharmacy Consultant, who will provide a copy of the review to the Director of Nurses. Any License Nurses found with deficient technique will be retested to until satisfactory return demonstration has been achieved. • Outcome of the Pharmacy's random monthly medication pass review will be reported by the Director of Nurses to the Quarterly Quality Assurance & Assessment Committee for further follow-up and recommendations. • Corrective action will be completed by September 8, 2012.	9/8/12
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 323	**F323** Free of Accident Hazards/Supervision/Devices • Effective immediately on 8/5/12 the barber/beauty shop supplies were locked in the utility room • On 8/6/12, in a 1:1 in-service by administration, grooming nurses and/or beauticians were instructed to lock-up all hazardous supplies/equipment when not in use. (Continued on Page 17 of 31)	

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F 323	Continued From page 18 Based on observation and interview, the facility failed to ensure residents environment were free from accident hazards. During the initial tour of the facility, the barber/hair salon room that stored chemicals and sharp instruments was left open. This had a potential for residents to wander in and exposed themselves to these supplies. Findings: On 8/3/12, at 7:55 p.m., during the initial tour, the door to the barber/hair salon room was left unlocked. The room was adjoined to a shower room. During an interview with licensed vocational nurse (LVN 3) at the same time, she stated the door was supposed to be locked when not in use, but they have a hard time explaining that to the beautician. The following items were observed: a. Three bottles of unidentified hair chemicals. b. Two bottles of unidentified cleansing solutions. c. Hair dryer d. Curly iron e. Eight razors f. Four scissors g. Four nail cutting devices During an interview with the assistant director of nursing on 8/4/12, at 10:20 a.m., she stated it was not safe to leave the door open. She stated they have some residents who were confused and wander into rooms. She stated they did not have a policy regarding accident hazards as it related to supplies in the barber/hair salon room but she concur that they had residents who are	F 323	F323 Free of Accident Hazards/Supervision/Devices (Continued From Page 18 of 31) • During Environmental Safety rounds made by Administrative Staff during the week of 8/31/12-9/6/12, beauty supplies were found to be locked –up when not in use. No other environmental hazards were observed. • On 8/6/12 Director of Staff Development provided an in-service to Nursing and the Beautician regarding accident prevention and locking of the beauty shop supplies. Daily environmental rounds will be made by Administration and/or Designee to ensure the facility is free from accident hazards & the beauty supplies are locked when not in current use. Administration ordered *Solly Mate* locking beauty salon trolleys (see attached) to provide secured storage of supplies. Delivery was received 9/8/12. Grooming nurses were provided in-service by Staff Developer. • Outcome of the daily rounds will be reported to Director of Nurses and Administration. Non-compliances will be corrected promptly and reported to the Quarterly Quality Assurance & Assessment Committee for further follow-up and recommendations. • Corrective action will be completed by September 8, 2012..	9/8/12

Salon & Spa Equipment

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Home > EQUIPMENT > Inventory Reduction Sale > Sally Mate Locking Trolley

Sally Mate Locking Trolley

Sally Item #: SBS-965622

The Sally Mate Locking Trolley features a built-in organizer top and 4 removable trays to keep your salon supplies organized and within easy reach.

This item must be shipped via ground transportation.

This product cannot be shipped to Canada, Puerto Rico, AK, HI

In-Stock Online
Available for Order Through Sally Stores

Online Price: $100.00
Sale Price: $79.99

QTY: 1

plastic

Larger View

Specifications

Assembly Required: Some Assembly Required
Special Features: Smudge-Free Textured Finish
Dimensions (H x W x D): 32"H x 13"W x 14"D

Overall Rating
Value For Price
Meets Expectations

5 of 5 (100%) customers would recommend this product to a friend.

Printable Reviews

Wahl
Online Price: $52.99

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F 323	Continued From page 17 confused and will wander in, exposing themselves to these supplies.	F 323		
F 363 SS=E	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the dietary staff failed to ensure menus are followed. During the kitchen observation, the menu indicated the dietary staff was going to serve okayu, a Japanese rice porridge, however, the dietary supervisor decided to serve an American dish, mashed potato without informing residents. Findings: On 8/4/12, at 11 a.m., an inspection of the kitchen was conducted a food preparation was performed with the dietary supervisor and dietary staff. A review of the menu revealed food being served for lunchtime were clam chowder soup, slice ham loaf with gravy, rice/okayu, honey glazed carrots and pie. During observation of the tray line food preparation, food being served was ham loaf, carrots, clam chowder, rice, pie, steam rice and mashed potato was served for the puree diet.	F 363	F363 Menus Meet Resident Needs/Prep in Advance/Followed • With continual and ever changing needs and wishes of residents, the Dietary Department will continue its endeavors to provide for the nutritional needs of the residents and to accurately post menus as being served. • The Dietary Supervisor and the Cooks, will check the menus for errors or for corrections prior to posting. • If there are any changes to the posted menus, the Dietary Supervisor will immediately write the changes and the reason for the changes on the posted menus. • Dietician shall monitor on weekly basis on varying days of the week for compliance with feedback to be Administration. • Compliance will be reviewed at the Monthly Quality Assurance and Assessment Committee. Correction will be completed by September 8, 2012.	8/5/12 9/8/12

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F 363	Continued From page 18 The dietary supervisor stated she did not serve okayu because she felt the menu called for more of an American type meat and not a Japanese type meal and that she should have told the residents that she was not going to serve okayu, but did not.	F 363		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to serve food that is palatable and attractive according to the majority of the ethnicity and cultural background of residents residing in the facility and as stated by two of 20 sample residents (1, 2) and five of six alert and oriented residents who attended the group meeting. A test tray was requested during the kitchen observation which lack in palatability was concurred by facility staff and the survey team. Findings: a. On 8/2/12, at 7:30 p.m., an interview was conducted with Resident 1. Resident 1 was alert and oriented and able to make needs known. The resident stated the food in the facility was tasted bad, and had no flavor. The resident then stated the food was not of Japanese culture and that	F 364	F364 Nutritive Value/Appearance/Palatable/Proper Temperature (See Page 20 of 31)	

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SOUTH BAY KEIRO NURSING HOME	18115 S VERMONT AVE GARDENA, CA 90247

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F 364	Continued From page 19 most of the residents who resided in the facility were of Japanese ethnicity and was appalled that the food was not tailored to the culture. The resident further stated it pertained to the breakfast, lunch and dinner meals. A review of Resident 1's Record of Admission indicated the resident was admitted to the facility on 7/30/12 with diagnoses that included left hip fracture. A review of the resident's physician's orders dated on admission indicated the resident had no dietary restrictions and was on a regular diet. b. On 7/26/12, at 9:30 a.m., an interview was conducted with Resident 2. Resident 2 was alert and oriented and able to make needs known. Upon interview, the resident stated the food in the facility tasted bad, was greasy and salty. A review of the resident's current quarterly Minimum Data Set dated 5/13/12 indicated the resident was assessed with having the ability to understand and communicate with others with no difficulty. A review of Resident 2's physician's orders dated diet orders dated 9/9/10 indicated the resident's diet was for a regular diet. c. On 7/27/12, at 6:45 p.m., during group meeting five of six residents complained the food in the facility had no flavor and the recipe was not of Japanese type dishes. The residents further stated the Japanese pickles just tasted "awful". d. On 7/28/12, at 11:50 a.m., a test tray of a	F 364	F364 Nutritive Value/Appearance/Palatable/Proper Temperature • With continual and ever changing needs and wishes of residents, the Dietary Department will continue its endeavors to provide for the nutritional needs of residents while observing appropriateness of resident desires and all possible medical restrictions. • In order to better accommodate the wishes and demands of the resident, the Dietary Supervisor will organize a Menu Advisement Committee. • The Committee will meet quarterly and include culturally/ethnically diverse residents, family members, Cooks and staff. • The Dietary Supervisor will schedule the Menu Advisement Committee meetings, notify Committee members and conduct the meetings. The members will be asked to offer feedback on current menus, with an emphasis on providing suggestions. Residents' preferences, recipes, food availability, preparation time and cooking methods will also be discussed during the meetings. (Continued on Page 21 of 31)	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555306	A. BUILDING _____ B. WING _____	08/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH BAY KEIRO NURSING HOME	15115 S VERMONT AVE GARDENA, CA 90247

(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 364	Continued From page 20 puree and chopped diet tray were requested from the dietary supervisor. In the presence of the dietary supervisor, two other surveyors and the activity director, who was of Japanese descent, tasted both the puree and chopped food trays. The foods that were served were chopped and honey glazed puree carrots, mashed potatoes, puree and chopped ham loaf with gravy, clam chowder soup, puree and cherry pie. It was concurred by three surveyors and the activity director that the puree carrots, clam chowder, and mashed potato had no flavor and two surveyors concurred that the chopped glazed ham was of poor and salty taste. The pie was sour and in an interview with the dietary supervisor, the pie was store bought. Concurrently, at noon, an interview was conducted with the dietary supervisor who stated she had a Japanese recipe for some of the food items; however, it was difficult to prepare and cook many of Japanese type dishes because it required a lot of ingredients and did not have the time to prepare a lot of the meals in the small amount of time.	F 364	F364 Nutritive Value/Appearance/Palatable/Proper Temperature (Continued From Page 20 of 31) • Random Resident Satisfaction Studies will be conducted weekly by the Dietary Supervisor with a focus on dietary services. Outcome of the Resident Satisfaction Studies will be provided to Administration and the Dietician • Findings will be discussed at the Monthly Quality assurance and Assessment Committee. The committee will make further recommendations as necessary. • Corrective action will be completed by 9/7/12	9/7/12
F 368 SS=E	483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily.	F 368	F368 Frequency of Meals/Snacks at Bedtime (See Page 22 of 31)	

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SOUTH BAY KEIRO NURSING HOME	15115 S VERMONT AVE GARDENA, CA 90247

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F 368	Continued From page 21 When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to offer bedtime snacks daily to five of six alert and oriented residents that attended the group meeting. The residents stated they did not know they were allowed to have bedtime snacks and would be hungry at night. Findings: On 8/3/12, at 7 p.m., during the Group Meeting, five of six alert and oriented residents stated they were not offered snacks in the evening time. They stated sometimes they go to bed hungry. Three of the residents stated they could not understand why they were not allowed to have a snack before bedtime. One of the residents stated you could have a bedtime snack if you ask for one and if the nurses were not busy. Another resident stated the nurses told her snacks were only given to residents with orders from the physician for nourishments. During an interview with the licensed vocational nurse (LVN 3) on 8/3/12, at 8:20 p.m., she stated she was only offering snacks to the resident that had a physician's order. She stated she was not aware all residents had a right to a bedtime snack.	F 368	F368 Frequency of Meals/Snacks at Bedtime • The facility continues to provide at least 3 meals per day, in compliance with the regulation that no more than 14 hours between a substantial evening meal and breakfast the following day. In addition Bedtime Snacks shall continue to be stocked at Stations 1 and 2 by the dietary staff. • Nursing staff will be instructed to offer all residents an evening snack unless contraindicated by the diet order. Spread Sheet Log as mentioned will be completed to indicate consumption or refusal of snacks. • Random Resident Satisfaction Studies will be conducted weekly by the Director of Nursing or her designee. Outcome of the Resident Satisfaction Studies and non-compliances will be provided to Administration. • Findings will be discussed at the Monthly Quality assurance and Assessment Committee. The committee will make further recommendations as necessary. • Corrective action will be completed by September 7, 2012	9/7/12

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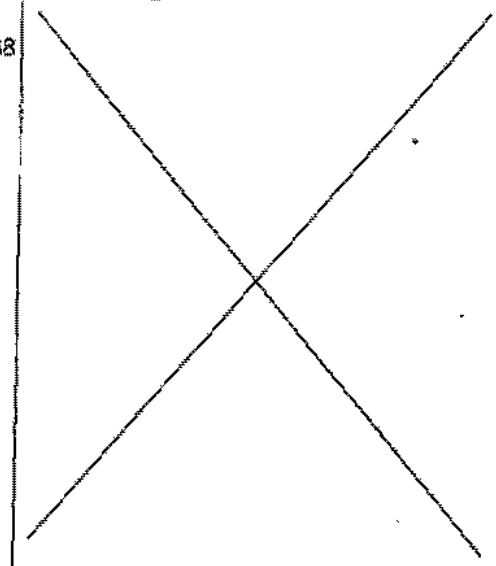
F 368	Continued From page 22 and she could not provide documented evidence of the residents who did or did not receive snacks. During an interview with the dietary supervisor on 8/4/12, at 11 a.m., she stated dietary staff left a cart full of cold and warm snacks out at the nurses' station for the nurses to pass out for bedtime snacks and that nurses are suppose to document on a spreadsheet which residents received snacks and the type of snack was given. A review of the spreadsheet presented by dietary supervisor indicated no evidence that residents received any snacks at bedtime for the entire month of July to August 3, 2012. The dietary supervisor further stated the cart is left out in the hallway for residents to freely get up out of bed and get a snack at bedtime.	F 368		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the	F 431	F431 Drug Records, Label/Store Drugs & Biologicals (See Page 24 of 31)	

Centers for Medicare & Medicaid Services
National Medicare, Medicaid and CHIP Flu Education Campaign

Get the Flu Vaccination--not the Flu! No Cost – No Excuses

The Food and Drug Administration recently announced that it has approved vaccines for the 2011-2012 influenza seasons and that the seasonal influenza vaccine protects against three strains of influenza:

- A/California 7/2009 (H1N1) – like virus
- A/perth /16/2009 (H3N2) – like virus
- B/Brisbane/60/2008 – like virus

As a health care provider, you are the first line of defense in communicating to your patients the importance of getting vaccinated. It is equally important for you and your health care staff to be vaccinated as well. Key messages to share with your patients include:

- The flu vaccine is available at no additional out-of-pocket cost for Medicare patients and for children eligible for Medicaid and CHIP. There is no coinsurance or copayment applied to this benefit, and they will not have to meet their deductible.
- The flu vaccine can prevent the flu; it does not give people the flu. Getting a flu vaccine is the best thing you can do to keep you from getting sick this flu season. This year, one flu vaccine will protect you from three different types of flu virus, including the 2009 H1N1 virus that caused much illness two seasons ago. Additionally, by protecting yourself, you are also protecting those you care about from getting the flu from you.
- All adults age 65 years and older, and people who are under 65 who have chronic illness, including heart disease, lung disease, diabetes or end-stage renal disease should get a flu vaccine.
- Refer your patients to www.medicare.gov or call 1-800-MEDICARE (1-800-633-4227) to get a free copy of "Staying Healthy: Medicare's Preventive Services." TTY users should call 1-877-486-2048.
- Additionally, for non-Medicare patients, beginning Sept. 23, 2010, health plans will be required to cover recommended preventive services without charging copayments, co-insurance or deductibles.

Helpful tips for patients to follow during flu season:

- Cover your nose and mouth with a tissue when you cough or sneeze. Throw the tissue in the trash after you use it. If you don't have a tissue, cough or sneeze into your upper sleeve or elbow, not your hands.
- Wash your hands often with soap and water, especially after you cough or sneeze. Alcohol-based hand cleaners also work.
- Avoid touching your eyes, nose or mouth. Germs spread this way.
- Try to avoid close contact with sick people.

• Stay home if you are sick until at least 24 hours after you no longer have a fever (100 degrees Fahrenheit or 37.8 degrees Celsius) or signs of a fever (without the use of a fever-reducing medicine.
• Follow public health advice, if it is given, regarding school closures, avoiding crowds and other social distancing measures.

The website www.flu.gov has resources to help health care professionals stay informed about the latest flu information. Please visit the following link for additional provider resources on immunizations: www.cms.gov/Immunizations/. More information is available at www.healthcare.gov .

This information prepared by the U.S. Department of Health and Human Services.

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F 431	Continued From page 23 facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a *missing* dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to store and dispose of drugs and/or biologicals and accurately reconcile controlled drugs in accordance with State law Title 22 Section 72353 (b). The nursing staff failed to account for the controlled drugs among themselves prior to the start/end of their working shift and failed to ensure drugs are stored in locked compartments accessible only to designated/authorized personnel. Findings: a. During an observation and record review, on 8/2/12 , at 7:30 p.m., the controlled drug/count record sheet lacked signatures. Further review identified that on 8/2/12, the licensed nurses on the 7 a.m. to 3 p.m. and the 3 p.m. to the 11 p.m., failed to account for the narcotic/controlled drugs	F 431	F431 Drug Records, Labels/Store Drugs & Biologicals • Effective 8/5/12 forward the controlled drugs have been reconciled and have been signed for by each licensed nurse at the beginning and end of the shifts. Additionally, the medication refrigerator has been locked from 8/5/12 going forward. The Nurses responsible received a 1:1 in-service with the Assistant Director of Nurses regarding failure to lock the refrigerators & signing of the narcotic count as per facility policy. (Continued on Page 25 of 31)	

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F 431	Continued From page 24 during their working shift. During an interview with the licensed vocational nurse (LVN 3) at the same time, she stated she failed to count and signed for the controlled drugs during her shift. She stated she just forgot to do it. When asked if she counted the controlled drugs with another nurse, she offered no comment. A review of the facility's policy on Controlled Substances/Medication and Storage indicates all controlled substances must be accounted for. Two licensed nurses must count the controlled substances together. Both individuals must sign the designated narcotic record. The facility staff failed to implement the above policy for its residents. During an interview with the assistant director of nursing, on 8/4/12, at 11:15 a.m., she stated she was disappointed that staff failed to follow the policy. She stated they had been in-service to be careful with narcotics and controlled substances. b. During the general observation on 8/3/12 at 7 p.m., with the charge nurse, the refrigerator in the medication room was left unlocked. The emergency kits which contained multiple narcotics and injectables was left unlocked. During an interview with the assistant director of nursing on 8/3/12, at 7:30 p.m., she stated she could not explain why staff left the above medications unlocked. She further stated they had installed a key lock so that it could be kept safely. She stated they had been in-service to keep the medications in locked compartments and was upset to know this is not being done.	F 431	F431 Drug Records, Labels/Store Drugs & Biologicals (Continued From Page 24) • Controlled drug count sheets and medications refrigerators were checked by the Director of Nurses/Designee week of 8/31-9/8/12 with the medication refrigerators locked and controlled sheets found to be complaint. • Random checks for locking of refrigerators, and signing of the Narcotic Sheets will be checked weekly by the RN supervisor with non-compliances reported to the Director of Nurses for immediate correction. Pharmacy Consultant will also monitor for compliance in these areas as part of the monthly drug regimen review. • Outcome of the weekly RN Supervisor checks and the Monthly Pharmacy Regimen Review will be reported by the Director of Nurses at the Quarterly Quality Assurance & Assessment Committee Meetings for further action as necessary. • Corrective action will be completed by September 8, 2012	9/8/12

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F 431	Continued From page 25 Record review of the facility undated policy and procedure on Storage of Drugs, indicated for the safety of the residents and for drug accountability, drugs must be kept in locked compartments. The facility failed to implement the above policy for each residents.	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted	F 441	F441 Infection Control, Prevent Spread, Linens (See Page 27 of 31)	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH BAY KEIRO NURSING HOME	13116 S VERMONT AVE GARDENA, CA 90247

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F 441	Continued From page 26 professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to maintain an infection control program designed to provide a safe and sanitary environment to help prevent the development and spread, and transmission of disease and infection for two of 20 sample residents (2, 17). Resident 2, who did not require residing in isolation room, resided in a room with another resident (4) who required being in isolation where staff and visitors had to wear protective equipment. Resident 2 was not protected from the potential of acquiring an infection from Resident 4. The facility staff failed to wash her hands after removing the Resident 17's soiled dressing. Findings: a. On 8/2/12, at 7:10 p.m., outside of Resident 2's room was a plastic shelf unit with drawers that stored disposal yellow gowns, gloves and masks. Concurrently, an interview was conducted with the resident in the presence of the rehabilitation nurse, and the resident stated she was upset because she felt as if the food was, " just passing through". The nurse clarified with the resident and questioned if the resident was having	F 441	**F441** Infection Control, Prevent Spread, Linens • As of 8/6/12 resident #4 has been discontinued from isolation and course of Antibiotics completed on 8/6/12. Resident #2 was re-assessed by the Assistant Director of Nurses and the Physician on 8/10/12 for any possible infection and expressed no more health concerns at this time. The Treatment Nurse for Resident #17 received a 1:1 in-service from the ADNS regarding washing of hands after removing dressings from the residents. Effective 8/5/12 forward, the treatment nurse has been compliant with hand washing during wound care. • Infection Control Nurse/Designee made rounds week of 8/31/12-9/6/12 with no deficient infection control practices observed. (Continued on Page 28 of 31)	

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F 441	Continued From page 27 diarrhea and the resident stated she no longer wanted to talk about it. In a later interview, the nurse was questioned by the surveyor as to what type of isolation the resident was in and she stated that Resident 4 required contact isolation and that Resident 2 did not require isolation. A review of Resident 2's Record of Admission indicated the resident was admitted to the facility on 9/9/10 with diagnoses that included gastrointestinal bleeding, high blood pressure, and low blood count. A review of the resident's current quarterly Minimum Data Set dated 5/13/12 indicated the resident was assessed with having the ability to understand and communicate with others with no difficulty. The resident was also assessed as requiring supervision with going to the bathroom and personal hygiene such as brushing teeth, washing hands and face, and uses a walker to walk in and around the corridors and the room. A review of Resident 4's physician's orders dated 7/31/12 indicated to give the resident antibiotic treatment Nitrofurantoin 100 milligrams twice a day for 7 days and Cephalexin 500 milligrams twice a day for 7 days orally for ESBL and urinary tract infection and on 8/1/12, an order to move the resident into Resident 2's room for Contact Isolation (ESBL is "extended-spectrum beta lactamase "a gram negative bacteria that is multi-drug resistant). On 8/3/12, at 6:10 p.m., an interview was conducted with LVN 1 who stated Resident 2 had not reported any loose bowel movements to staff and no reports have been made or documented.	F 441	**F441** Infection Control, Prevent Spread, Linens (Continued From Page 27) • In-service given by the Director of Nurses and Infection Control Nurse regarding Prevention of Infection & hand washing on 9/6/12. Weekly infection control rounds will be conducted by the Infection Control Nurse/Designee with any deficient practices report to the Director of Nurses and corrected promptly. Policy for handling residents with ESBL was reinforced with nursing along with protective barriers, and methods for disinfecting of soiled surfaces. • The Director of Nurses will report outcome of the weekly rounds to the Quarterly Quality Assurance & Assessment Committee Meetings for further action as necessary. • Corrective action will be completed by September 8, 2012.	9/8/12

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F 441	Continued From page 28 LVN 2 further stated Resident 2 was fairly independent getting up out of bed going to the bathroom on her own and unless the resident reported loose stools, the staff would be unable to monitor the resident's bowel movement activity. LVN 2 then stated that Resident 4 was in contact isolation for ESBL in the urine and had an indwelling catheter. The staffs were required to wear gown and gloves when in contact with Resident 4 and the resident's urine and used universal precautions. The surveyor questioned if staff needed to use gown, gloves and universal precautions when in contact with Resident 4's urine, how Resident 2 was protected from contact with Resident 4's infected urine since Resident 2 used the same toilet that staff emptied Resident 4's urine in. LVN 1 stated they had no way to ensure Resident 2 was protected from Resident 4's infected urine especially since they used the same bathroom. On 8/4/12, at 9:30 a.m., an interview was conducted with Resident 2 who stated she had been having loose stools after every meal at least three times a day for the last two to three days and have told several staff but felt staff haven't listened to her concerns therefore she stopped them. A review of facility's policy and procedure for Multi-Drug Resistant Organisms (MDRO) dated January 2011 indicates it is the facility's policy to implement infection control measures to prevent the spread of communicable diseases and conditions. Prevention and control of MDRO transmission which includes ESBL, includes	F 441		

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F 441	Continued From page 29 standard contact precautions such as hand washing, the use of protective barriers such as gloves, when touching surfaces soiled with blood or other body fluids. Gowns, when anticipated that clothing will become soiled with blood or other body fluids or when in contact with soiled surfaces or masks or face shield if blood or body fluids may be splashed or sprayed into the mucous membranes of the eyes, nose and or mouth. Disinfection of soiled surfaces and high touch surfaces as well as equipment daily or more frequently by designated staff member(s) should be done in order to prevent the spread of MDRO and other pathogenic microorganism. b. On 8/4/12, at 10:40 a.m., during a wound care observation, the treatment nurse was observed put a pair of gloves, and removed Resident 17's sacral area (sitting bone) dressing, discarded the soiled dressing into a plastic bag, and removed her gloves. Without washing her hands, she put a new gloves on and then cleansed wound with normal saline solution. The treatment nurse removed gloves again, put a new pair of gloves on and applied the new wound dressing without washing her hands. On 8/4/12, at 11:20 a.m., during an interview, the treatment nurse stated she did not wash her hands after she removed soiled dressing, because she will put on a new pair of gloves. According to the facility undated policy and procedure titled "Hand Washing", indicated all staff members will wash their hands before and after direct resident care and after contact with	F 441		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555306	A. BUILDING _____ B. WING _____	08/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH BAY KEIRO NURSING HOME	15115 S VERMONT AVE GARDENA, CA 90247

(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 441	Continued From page 30 potentially contaminated substances to prevent, to the extent possible, the spread of infections. Washing hands before and after touching wounds of any kinds.	F 441		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide a functional environmental for residents, staff and the public by ensuring the disability wall switch opener was in working order. Findings: On 8/4/12, at 10:30 a.m., the disability wall switch opener from the entrance to the front door was not working when pressed from the outside switch. This switch allowed residents, staff as well as the public or visitors who needed access into the building by accessing it through an automatic door opener via disability wall switch opener. At 10:45 a.m., of the same date, the observation was confirmed with the maintenance supervisor who stated a battery needed to be replaced. At 2 p.m., an interview was conducted with the maintenance supervisor who stated the battery was not the problem and that he needed to look further into a possible electrical issue.	F 465	F465 Safe/Functional/Sanitary/Comfortable Environment • In an ongoing effort to make enhancements to the facility's physical plant, refurbishment of the Lobby included the installation of a handicapped accessible front door, which included the installation of wireless wall mount automatic door opener switch. • Upon the replacement of the battery by the EVS Supervisor, a repairman was called and on 8/6/12 the exterior wall mount switch was place back into service. • The operation of the automatic door will be monitored by security with any reports malfunction to be reported immediately to the EVS Supervisor and administration.	8/6/12