STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555065	A. BUILDING _____ B. WING _____	07/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIEW PARK CONV HOSP	3737 DON FELIPE DRIVE LOS ANGELES, CA 90008

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during a recertification visit. Representing the Department of Public Health: [redacted] Total Population: 90 Sample Size: 18 Highest scope and severity: E	F 000	View Park Convalescent Hospital makes its best efforts to operate in full compliance with both Federal and State regulations. Nothing included in this plan of correction is an admission otherwise. Alameda Care Center has submitted this plan of correction in order to comply with its regulatory obligation and does not waive any objection to the merit or form of allegation contained herein. The submission of this plan of correction constitutes our allegation for compliance.	
F 246 SS=D	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 observation, interview, and record review, the facility failed to ensure the call light was within reach for 1 of 18 sampled residents (Resident 8). This had the potential to cause Resident 8's needs not to be met. Findings: On July 17, 2011, at 10:30 a.m., Resident 8 was	F 246	F246 a- Corrective Action: The DON immediately made the nurses aware of the findings and gave 1:1 in service on the policy and procedure of accommodation of needs include the call light and hydration management. b- Identification of others The DON, and the DSD made round, checked all residents, to ensure compliance.	

HEAD - WEST DISTRICT
RECEIVED
SEP 7 2011

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

Administrator 9-2-11

ficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days ing 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 following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued am participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555065	A. BUILDING _____ B. WING _____	07/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIEW PARK CONV HOSP	3737 DON FELIPE DRIVE LOS ANGELES, CA 90008

(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 1	F253		

observed sitting in her wheelchair, her call light was not within her reach. The resident saw the surveyor and asked her for assistance with getting her water.

On July 17, 2011, at 10:35 a.m., during an interview, the director of staff development stated Resident 8's call light should have been within reach of the resident.

A review of Resident 8's Admission Face Sheet revealed the resident was re-admitted to the facility on March 15, 2011, with diagnoses that included cerebrovascular accident (a stroke) and gastrostomy tube placement (a tube placed in the stomach through the abdomen to provide nutrition).

According to an annual Minimum Data Set (MDS), a standardized assessment tool, dated March 12, 2011, the resident was moderately impaired in cognition. The resident was usually able to make himself understood and usually understood others. The resident was totally dependent on staff for activities of daily living (ADL).

A facility policy titled, "Call Lights System" undated indicated the call light would be within the resident reach at all times.

F 253 SS=D 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES

The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.

F 246 a- Corrective Action:
The DSD replaced the bed pans and drinking glasses that not labeled, the maintenance supervisor repaired the broken wooden closet doors and changed the window curtains for room 114, changed the shower curtain, repaired the wheelchairs and Geri chair arm rests, and the grab bar in the hallway

b- Identification of others
The administrator, the DSD, the housekeeping and maintenance supervisor made round to all rooms, checked all medical equipments, no problem identified.

c- Measures to prevent recurrence:
The administrator gave in service to staff on environment and medical equipment includes safety, infection control. The housekeeping supervisor, the maintain supervisor will check the medical equipments and environment daily, the DSD and RN supervisor will check residents' personal items and will label items during daily round if necessary. Administrator

F 253 and DON will randomly check for compliance.

PRINTED: 08/24/2011
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
	555065	A. BUILDING _____ B. WING _____	07/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIEW PARK CONV HOSP	3737 DON FELIPE DRIVE LOS ANGELES, CA 90008

(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 253	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility's housekeeping, nursing, and maintenance staff failed to ensure the facility was kept in an orderly and comfortable manner. The facility failed to label residents' personal used items, closet doors would not close, curtains were stained, rails were loose, and wheelchairs and Geri chairs' arm rests were cracked and torn which had the potential to cause skin tears. Failure to provide housekeeping and maintenance services places residents at risk for living in an unkempt environment and feelings of low self esteem. Findings: On July 16, 2011, at 7:30 a.m., during the initial tour of the facility, the following were observed: 1. Multiple bed pans and wash basins in residents' bathrooms and on the floor were unlabeled. 2. Drinking glasses in residents' bathrooms on the window sill. 3. Multiple wooden closet doors off the track, broken (with splintered wood) and that would not close. 4. Room 114 window curtains stained 5. The shower room near Room 135 had a shower curtain that was stained with what appeared to be mold 6. Multiple wheelchairs and Geri chairs' arm rests were torn and cracked 7. Multiple areas along the wall in the hallway had a rail along the bottom of the wall (blue) that was loose and pulling away from the wall.	F 253	d- Monitoring performance: The administrator will present the recapitulation of the findings daily for review and action as indicated. e- Corrective action will be completed on 9/5/11	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555065	A. BUILDING _____ B. WING _____	07/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIEW PARK CONV HOSP	3737 DON FELIPE DRIVE LOS ANGELES, CA 90008

(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 253	Continued From page 3 On July 16, 2011, at 8:10 a.m., Licensed Vocational Nurse 1 (LVN 1) acknowledged the findings found on tour and stated she would inform the maintenance/housekeeping staff. On July 17, 2011, at 3:50 p.m., the housekeeping supervisor was made aware of the loose blue rails along the wall and stated he would repair them.	F 253		
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 notify the physician	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555065	A. BUILDING _____ B. WING _____	07/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIEW PARK CONV HOSP	3737 DON FELIPE DRIVE LOS ANGELES, CA 90008

(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 279	Continued From page 4 and ensure a plan of care was created for a resident, who had a change in condition for one of 18 sampled residents (Resident 11). This had the potential to cause further decline in the resident's condition. Findings: On July 17 2011, at 11 a.m., Resident 11 was observed lying in her bed complaining it was hot. A fan was observed on Resident 11's bed side table that was on. On July 17, 2011, at 11:15 a.m., the maintenance supervisor checked the room temperature in Resident 11's room. The room temperature was 73 degrees Fahrenheit. On July 18, 2011, at 10:30 a.m., Resident 11 was observed lying in bed complaining it was hot and the fan was on. On July 18, 2011, at 10:35 a.m., during an interview, Resident 11's roommate stated the room temperature was fine. She stated Resident 11 always complained about being hot. On July 18, 2011, at 10:45 a.m., during an interview, Registered Nurse 2 (RN 2) stated Resident 11 started complaining of being hot approximately two months ago. She stated the resident would some time pull her clothes off when she was hot and the family brought the fan to keep the resident cool. RN 2 stated the physician had not been notified nor did they have a care plan in place regarding Resident 11's change of condition.	F 279	F279 a- Corrective Action: The MDS coordinator did comprehensive assessments for resident 11, updated the care plans for complaint of being hot. b- Identification of others : The MDS coordinator and the RN supervisor reviewed clinical records for all residents, no problem identified c- Measures to prevent recurrence: The DON gave in service to the MDS coordinator and all license nurses on the policy and procedure of change of condition includes assessments and care plans, the MDS consultant will review the resident's assessments and care plans monthly for 3 month then quarterly, the DON will randomly review the clinical records for compliance. d- Monitoring performance: The MDS coordinator will present the recapitulation of the findings to the monthly QA meeting for review and action as indicated. e- Corrective action will be completed on 9/5/11	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555065	A. BUILDING _____ B. WING _____	07/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIEW PARK CONV HOSP	3737 DON FELIPE DRIVE LOS ANGELES, CA 90008

(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 279	Continued From page 5 A review of Resident 11's Admission Face Sheet, revealed the resident was admitted to the facility on April 17, 2011, with diagnoses that included cerebrovascular accident (a stroke), hypertension, and gastrostomy tube placement (a tube placed in the stomach through the abdomen provide nutrition). According to an annual Minimum Data Set (MDS), a standardized assessment tool, dated June 26, 2011, Resident 11 was moderately impaired in cognition. The resident was usually able to make himself understood and usually understood others. The resident was totally dependent on staff for activties of daily living A facility policy titled, "Change of Condition" undated indicated upon change of any condition the nurses would do the following: Notify the physician promptly, daily assessment, care plan the change.	F 279	F286 a- Corrective Action: The MDS coordinator did comprehensive assessments for resident 12. b- Identification of others : The MDS coordinator and the RN supervisor reviewed MDS assessments for all residents, all in compliance. c- Measures to prevent recurrence: The DON gave in service to the MDS coordinator on the policy and procedure of resident assessments include the admission assessments, change of condition assessment, quarterly assessments, etc. the medical record will audit the assessment completion for all residents, the MDS consultant will check assessment completion monthly and the DON will randomly review for compliance. d- Monitoring performance: The DON will present the recapitulation of the findings to the monthly QA meeting for review and action as indicated. e- Corrective action will be completed on 9/5/11	
F 286 SS=D	483.20(d) MAINTAIN 15 MONTHS OF RESIDENT ASSESSMENTS A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facilities nursing staff failed to ensure they completed an initial/admission Minimum Data Set (MDS) Assessment for one of 18 sampled residents (12). Failure to complete an initial/admission assessment places residents at risk for non assessment and non continuity of	F 286		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555065	A. BUILDING _____ B. WING _____	07/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIEW PARK CONV HOSP	3737 DON FELIPE DRIVE LOS ANGELES, CA 90008

(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 286	Continued From page 6 care. Findings: On July 17, 2011, at 1:25 p.m., during an interview, Registered Nurse 1 (RN 1) stated Resident 12's admission MDS Assessment should have been completed within 14 days from admission (July 13, 2011) but because of the new 3.0 system, her other job responsibilities and the large volume of MDS assessments that needed to be completed, she was unable to complete it on time. A review of Resident 12's Admission Record indicated she was admitted to the facility on June 29, 2011. A review of Resident 12's Medical Records indicated no written documentation that an initial/admission MDS Assessment was completed. The resident was admitted to the facility on June 29, 2011, an initial/admission MDS should have been completed by July 13, 2011. A facility policy titled, "Assessment of Residents" undated indicated the Minimum Data Set shall be complete for each resident regardless of payer status in facilities certified by the Medicare/Medicaid programs. The initial assessment is to be complete within 14 days after admission.	F 286		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a	F 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555085	A. BUILDING _____ B. WING _____	07/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIEW PARK CONV HOSP	3737 DON FELIPE DRIVE LOS ANGELES, CA 90008

(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 315	Continued From page 7 resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility's nursing staff failed to ensure two of 18 sampled residents (3, 8), who had an indwelling urinary catheters, had the intake and output (I&O) monitored and evaluated and/or had their drainage bag placed in the correct position, below the bladder. Failure to obtain, calculate and evaluate the I&O and to place a residents indwelling urinal catheter below the resident's bladder places residents unrecognized urinary problems, infections and dehydration. Findings: a. On July 16-17, 2011, Resident 3 was observed with an indwelling urinary catheter hanging on the side of the bed. On July 16, 2011, at 3:58 p.m., the catheter was noted with clear urine and sediments. On July 17, 2011, at 2:30 p.m., during an interview and after reviewing Resident 3's medical records, Licensed Vocational Nurse 1 (LVN 1) stated she remembered completing the resident's I&O but could not find the documentation.	F 315	F315 a- Corrective Action: The RN supervisor did comprehensive assessments for resident 3, 8, updated the information with the MD, and initiated the intake and output for both residents for 30 days b- Identification of others : The RN supervisor reviewed the residents who are on intake and output monitoring, and all I&O monitoring records are complete. c- Measures to prevent recurrence: DSD gave in-service to C.N.A's on proper positioning of the drainage bag. DON gave in service to licensed nurses on the policy and procedure of I&O record includes the calculation and evaluation. Medical Records Director will audit the I&O monitoring record monthly, the RN supervisor will check the record monthly and the DON will randomly review for completion. d- Monitoring performance: The DON will present the recapitulation of the findings to the monthly QA meeting for review and action as indicated. e- Corrective action will be completed on 9/5/11	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555065	A. BUILDING _____ B. WING _____	07/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIEW PARK CONV HOSP	3737 DON FELIPE DRIVE LOS ANGELES, CA 90008

(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 315	Continued From page 8	F 315		

A review of Resident 3's Admission Records indicated she was admitted to the facility on June 16, 2011.

Physician's Orders, dated June 17, 2011, indicated Resident 3 was to have an indwelling urinary catheter to bed side drainage.

A review of Resident 3's Medical Record (multidisciplinary progress record, assessments, medication assessment record [MAR]) indicated no written documentation that I&Os had been obtained and monitored.

A facility policy titled, "Fluid Intake and Output" undated indicated fluid intake and output will be recorded on all residents with an indwelling catheter. Daily intake and output will be recorded for a minimum of 30 days. At the completion of the 30-day period a licensed nurse will evaluate the patient to determine further need for documentation of intake and output. The evaluation will be recorded on the intake and output assessment form. The completed intake and output assessment form will be maintained in the patient's medical record.

b. On July 17, 2011 at 11: 05 a.m., Resident 8 was observed lying in bed with an indwelling urinary catheter attached to the bed frame. There was urine observed in the drainage tubing. When Certified Nursing Assistant 2 (CNA 2) was observed changing the resident's diaper, she placed the indwelling catheter bag, with urine in the drainage tubing in the resident's bed causing the urine to back up into the bladder. The certified nursing assistant left the drainage bag in the bed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555065	A. BUILDING _____ B. WING _____	07/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIEW PARK CONV HOSP	3737 DON FELIPE DRIVE LOS ANGELES, CA 90008

(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 315	Continued From page 9 until she finished changing the resident's diaper. A review of the resident's admission record disclosed Resident 8 was readmitted to the facility on June 24, 2011, with a diagnoses that included dysphagia difficulty swallowing) and cerebrovascular accident (stroke). The Minimum Data Set, an assessment and care screening tool, dated July 5, 2011 indicated the resident's cognition was severely impaired and was totally dependent on staff for her care needs. The resident had an indwelling catheter and was incontinent of bowels. When interviewed on July 17, 2011 at 12:30 p.m., CNA 2 stated she should not place the indwelling catheter and drainage bag in the bed.	F 315		
F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility's nursing staff failed to ensure they had a medication error rate no greater than five percent (%). On July 16-17, 2011, medication pass observations were conducted to three licensed vocational nurses (LVN), 47 opportunities for error were observed with eight errors, yielding a medication error rate of 17%. Findings:	F 332		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555065	A. BUILDING _____ B. WING _____	07/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIEW PARK CONV HOSP	3737 DON FELIPE DRIVE LOS ANGELES, CA 90008

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 332	Continued From page 10 a. On July 17, 2011, at 8:25 a.m., LVN 1 was observed administering medication to Resident 12. Resident 12 received all medications prescribed to her including Aggrenox (used to reduce the risk of stroke in people who have had blood clots) 25-200 milligrams (mg) (a red/white capsule), which was opened and the contents of the capsule was crushed and mixed with applesauce. Following the medication pass the medications administered to the resident were reconciled against the physician's orders. On July 17, 2011, at 3:20 p.m., during an interview, LVN 1 stated the resident could not swallow the capsule and there was no other form of the medication that could be substituted. She acknowledged she had not contacted the resident's physician in order to obtain an amended order. Physician's Orders, dated June 29, 2011, indicated Resident 12 was to receive Aggrenox 200/25 mg two times daily for deep vein thrombosis (a condition in which a blood clot (thrombus) forms in one or more of the deep veins in the body, usually in the legs) prophylaxis. According to the Geriatric Dosage Handbook, Including Clinical Recommendations and Monitoring Guidelines, 12th Edition, 2007, p. 126-127; Aspirin and Dipyridamole (Aggrenox): Antiplatelet Agent Administration: Capsule should be swallowed whole; do not crush or chew Patient Information: Swallow capsule whole without chewing or crushing	F 332	a-Corrective Action: The DON made the licensed nurses aware of the findings and gave 1:1 in service on the policy and procedure of medication administration include the right patient, right dosage, right time, etc. b-Identification of others :. The DON and RN supervisor observed medication administration on all shifts to ensure all compliance. c- Measures to prevent recurrence: The DON gave in service to licensed nurses on the policy and procedure of medication administration includes the right patient, right dosage, and right time. Also, add the list of do not crushed medications in the MAR. The pharmacy consultant will follow medication administration procedure monthly for 6 month then as indicated, the DON will randomly observe the medication administration for compliance. In addition, licenses nurses will perform a 3-way audit when they do their weekly summary that will consist of checking the doctor's order, medication sheet and the medication.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555065	A. BUILDING _____ B. WING _____	07/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIEW PARK CONV HOSP	3737 DON FELIPE DRIVE LOS ANGELES, CA 90008

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 332	Continued From page 11 A facility Do Not Crush Medication List, dated January 31, 2008, indicated Aggrenox was a slow release medication and should not be crushed. b. On July 16, 2011 at 10:10 a.m., during the medication pass observation, LVN 2 was observed administering multivitamins with minerals to Resident 6. LVN 2 crushed Diovan 320 milligrams (mg) mixed with water, and poured the medication into the gastrostomy tube (GT, a tube surgically placed through the abdominal wall directly to the stomach). The powdered medication did not completely dissolve, half of the medication was left in the medication cup, and the medication nurse poured water in the medication cup with the powdered medicine. The nurse picked up the medication cup, the cup fell out of her hands and spilled on the floor, therefore the resident did not get all of her medication. A review of the physician's orders, dated July 15, 2011, disclosed the following orders: 1. Multivitamins 5 ml liquid by gastrostomy tube daily. However, multivitamins with minerals was given. 2. Diovan 320 mg by gastrostomy tube. 3. Zinc sulfate 220 mg by GT daily for 6 weeks for wound healing. LVN 2 failed to administer zinc sulfate 220 mg as ordered by the physician. On July 16, 2011 at 3 p.m., during a clinical record review, there was no documentation that LVN 2 reported to the physician that Resident 8	F 332	d- Monitoring performance: The DSD will present the recapitulation of the findings to the monthly QA meeting for review and action as indicated. Competency performance check will be done every month for the next 6 months and quarterly thereafter for 1 year, then yearly. e- Corrective action will be completed on 9/5/11	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555065	A. BUILDING _____ B. WING _____	07/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIEW PARK CONV HOSP	3737 DON FELIPE DRIVE LOS ANGELES, CA 90008

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 332	Continued From page 12 did not receive all her Diovan dose during the medication pass. On July 17, 2011 at 4 p.m., during an interview LVN 2 had a blank stare when questioned about the medication errors. c. On July 17, 2011 at 9:30 a.m., during the medication pass observation for Resident 7, LVN 2 gave the following medications: Actos 15 mg by mouth, multivitamins one tablet by mouth, and Miralax one teaspoon by mouth. A review of the physician orders, dated April 26, 2011, revealed orders for the following medications: 1. Actos 15 mg by mouth daily with meals. 2. Multivitamins with minerals 1 tablet by mouth daily. 3. Abilify 10 mg tablet by mouth daily for psychosis. LVN 2 failed to administer the Abilify 10 mg as ordered by the physician. There was a physician's order, dated May 19, 2011, for Miralax 1 tablespoon by mouth three times a day for constipation. When interviewed on July 17, 2011 at 3 p.m., LVN 2 did not have a response to the medication errors.	F 332		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555065	A. BUILDING _____ B. WING _____	07/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIEW PARK CONV HOSP	3737 DON FELIPE DRIVE LOS ANGELES, CA 90008

(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 371	Continued From page 13 (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure dietary staff wore gloves and hair nets during the preparation of food; they failed to ensure food placed in the refrigerator was labeled; they failed to ensure they were able to verify expiration dates of canned food items stored in the pantry; they failed to ensure drinks were within a safe temperature range; and they failed to ensure residents received an appropriate portion of meat with their meals. These practices had the potential to cause food borne illnesses, hunger and weight loss. Findings: On July 16, 2011, at 7 a.m., during the initial tour of the kitchen the following were observed: 1. Staffs 1 and 2 were observed preparing food and were not wearing gloves or hair net. 2. A bowl of apple sauce was observed in the refrigerator without a date. On July 17, 2011 at 11:30 a.m., the following was observed: 1. Six cans of gold-n-sweet pan release and two cans of Heinz condensed tomato soup was	F 371	F371 a-Corrective Action: The Dietary Supervisor immediately made the dietary staff aware of the findings replaced all food that were not labeled, and replaced all drinks that were not stored in the right temperature, and checked food expiration date. The administrator gave 1:1 in service on food preparation and infection control includes proper use of gloves and hairnet. b-Identification of others:. The administrator and the dietary supervisor observed the food preparation, checked food storage, no problem identified. c-Measures to prevent recurrence: The Dietary Supervisor gave in service to the dietary staff on the dietary manual includes the food preparation, storage, temperature, proper use of glove and hair net, labeling, etc. The dietary supervisor will check food storage, meal preparation daily, the registered dietitian will check the kitchen and observe food preparation monthly, the administrator and registered dietitian consultant will randomly check for compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555065	A. BUILDING _____ B. WING _____	07/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIEW PARK CONV HOSP	3737 DON FELIPE DRIVE LOS ANGELES, CA 90008

(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 371	Continued From page 14 stored on the shelf without expiration dates. The dietary supervisor was unable to verify when the cans expired. On July 17, 2011, at 11:45 a.m., during an interview, the dietary supervisor stated the staff should wear gloves and hair nets. She stated the applesauce should have been labeled and she should have been able to verify when the canned goods expired. On July 18, 2011, at approximately 12:45 p.m., the temperatures of the milk and juice were tested; they were on the last trays served to the residents. The temperatures of the milk and juice were 65 degrees Fahrenheit. On July 18, 2011, at 12:50 p.m., during an interview, the dietary supervisor stated the temperature of the milk and juice should have been 41 degrees Fahrenheit or below. A review of an undated facility policy titled "Daily Food Temperature Control" indicated cold foods shall be less than 41 degrees Fahrenheit. On July 18, 2011, at 12:15 p.m., during a tray line observation (lunch), a dietary staff was observed measuring, picking up food and placing it on the residents' trays using tongs (a utensil use to pick up food). The tongs were used for the first two carts before the dietary staff was told by the dietary supervisor to use a scoop. On July 18, 2011, at 12:25 p.m., during an interview, the dietary supervisor stated the staff member should have used the scoop for all the tray line.	F 371	d- Monitoring performance: The Dietary Supervisor will present the recapitulation of the findings to the monthly QA meeting for review and action as indicated. e- Corrective action will be completed on 9/5/11	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555065	A. BUILDING _____ B. WING _____	07/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIEW PARK CONV HOSP	3737 DON FELIPE DRIVE LOS ANGELES, CA 90008

(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 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility's nursing staff failed to ensure consents obtained for three of 18 sampled residents (1, 3, and 12) were complete. Failure to complete consents places the facility out of compliance with the informed consent requirements. Findings: On July 17, 2011, at 1:20 p.m., during an interview, the director of nursing (DON) stated consents should be fully completed with the responsible party named, who gave consent and the physician's signature and date they signed. a. A review of Resident 1's medical records indicated consents for bilateral side rails, dated November 29, 2010; a lap buddy across the wheelchair for safety from falls and injuries, dated February 1, 2011; Haldol 0.5 milligrams (mg) at	F 514	F541 a- Corrective Action: The DON completed the consent after updated the consent information with the primary physician and the responsible party for resident1. 3, and 12 b- Identification of others:. The MDS coordinator and the RN supervisor reviewed the consents for all residents, all in compliance. c- Measures to prevent recurrence: The DON gave in service to licensed nurses on the policy and procedure of the informed consent, the medical record will audit the completion of informed consent for all residents monthly for 3 month then quarterly, MDS coordinator and RN supervisor will review the informed consent quarterly and the DON will randomly check for compliance d- Monitoring performance: The Dietary Supervisor will present the recapitulation of the findings to the monthly QA meeting for review and action as indicated. e- Corrective action will be completed on 9/5/11	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555065	A. BUILDING _____ B. WING _____	07/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIEW PARK CONV HOSP	3737 DON FELIPE DRIVE LOS ANGELES, CA 90008

(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 514	Continued From page 16 bed time for screaming and yelling out, dated November 29, 2010; and Ambien 10 mg at bed time for inability to sleep all night, dated November 29, 2010. The consents were missing dates the physician signed, the name of the responsible party who gave the consent for the physical or chemical restraint and/or confirmation of how the physician obtained the authorization. b. A review of Resident 3's medical records indicated consents for bilateral side rails to prevent fall/injury from bed and up on Geri chair for proper body alignment both dated June 17, 2011. The consents were missing dates the physician signed, and/or how the consent was obtained by the physician. c. A review of Resident 12's medical records indicated a consent for Desyrel 12.5 mg at bed time as needed for insomnia, dated June 30, 2011. The consent was signed by the physician without a date.	F 514		