STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555071	A. BUILDING _____ B. WING _____	01/14/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYVIEW CONV HOSP	2000 W WASHINGTON BL LOS ANGELES, CA 90018

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: 2013.03.04 10:23:07 -08'00'

(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: 10207, RN, HFEN 25997, RN, HFEN Total Population: 93 Sample Size: 18	F 000	**Sunnyview POC** **Disclaimer:** **The signing of this plan of corrections is not an admission or agreement by this statement of deficiencies and plan of correction. In fact, this plan of correction is submitted exclusively to comply with state and federal law. The plan of correction serves as an allegation of compliance.**	
F 253 SS=E	Highest Scope and Severity: F 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the housekeeping and maintenance staff failed to ensure that residents' rooms and common areas were maintained in a sanitary and orderly manner by having rooms with window sills and screens in disrepair, soiled privacy curtain, soiled floors and gaps between the double exit doors. Equipment and common areas not maintained clean and in good repair may create an unsafe and uncomfortable environment that may lead to injury, and attract pests due to unsanitary conditions. Findings:	F 253	**F253** **Immediate Corrective Action:** Immediately upon notification on 1/10/13 the Maintenance Supervisor ordered items to repair specified items. The Maintenance Supervisor installed a weather strip on 1-22-13 to repair gap between exit doors, installed new window sills on1/30/13 to replace cracked and rusted window sills in specified rooms, installed new window screen frames on 1/30/13 to repair bent window screen frame in specified rooms and installed new window on 1/30/13 to replace cracked window in specified room. Upon notification the privacy curtain in specified rooms were removed, washed and	1-30-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Annya Gooden	ADMINISTRATOR	2-15-13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 253	Continued From page 1 A. On January 10, 2013 from 8:00 a.m. to 10:00 a.m., during a general observation tour, the surveyor, in the presence of maintenance staff, observed the following deficiencies with the physical environment: 1. There was a 1/2-inch vertical gap between the exit doors located by the smoking area. 2. The window sills in Rooms 27 and 28 were cracked, rusted, had sharp edges, and had chipping paint. 3. The window screen frames to Rooms 27 and 28 were bent and not properly installed in the window frame. 4. The privacy curtain to Bed 28A was soiled and stained. 5. The window was cracked in Room 28. During an interview with maintenance and housekeeping staff at the time of the observation, they indicated they were unaware of the problems but would clean and repair the areas of concern. B. During the initial tour and during general observations of the facility on January 8, 2013 between 8 a.m., to 11:45 a.m., the surveyor noted the following: 1. Room 35- privacy curtains had brown and grey stains and dark sticky stains on floor, two trash cans overflowing. 2. Room 32- dark sticky stains on floor, food debris on bedside tables and floor.	F 253	replaced with clean privacy curtains, floor was mopped in specified areas to remove stains and debris from specified resident room floors, bedside tables were cleared and cleaned in specified rooms, stains on bathroom wall in specified room was cleaned, and trash can was emptied in specified room. **Identification of others at risk:** Upon identification on 1/10/13, visual assessments were completed on all resident rooms to identify needed repair of window sills, bent window screen frames and cracked windows. A monthly CQI housekeeping and maintenance checklist will be implemented to identify repairs. This will be completed by the Maintenance and Housekeeper Supervisor. Visual observations by the Housekeeping Supervisor were also completed on all resident rooms to identify soiled privacy curtains, stains on floors, over flowing trash cans, debris on bedside tables, and stains on bathroom walls.	

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F 253	Continued From page 2 3. Room 31- food debris on bedside tables and floor. 4. Room 28-brown and grey stains on privacy curtains, dark grey stains on floor, brown stains on bathroom walls and floors. 5. Room 26- large sticky purple stain on floor. Trash can overflowing. On January 8, 2013 at 9:10 a.m., Resident 2 apoligized to the surveyor, in the company of LN 30, for her floor being dirty. Review of the facility's "Daily Cleaning Checklist", indicated between 6 am to 11 a.m. the trash cans in the resident rooms would be emptied, the resident bathroom walls, sink, and toilets would be cleaned, resident room table tops cleaned and the resident room floors would be cleaned. On January 8, 2013 at 11:10 a.m. Resident 2's floor was noted to still have the large sticky purple stain. Review of the November 28, 2012 Resident Council Meeting minutes indicated residents attending the meeting requested the housekeeping staff clean the bathroom floors. On January 15, 2013 at 3:50 p.m., the Housekeeping Supervisor stated the dirty floors, food debris, and dirty bedside tables were left from the night before. In addition, the supervisor stated the facility would be implementing something where the resident rooms were cleaned more regularly. Review of the facility's undated Housekeeping Supervisor job description indicated he would	F 253	**Process to Prevent Recurrence:** An in-service was given on 2/13/13 to housekeeping staff by the Housekeeping Supervisor. Weekly rounds will be conducted by the Housekeeper Supervisor to ensure all resident rooms are free of soiled privacy curtains, stained floors, overflowing trash cans, debris on bedside table and stains on bathroom walls. **Monitoring Process:** The process will be monitored by the Administrator and Housekeeping Supervisor by conducting visual checks and using CQI checklist of all areas on a monthly basis. Findings will be reported to the Quality Assurance Committee monthly for review and further action as needed.	

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F 253	Continued From page 3 oversee and supervise all aspects of the housekeeping service for the facility.	F 253		
F 258 SS=E	483.15(h)(7) MAINTENANCE OF COMFORTABLE SOUND LEVELS The facility must provide for the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to maintain comfortable noise levels for six of ten residents attending the group meeting. This deficient practice had the potential of impairing resident sleep patterns, ability to concentrate, and socialization with other residents. Findings: During the initial tour on January 8, 2013 at 8 a.m., Licensed Nurse (LN 30) had to stop talking five times due to the excessively loud noise made when the staff rolled laundry and trash barrels. On January 8, 2013 at 10:10 a.m., when the Maintenance Supervisor (MS) was asked why the carts made so much noise, he showed the surveyor a copy of an invoice dated November 2012, and stated he was waiting for an order of wheels to replace the very loud wheels. The MS showed the surveyor a cart with new wheels that rolled silently. When asked why the facility had not yet received the wheels, the MS stated the person that was supposed to deliver the wheels was on vacation.	F 258	**F 258** **Immediate Corrective Action:** Upon identification on 1/8/13, the maintenance supervisor received the proper wheels and immediately installed them on the barrels. **Identification of others at risk:** On 1/8/13, the Maintenance Supervisor evaluated all barrels and carts by using visual checks throughout the facility to identify if noisy wheels needed to be replaced. The Maintenance Supervisor will add visual observation of barrels to the monthly environmental checklist to ensure compliance. **Process to Prevent Recurrence:** An In-service was conducted on 2/13/13 to the Maintenance Supervisor by the Administrator regarding identifying items within the facility that may affect the comfortable sound levels within the facility.	1-8-13

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F 258	Continued From page 4 Review of the facility's Maintenance Supervisor Job Description indicated he would have the ability to apply commonsense understanding to carry out instructions and the ability to deal with maintenace problems in the facility. On January 8, 2013 at 1:40 p.m., the MS stated he had picked up the wheels and would start changing the cart wheels to the quieter wheels. On January 10, 2013 at 1:30 p.m., eight of the ten residents attending the group meeting complained about the noise of the carts being wheeled throughout the facility day and night. Six of the ten residents stated they had been awakened during the night by the sound of the carts being pushed by the facility staff. Review of the facility's undated "Comfortable Sound Levels" policy indicated the facility would provide comfortable sound levels to ensure the residents were able to concentrate, ensure sound levels were kept at a comfortable level during the evenings and nights, and the sound levels would be maintained at a comfortable level for resident's with dementia (loss of brain function affecting memory, thinking and behavior). On January 15, 2013 at 2:30 p.m., the MS gave the surveyor a copy of the receipt for the wheels he had purchased, and stated he would be changing the wheels on all of the carts. On January 15, 2013 at 3:10 p.m., two residents from the group meeting stated they had noticed the carts did not wake them up anymore.	F 258	**Monitoring Process:** The process will be monitored by the Maintenance Supervisor by conducting visual checks of all facility areas on a monthly basis. Findings will be reported to the Quality Assurance Committee monthly for review and further action as needed.	
F 441	483.65 INFECTION CONTROL, PREVENT	F 441		

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F 441 SS=D	Continued From page 5 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 professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	**F441** **Immediate Corrective Action:** Upon notification on 1-14-13, the Director of Nursing Services and the Administrator reported the symptomatic residents to the Department of Public Health, Acute Communicable Disease Control. Public Health Nurse visited facility on 1/22/13 to ensure the facility was in compliance. The Director of Nursing Services submitted supporting documents to the Department of Public Health as requested. The Director of Nursing Services revised the policy and procedure for infection control program related to surveillance and tracking. **Identification of Others at Risk** A monthly decubitus/ skin ulcer committee will be implemented by the Director of Nursing Services and Treatment Nurse to review all body checks and skin assessments and will evaluate on a monthly basis. The Director of Nursing Services, Charge Nurses and Treatment Nurse will be responsible for evaluating and assessing current residents for	1-22-13

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F 441	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to implement an infection control program that included surveillance, tracking and reporting for 2 of 18 sampled residents (12, 15). Residents 12 and 15 were symptomatic of, and treated for scabies (an infestation of human skin by a microscopic itch mite that burrows under the top layer of skin where it lives and lays eggs) within a two week time period. The facilities failure to implement an infection control program that included reporting to the appropriate agencies, placed other residents at risk for developing the infection. Findings: 1a. During the initial tour on January 8, 2013 at 8 a.m., Resident 12 was identified as being on isolation for a positive scabies skin scraping. Review of Resident 12's Admission and Discharge Summary indicated he was admitted to the facility on October 3, 2011, with diagnoses that included hypertension (high blood pressure), Huntington's Chorea (a genetic disease characterised by abnormal movement and reflexes of the extremities and loss of brain function), and diabetes mellitus (elevated blood sugar levels). Review of Resident 12's minimum data set (MDS) a comprehensive assessment tool, dated January 2, 2013, indicated he was mildly cognitively mildly impaired, and required extensive assistance with bathing, eating, and personal hygiene.	F 441	signs and symptoms of scabies such as rashes and skin itching. A wound care consultant will conduct weekly assessments and observations will be done on a monthly basis. **Process to Prevent Recurrence:** The Director of Nursing Services, Charge Nurses and Treatment Nurses will review resident's weekly skin report, analyze trends and provide appropriate interventions as needed. In-service was provided by The Director of Nursing Services on 2-14-13 to staff regarding scabies prevention and control. **Monitoring Process:** The Administrator, Director of Nursing Services and Treatment Nurse will attend the monthly decubitus/ skin ulcer committee meeting and the findings will be presented to the monthly Quality Assessment and Quality Assurance Committee for review and follow up.	

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F 441	Continued From page 7 Review of Resident 12's Dermatology Consults indicated he had a positive skin scraping for scabies on January 4, 2012, for which he was placed on 24 hour isolation, and medicated with elimite cream (a cream applied to the skin to treat scabies infestation) and ivermectin (an oral medication administered to treat scabies). 1b. Review of Resident 15's Admission and Discharge Summary indicated she was admitted to the facility on December 19, 2012 with diagnoses that included schizophrenia (mental illness characterized by breakdown of thought processes and poor emotional responses), hypertension, and hyperlipedemia (elevated blood lipid levels). Review of Resident 15's MDS dated December 31, 2012, indicated she was intact cognitively, able to understand and make herself understood. Further review of the MDS indicated the resident required one person physical assistance with personal hygiene. Review of a Dermatology Consult dated December 28, 2012, indicated Resident 15 had itching and a rash, was placed on isolation, and treated with elimite cream and ivermectin for scabies on December 20, 2012. The Dermatology Consult included an order for the resident to receive a second, follow-up treatment with elimite on December 27, 2012. On January 14, 2013 at 2:45 p.m., the director of nurses (DON) stated it was the facility's policy to report a scabies outbreak to the Department of Public Health and Licensing and Certification if	F 441		

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F 441	Continued From page 8 two or more residents have positive skin scrapings. Review of the facility's undated "Policy and Procedure: Scabies", indicated the facility would report to Licensing and Certification and the local Public Health Nurse any two or more persons diagnosed with scabies and circumstances indicate it has been acquired within the facility. In addition, the facility's policy indicated person's who have been previously infested can develop symptoms 1 to 4 days after re-exposure. Resident 12 had a history of having been treated for scabies on three occasions prior to the positive skin scraping on January 4, 2013. Resident 12's positive skin scraping was obtained six days after Resident 15 received a second dose of elimite for scabies. Review of "Management of Scabies Outbreaks In California Health Care Facilities" published in 1999 by the California Department of Health Services, Division of Communicable Disease Control in conjunction with Licensing and Certification, indicated the definitions of an outbreak as: -Two or more residents, staff, and/or family members with confirmed positive skin scrapings, or -One confirmed (positive skin scraping) and at least two clinically suspect cases in residents, staff, and/or family members, or -At least 2 clinically suspect cases identified during a two week time period. Resident 12 and Resident 15 were both clinically syptomatic for scabies within a six day time	F 441		

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F 441	Continued From page 9 period. On January 28, 2013 at 9:15 a.m., a representative from the Department of Public Health, Acute Communicable Disease Control stated two or more symptomatic cases should be reported as an outbreak. In addition, the representative stated their department had not been notified there were 2 residents in the facility symptomatic of scabies within a two week time period.	F 441	**F456** **Immediate Corrective Action:** Upon notification on 1/10/13, the Maintenance Supervisor replaced the hot water temperature alarm sensor with a new sensor.	1-16-13
F 456 SS=F	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide a safe, sanitary, and comfortable environment for residents by having the hot water temperature alarm not functional, by not providing an air gap from the drain lines to the floor sinks for the hot water heater and water softener, and by having the drain line for the reach-in refrigerator unit not properly secured and maintained in the kitchen. Equipment and alarm devices that are not maintained in good operating condition do not allow proper drainage of waste water and/or alert staff when the hot water exceeds 120 degrees Fahrenheit that may cause scalding, and have the potential to affect all residents. Findings:	F 456	**Identification of Others at Risk:** a. On 1/10/13, the Maintenance Supervisor measured the temperature of all resident restroom sink faucets and shower rooms to ensure water temperature did not exceed 120 degrees. b. The drain lines from the top of the floor sink for the water heater and the water softener was lifted by the Maintenance Supervisor on 1/10/13 to allow a 1 inch air gap. c. The wooden block was removed by the Maintenance Supervisor from the drain line of the reach-in refrigerator. The Maintenance Supervisor installed and mounted new drain line with approved material on 1/16/13.	

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F 455	Continued From page 10 On January 10, 2013 from 8:00 a.m. to 10:00 a.m., during a general observation tour of the facility, the surveyor, in the presence of the maintenance staff, observed deficiencies with the following equipment: a. The hot water temperature alarm (designated for all residents' rooms and shower rooms) located by nursing station 2 was not in operating condition. During an interview with the maintenance supervisor at the time of the observation, he stated that when the hot water heaters were installed the workers may have disconnected the hot water alarm device. b. There was no 1-inch air gap from the drain lines to the top of the floor sink for the water heater and the water softener located in the linen chute room on the southwest side of the facility. During an interview with the maintenance supervisor at the time of the observation, he indicated he was unaware of the requirement. c. The drain line for the reach-in refrigerator in the kitchen was not properly supported. The drain line was supported by unfinished wooden blocks (not durable and uncleanable material), and one block was placed on the side creating slope away from the floor sink. During an interview with the maintenance supervisor at the time of the observation, he indicated he would properly secure the drain line with approved material.	F 456	**Process to Prevent Recurrence:** In-service was completed on 2-14-13 by Administrator to Maintenance Supervisor regarding identifying and conducting visual checks on the hot water temperature alarm, drain lines with no 1 inch air gap and properly mounted drain lines during weekly environmental rounds. **Monitoring Process:** The Maintenance Supervisor will monitor the hot water temperature alarm to ensure it is operating, monitor all drain lines to ensure they are properly mounted and monitor drain lines to ensure they have 1 inch air gap from ground during monthly environmental rounds. Environmental concerns will be evaluated on a monthly basis during the Quality Assurance Committee for compliance.	
F 518 SS=D	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS The facility must train all employees in emergency procedures when they begin to work in the facility;	F 518	**F518** **Immediate Corrective Action:** Upon identification on 1/10/13, the Maintenance Supervisor purchased all missing items for the disaster kit and replaced the items immediately.	1-10-13

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F 518	Continued From page 11 periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to have procedures in place for the preparation of a disaster by not having one of one disaster kits complete and organized. In the event of a natural disaster such as an earthquake, immediate access to items in a disaster kit would allow for quick emergency response for residents'/occupants' safety in the facility. Findings: On January 10, 2013, from 8:00 a.m. to 10:45 a.m., during a general observation tour, the surveyor, in the presence of the maintenance supervisor, observed that the disaster kit located in Station 2 was incomplete and disorganized. The equipment and supplies that were missing according to the disaster kit inventory listed in the disaster manual: 1. safety glasses 2. rope 3. coins 4. wrenches 5. saw 6. extension cords 7. sugar packets 8. orange juice 9. 50 person first aid kit	F 518	**Identification of Others at Risk:** The Maintenance Supervisor and Director of Staff Development will be responsible for conducting visual checks using a disaster plan check list to ensure all items are in the disaster kit on a monthly basis. **Process to Prevent Recurrence:** The Maintenance Supervisor and Director of Staff Development were in-serviced on 2/13/13 by the Administrator regarding monitoring the disaster kit on a quarterly basis to ensure all items in disaster kit are available and neatly organized. **Monitoring Process:** The Maintenance Supervisor will monitor the disaster kit on a monthly basis by checking if all items are present on the supply list. The Maintenance Supervisor will replace any missing or expired items from the disaster kit when identified. The Maintenance Supervisor will sign a log at the completion of the disaster kit review.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555071	A. BUILDING _____ B. WING _____	01/14/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYVIEW CONV HOSP	2000 W WASHINGTON BL LOS ANGELES, CA 90018

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F 518	Continued From page 12 During an interview with the maintenance supervisor at the time of the observation, he stated he didn't know who was responsible for the maintenance of the disaster kit. He also indicated that there was no system in place to ensure that all the supplies were accounted for on a routine basis.	F 518		