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

PRINTED: 07/31/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055619	A. BUILDING _____ B. WING _____	C 07/29/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLOTT NURSING HOME	800 EAST FIFTH STREET ONTARIO, CA 91764

(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 an abbreviated survey to investigate a complaint. Complaint number: CA00361595 Representing the California Department of Public Health: 26774 The investigation was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility. One deficiency was issued for complaint number: CA00361595	F 000	Plott Nursing Center ("PNC") makes its best effort to operate in full compliance with both Federal and State Law. Nothing included in this Plan of Correction is an admission otherwise. PNC has submitted this Plan of Correction in order to comply with its regulatory obligations and does not waive any objections to the merits or form of any allegations contained herein. Please note that PNC may contest the merits and/or form of any deficiency or findings alleged below and may take reasonable steps to appeal them. This Plan of Correction constitutes PNC's allegation of substantial compliance. **[F309] 483.25 Provide Care/Services for Highest Well Being** It is the policy and practice of PNC to operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility.	
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 that one of three sampled residents (Resident care plan interventions to prevent falls were implemented, which placed Resident at risk for repeat fi and i	F 309	**Corrective Action** **Findings 1-2:** On or before under the supervision of the DON. Resident A will have a and will wear shoes before sitting in r. Nursing staff will be in-serviced regarding resident need for a n and for wearing shoes 8/12/13 08/29/13	08/12/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Tony Lynch

TITLE: Administrator

(X6) DATE: 08/12/13

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 309	Continued From page 1 Findings: During a tour of the facility on at M. Resident was observed to be sitting in outside of room eating lunch. There were no staff visible in the hallway, and had no call light within reach to summon help if needed. Resident was noted to have a bandage on the top of was wearing socks without shoes, and was not locked. There was no alarm device observed on During a review of Resident clinical record at , the record indicated that Resident was admitted with diagnoses that inc cerebral vascular accident was on Hol e. During a review of the nurses notes dated , the nurse had documented, "V/S (vital signs) (blo PM, resident slipped pain to eyebrow. Noted cut open area..." A second note had been written on the same day at M, from the interdisciplinary team (IDT) who met to review Resident fall. The IDT documented the had resulted from "Resident was up in and slowly fell forward towards the floor sustaining a small to the eyebrow." The IDT recommended Resident A be placed back in after lunch. During a review of his care plan titled " " and initiated on ventions had been listed to prevent a reoccurrence of falls on most	F 309	when hair, as well as other interventions in Resident A's care plan. **Procedure for Identifying Potentially Affected Patients** As all residents may be potentially affected by the alleged deficient conduct contained herein, PNC will take corrective action in relation to all residents. Therefore, no procedure for identifying potentially affected residents is necessary. **Corrective Action for Potentially Affected Patients** On or before Au inder the supervision of the DON, nursing staff will be in-serviced regarding implementation of care plan interventions to prevent falls. **Measures Adopted for Systemic Change** Systemic change will be achieved through the new procedure for monitoring corrective actions and quality assurance as set forth below. **Monitoring of Corrective Action and Quality Assurance** The Quality Assurance Nurse or designee will observe wheel chair residents who are at risk for falls to verify implementation of care plan interventions to prevent falls. Observations will be unannounced and a report of the findings will be submitted to the DON, who will review the results and	08/29/13

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F 309	Continued From page 2 recently, on , which included, "...: . Shoes on and socks to prevent from slipping from wheelchair." A second care plan dated , following a fall with , 2013, related to Resident use of the call light. The interventions listed included: "Frequent visual checks at least every two hours to ensure the call light was in reach..." During an interview with the charge nurse (LVN 1) at the same time of the observation on , 20 PM, she confirmed that Resident A did not have an alarm on , was less, and there was not a call light within reach. LVN 1 also acknowledged that the care plan interventions were not implemented.	F 309	bring the report to the Quarterly Quality Assurance Committee, which will also review the results and recommend any changes as necessary.	