| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055104 | A. BUILDING _____ B. WING _____ | 10/16/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUNSET MANOR CONV HOSP | 2720 NEVADA AVENUE EL MONTE, CA 91733 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 000 | INITIAL COMMENTS<br><br>The following reflects the findings of the Department of Public Health during a Recertification Survey.<br><br>Representing the Department of Public Health:<br><br>Surveyor ID #27680<br>Surveyor ID #28074<br>Surveyor ID #30258<br>Surveyor ID #16279<br><br>Total Resident Population: 68<br>Total Resident Sample Size: 15 | F 000 | Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. This Plan of Correction is prepared and/or executed because it is required by the provisions of Health and Safety Code Section 1250 and 42 C.F.R. 405.1907<br><br>2012 NOV 13 PM 4:22<br><br>HEALTH FACILITIES INSPECTION DIVISION ADMINISTRATION | |
| F 241 SS=E | Highest Severity and Scope: E<br>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and record review the facility failed to ensure a bucket was underneath the shower chair to contain the feces and urine of Resident 10. Consequently, the resident's urine and feces dropped directly onto the carpet and tile on the floor, while the CNA wheeled the resident down the hall in a shower chair, and the facility failed to ensure that Staff speak in a language that four of five residents attending the group interview, could understand, especially while providing care. This resulted in | F 241 | **Corrective Action(s) Specified to Resident(s) Identified**<br>A bucket was placed immediately underneath the shower chair of resident #10.<br>**Corrective Action(s) for Potentially Affected Resident(s)**<br>An in-service was provided to the CNAs on 10/18/12 by the DSD that a bucket should always be placed underneath the shower chair prior to use to catch resident's urine or fecal matter in case of residents incontinency episode.<br>**Systemic Corrective Action**<br>An annual in-service will be provided by DSD to nursing staff on maintaining resident's dignity, including proper use of shower chair.<br>**Monitoring Process**<br>The DON, DSD, Subacute Coordinator, and RN Supervisors will conduct random check during care by CNAs to residents to ensure that a bucket is placed underneath the shower chair during transport of residents to and from the shower room. The DON will report all negative findings to the QA Committee quarterly.<br>**Responsible Position(s)**<br>DON, DSD, Subacute Coordinator, RN Supervisor | 11-1-12 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| | ADMINISTRATOR | 11-8-12 |

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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055104 | A. BUILDING _____ B. WING _____ | 10/16/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUNSET MANOR CONV HOSP | 2720 NEVADA AVENUE EL MONTE, CA 91733 |

| (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 241 | Continued From page 1<br>the patient's feeling they were treated with a lack of dignity and disrespect.<br><br>Findings:<br><br>a. Resident 10 was admitted to the facility on October 13, 2007, and re-admitted on June 6, 2011, with diagnoses that included depression, dementia and gait disturbance. According to the Minimum Data Set (a standardized assessment form) dated June 17, 2012, Resident 10 usually was able to make herself understood and was able to usually understand others and was totally dependent on staff for her ADLs. The MDS also revealed that Resident 10 was always incontinent of bowel and bladder.<br><br>During the general observation on October 15, 2012, at 10 a.m. Resident 10 was observed being wheeled by a certified nurse assistant (CNA) along the hallway in a shower chair. Resident 10 was having a bowel movement and the feces dropped directly onto the floor tiles and the carpet. During an interview with the CNA, at the same time, she stated that she forgot to check if the shower chair had a bucket underneath to catch the urine and fecal matter in case the resident had an incontinency episode. During an interview with the facility supply manager and the Director of Staff Development (DSD), on the same day, they both stated that the staff were supposed to check that a bucket was under the shower chair all the time.<br><br>b. During a group interview on October 15, 2012, | F 241 | **Corrective Action(s) Specified to Resident(s) Identified**<br>An in-service was provided by the DON and DSD to the nursing staff on 10/18/12 regarding resident's right to have staff not speak in any language that the resident does not understand especially while providing care for them<br>**Corrective Action(s) for Potentially Affected Resident(s)**<br>Same as above<br>**Systemic Corrective Action**<br>An in-service will be provided annually by DSD to all staff regarding maintaining or enhancing each resident's dignity and respect, including the need for staff not to speak in any language that the resident does not understand, especially while providing care for them.<br>**Monitoring Process**<br>The DON, DSD, and Subacute Coordinator will conduct random checks during rounds on nursing staff to ensure that no other foreign language except English should be used when talking with co-workers in front of residents or when in resident care areas. DON will report all negative findings to the QA Committee quarterly.<br>The Activity Director, during monthly Resident's Council meetings, will reinforce residents rights to be treated with dignity and respect and will receive feedback from resident's regarding this issue. Any negative feedback will be addressed immediately and will be presented to the QA Committee quarterly.<br>**Responsible Position(s)**<br>DON, DSD, Subacute Coordinator | 11-1-12 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055104 | A. BUILDING _____ B. WING _____ | 10/16/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUNSET MANOR CONV HOSP | 2720 NEVADA AVENUE EL MONTE, CA 91733 |

| (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 241 | Continued From page 2<br>at 10 a.m., four out of five alert and oriented residents who attended the meeting stated that some of the staff, especially the Certified Nursing Assistants (CNAs), speak in different languages other than English, and this bothers them, especially when the staff are in their rooms providing care. They further stated that they had brought this concern to the staff 's attention and to the charge nurses, but it has not been resolved. However, the residents could not remember the date and time they told the staff about this issue.<br><br>During an interview with the Director of Nursing (DON) on October 15, 2012, at 11:30 a.m., she stated the staff should not speak any language that the residents would not be able to understand especially while providing care for them. | F 241 | | |
| F 246 SS=B | 483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview, and record review, the facility failed to promptly answer the call lights of four of five alert residents. | F 246 | **Corrective Action(s) Specified to Resident(s) Identified**<br>None identified<br>**Corrective Action(s) for Potentially Affected Resident(s)**<br>An in-service was provided by the DSD and DON to the nursing staff on 10/18/12 regarding answering call lights in a timely manner. In addition, all call lights were checked to ensure that they are within resident's reach and properly functioning.<br>**Systemic Corrective Action**<br>An in-service will be provided to all nursing staff by DSD quarterly on answering call lights in a timely manner.<br>**Monitoring Process**<br>The DON, DSD and Subacute Coordinator will conduct random checks during daily rounds to ensure that call lights are being answered promptly, are properly functioning and within in reach of the resident. The DON will report all negative findings to the QA Committee meeting quarterly.<br>The Activity Director, during monthly Resident's Council meetings, will ask for feedback from the residents regarding timely answering of call lights.<br>**Responsible Position(s)**<br>The DON, DSD, and Subacute Coordinator | 11-1-12 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055104 | A. BUILDING _____ B. WING _____ | 10/16/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUNSET MANOR CONV HOSP | 2720 NEVADA AVENUE EL MONTE, CA 91733 |

| (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 3<br>Findings:<br><br>During the group meeting on October 15, 2012, at 10 a.m., four of five residents stated the staff on all shifts (7 a.m. to 3 p.m., 3 p.m. to 11 p.m. and 11 p.m. to 7 a.m.) would take approximately 30 minutes to respond to the call light. One of the four residents stated that when he was in bed with a soiled diaper he would wait at least 30 minutes for a staff on duty during the three shifts to assist him. He also stated that this would take place at least once to twice a week. Another resident stated she was used to it now and was just happy that someone would come after she she put her call light on. The other two alert and oriented residents stated that the time varies when the call lights were not answered promptly.<br><br>During an interview with the director of nursing on October 15, 2012, at 11 a.m., the Evaluator asked about the residents' concern regarding their call lights not being answered promptly and the DON stated that she would look into the issue.<br><br>The facility's undated policy and procedure titled "Call Lights, Answering", indicated that the resident's call lights should be answered as soon as possible. | F 246 | | |
| F 257 SS=E | 483.15(h)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS<br><br>The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F | F 257 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055104 | A. BUILDING _____ B. WING _____ | 10/16/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUNSET MANOR CONV HOSP | 2720 NEVADA AVENUE EL MONTE, CA 91733 |

| (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 257 | Continued From page 4<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview the facility failed to provide safe and comfortable temperature levels (between 71 and 81 degrees) in eight randomly sampled rooms. Rooms 30, 31, 32, 33, 35, 38, 42, and 44.<br><br>Findings:<br><br>During an initial tour on October 10, 2012, at 11:17 a.m., Resident 9 stated his room gets very cold at night.<br><br>On October 12, 2012 at 7:45 a.m., the maintenance supervisor, accompanied by the evaluator, took random temperature readings using an infrared thermometer, in eight randomly sampled rooms. The following rooms were found to be outside the federal regulation temperature range of 71 -81 degrees Fahrenheit (F).<br>Rooms Degrees F<br>30 70<br>31 68<br>32 66<br>33 68<br>35 70<br>38 64<br>42 69<br>44 66<br><br>During an interview on October 12, 2012, at 7:45 a.m., the maintenance supervisor was asked about the facility's policy regarding acceptable temperature range for resident rooms. The maintenance supervisor stated he was not sure but he would find out. The maintenance supervisor was also asked if he kept a log of the | F 257 | **Corrective Action(s) Specified to Resident(s) Identified**<br>Resident 9's room temperature was adjusted immediately.<br>**Corrective Action(s) for Potentially Affected Resident(s)**<br>Upon the Surveyor's findings, the Maintenance Director adjusted the temperatures in the facility to provide a comfortable temperature level. Window Air conditioning units in rooms were also adjusted or turned off to bring some of the temperature levels higher.<br>**Systemic Corrective Action**<br>An inservice has been given to all nursing staff on 10/18/12 regarding the importance of maintaining a comfortable temperature level. Many of the rooms have window air conditioning units and can be easily adjusted immediately. If the overall temperature is not comfortable, then the nurses must document this so the Maintenance Director can adjust it in the morning. If the temperatures are very uncomfortable, then the Maintenance Director or his designee will come in to adjust it immediately.<br>**Monitoring Process**<br>The Maintenance Director will check the temperatures in the building every morning and every evening before he goes home and will adjust temperatures accordingly. He will report temperatures that are outside of the required levels to the RN supervisors so they can document to the other shifts the findings and the need to keep the temperature levels comfortable.<br>**Responsible Position(s)**<br>RN Supervisors and the Maintenance Director | 11-1-12 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055104 | A. BUILDING _____ B. WING _____ | 10/16/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUNSET MANOR CONV HOSP | 2720 NEVADA AVENUE EL MONTE, CA 91733 |

| (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 257 | Continued From page 5<br>temperatures in the rooms. He stated he did not.<br><br>During an observation of the medication pass on October 12, 2012, at 8 a.m., licensed vocational nurse 2 (LVN 2) stated, "It's so cold in here I'm shaking." Also, during a group meeting on October 15, 2012, at 10 a.m., one of five residents stated his/her room is always too cold. | F 257 | | |
| F 312 SS=D | 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS<br><br>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, the facility failed to ensure good oral hygiene was provided for one (Residents 13) of 15 sampled residents (Resident 13), who had a gastrostomy tube feeding. This has the potential to result in periodontal disease and heart disease.<br><br>Findings:<br><br>A review of the admission record of Resident 13 indicated the resident was originally admitted to the facility on March 24, 2010 and was readmitted on March 21, 2012, with diagnoses that included hypertension (high blood pressure), Parkinson's disease (a brain disorder that leads to tremors and difficulty with walking, movement, and coordination), dementia (loss of brain function), and dysphagia (difficulty swallowing) with | F 312 | **Corrective Action(s) Specified to Resident(s) Identified**<br>Upon the surveyor's findings, the C.N.A. immediately rendered oral care to Resident 13.<br>**Corrective Action(s) for Potentially Affected Resident(s)**<br>All residents were checked to ensure that good oral hygiene was provided, and that their mouths were clean and lips/oral tissues were moist. An in-service was provided by the DSD on 10/18/12 to the nursing staff on providing good oral care to all residents at all times.<br>**Systemic Corrective Action**<br>An annual in-service will be provided by the DSD to nursing staff on proper oral care of the residents.<br>**Monitoring Process**<br>The DON, DSD, and Subacute Coordinator will randomly monitor during their rounds to ensure resident's mouths are cleaned. DON will report all negative findings to the QA Committee meeting quarterly.<br>DSD will conduct quarterly evaluation and teaching demonstration on CNAs, focusing on proper oral care techniques.<br>**Responsible Position(s)**<br>DON, DSD, Subacute Coordinator | 11-1-12 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055104 | A. BUILDING _____ B. WING _____ | 10/16/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUNSET MANOR CONV HOSP | 2720 NEVADA AVENUE EL MONTE, CA 91733 |

| (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 312 | Continued From page 6<br>gastrostomy tube feeding (GT- a tube inserted through the abdomen that delivers nutrition or medication directly to the stomach).<br><br>A review of a care plan dated March 21, 2012, indicated that the resident had self care deficits due to physical disabilities, cognitive impairment, contractures, and medical condition, and required total assistance with ADL. The care plan goal indicated that the resident would be clean, free from body odor, and dressed appropriately daily for three months. The nursing interventions included to assist the resident with oral care every shift and as needed.<br><br>The Minimum Data Set (MDS), a standardized assessment and care planning tool, dated September 16, 2012, indicated that the resident had a short and long term memory problem, was severely impaired in his cognitive skills for daily decision making, rarely/never understood others and rarely/never made himself understood, and required total assistance with activities of daily living.<br><br>During an observation on October 15, 2012, at 11:20 a.m., the resident was observed in bed with his eyes closed and his mouth opened. There was a thick yellow substance on the resident's tongue and on the right corner of his upper mouth and lower lip. The resident was receiving Pulmocare at 50 milliliters per hour (ml/hr) via an enteral pump machine.<br><br>During an interview on October 15, 2012, at 11:21 a.m., the surveyor and registered nurse (RN) 1 went inside the resident's room to check on the resident. RN 1 stated that the resident's mouth | F 312 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055104 | A. BUILDING _____ B. WING _____ | 10/16/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUNSET MANOR CONV HOSP | 2720 NEVADA AVENUE EL MONTE, CA 91733 |

| (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 312 | Continued From page 7<br>was "dirty" and she would have the certified nursing assistant (CNA) clean the resident's mouth.<br><br>During an interview with the CNA on October 15, 2011, at 1:45 p.m., she stated that she cleaned the resident's mouth between 7 a.m. to 8 a.m. that morning. She further stated that the resident has a lot of oral secretions and requires frequent oral care.<br><br>The facility's policy and procedure titled "Mouth Care" dated October 2010, indicated that the purposes of mouth care is to keep the resident's lips and oral tissues moist, to cleanse and freshen the resident's mouth, and to prevent infections of the mouth. The policy further indicated to review the resident's care plan to assess for any special needs of the resident.<br><br>A lack of good brushing and flossing habits frequently leads to periodontal (gum) disease. Bacteria from periodontal disease have been found in the plaque that clogs the arteries of people with heart disease. When oral bacteria enter the bloodstream, the immune system response causes inflammation and narrowing of the arteries. All of this greatly increases the risk of heart disease, heart attack and stroke. <http://www.colgate.com/app/Colgate/US/OC/Information /OralHealthBasics/CommonConcerns/GumDisease/Periodontits.cvsp<http://www.mayoclinic.com/health/periodontitis/DS00369/DSECTION=complications>, | F 312 | | |
| F 315 SS=D | 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER | F 315 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055104 | A. BUILDING _____ B. WING _____ | 10/16/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUNSET MANOR CONV HOSP | 2720 NEVADA AVENUE EL MONTE, CA 91733 |

| (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<br><br>Based on the resident's comprehensive assessment, the facility must ensure that a 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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and record review, the facility failed to ensure an indwelling catheter was securely anchored to facilitate urine drainage and to prevent a potential for accidental dislodgement leading to injury and urethral tear for one of three sample residents (1) with an indwelling catheter.<br><br>Findings:<br><br>During a general observation round on October 11, 2012, at 1 p.m. with the Registered Nurse (RN) Supervisor, there were 4 residents with an indwelling catheter on the Sub Acute Unit of the facility. One of the four resident's, indwelling catheter, was not anchored securely to prevent accidental dislodgment.<br><br>During an interview with the RN Supervisor on October 11, 2012, at 11:45 a.m., she stated that the the urinary collection bag is to be positioned below the resident's bladder all the time and there was no risk for a backflow of the urine. The RN | F 315 | **Corrective Action(s) Specified to Resident(s) Identified**<br>A Catheter leg strap was immediately applied on resident with no leg strap to securely anchor the catheter.<br>**Corrective Action(s) for Potentially Affected Resident(s)**<br>All residents with Foley Catheters were checked to ensure that leg straps were in place.<br>**Systemic Corrective Action**<br>An annual in-service will be provided by the DON and DSD to nursing staff on catheters and proper use of catheter leg straps.<br>**Monitoring Process**<br>DON, DSD, Subacute Coordinator, Treatment Nurse and RN Supervisors will randomly monitor during their rounds placement of leg straps on all residents with indwelling catheters. The DON will report all negative findings to the quarterly QA Committee meetings.<br>**Responsible Position(s)**<br>DON, DSD, Subacute Coordinator, Treatment Nurse, and RN Supervisor | 11-1-12 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055104 | A. BUILDING _____ B. WING _____ | 10/16/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUNSET MANOR CONV HOSP | 2720 NEVADA AVENUE EL MONTE, CA 91733 |

| (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 | F 315 | | |

Supervisor also stated the urinary catheters were placed for management of Stage III pressure ulcers (wounds that are so deep that there is damage to the muscle and bone, and sometimes to tendons and joints and all catheter tubing's should be anchored with a strap on the resident's thigh.

According to the admission record, Resident 1 was admitted to the facility on October 5, 2012, with diagnoses that included pneumonia, dysphagia (difficulty in swallowing) with gastrostomy tube ( surgically inserted tube to the stomach for the purpose of nutrition and medication), and pressure ulcers.

According to the Minimum Data Set (MDS) dated October 12, 2012, Resident 10 usually understood others and was able to make himself understood by others. The MDS also assessed that the resident was totally dependent with all aspects of his activities of daily living (ADLs) and had an indwelling catheter.

A review of the undated policy and procedure titled, Catheter (Indwelling), Insertion, on October 11, 2012, at 1 p.m., indicated " in order to avoid tension on catheter tubing, attach tubing to resident's leg using a leg strap. Ensure strap is applied comfortably and is not too tight. During an interview with the RN Supervisor, she stated that she was not aware that Resident 1's indwelling catheter tubing was not strapped.

It is recommended that all urinary catheters should be secured to the thigh for women and to the upper thigh or lower abdomen for men. Unsecured urinary catheters can lead to bleeding,

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055104 | A. BUILDING _____ B. WING _____ | 10/16/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUNSET MANOR CONV HOSP | 2720 NEVADA AVENUE EL MONTE, CA 91733 |

| (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 10<br>trauma, pressure sores around the meatus, and bladder spasms from pressure and traction. (JoAnn Mercer Smith, Catheter Securement November 8, 2008). | F 315 | | |
| F 322 SS=D | 483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS<br><br>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review the facility failed to check residuals prior to administration of medications for one randomly sampled resident (RSR 16). This failure had the potential to result in aspiration of stomach contents.<br><br>Findings:<br><br>The admission record indicated that RSR 16 was admitted to the facility on August 11, 2009, and readmitted on June 24, 2012, with diagnoses that included dysphagia (difficulty swallowing), and a history of tongue cancer.<br><br>A Minimum Data Set (MDS), a standardized assessment and care screening tool, dated August 24, 2012, indicated the resident was sometimes understood and sometimes able to | F 322 | **Corrective Action(s) Specified to Resident(s) Identified**<br>Upon the surveyor's findings, the licensed nurse checked gastrostomy's residual of Resident 16.<br>**Corrective Action(s) for Potentially Affected Resident(s)**<br>An in-service was provided by the DON on 10/17/12 to all licensed nursing staff regarding guidelines on checking of gastric residual prior to administration of medications or fluids via gastrostomy tube.<br>**Systemic Corrective Action**<br>An annual in-service will be provided by the DON regarding guidelines on administering medications through an enteral tube, including proper checking of gastric residual through enteral tubes.<br>**Monitoring Process**<br>The DON, Subacute Coordinator and RN Supervisor will conduct medication pass observation randomly every month. The Pharmacy Nurse Consultant will also conduct medication pass observation every 3 months. The DON will report all negative findings to the quarterly QA Committee meeting.<br>**Responsible Position(s)**<br>DON, Subacute Coordinator and RN Supervisor | 11-1-12 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055104 | A. BUILDING _____ B. WING _____ | 10/16/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUNSET MANOR CONV HOSP | 2720 NEVADA AVENUE EL MONTE, CA 91733 |

| (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 322 | Continued From page 11<br>understand others. The resident was totally dependent on staff for eating, dressing, toilet use, and personal hygiene. According to the MDS the resident was receiving nutrition via a gastrostomy-tube.<br><br>A physician's order dated June 24, 2012, indicated to check and record the residual every shift. The order also indicated to hold the feeding if the residuals are above 100 milliliters (ml/cc), then re-check in one hour. If residuals are still over 100 cc's after one hour the physician should be notified.<br>During an interview on August 12, 2012, at 9:00 a.m., licensed vocational nurse 2 (LVN 2) stated she knew she should have checked the residuals prior to administering medications to the resident via g-tube, however, she had forgot to check.<br><br>Review of the facility's policy titled, "Administering Medications through an Enteral Tube", revised October 2010, indicated the purpose of the policy is to provide guidelines for the safe administration of medications through an enteral tube (feeding tube). The policy indicated for all gastrostomy tubes, check placement and gastric contents. | F 322 | | |
| F 327 SS=D | 483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION<br><br>The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review the facility failed to notify the physician of recommendations | F 327 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055104 | A. BUILDING _____ B. WING _____ | 10/16/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUNSET MANOR CONV HOSP | 2720 NEVADA AVENUE EL MONTE, CA 91733 |

| (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 327 | Continued From page 12<br>made by the registered dietician (RD) for one of 15 sampled residents (Resident 4) to increase water flushes from three times a day to four times a day. This failure had the potential to result in inadequate hydration for the resident.<br><br>Findings:<br><br>The admission record indicated Resident 4 was admitted to the facility on August 19, 2010, and readmitted on September 6, 2012, with diagnoses that included diabetes (a group of metabolic diseases in which result in high blood sugar), and dysphagia (difficulty swallowing).<br><br>A Minimum Data Set (MDS), a standardized comprehensive assessment and care screening tool, dated August 20, 2012, indicated the resident was totally dependent on staff for transfers, dressing, eating, and personal hygiene. The MDS also indicated the resident was receiving nutrition via a gastrostomy tube (g-tube). In addition the care area assessment (CAA) summary triggered dehydration as a concern.<br><br>Review of a physician's order dated September 6, 2012, indicated to flush feeding tube with 200 milliliters (ml/cc) of water every eight hours (3 times per day).<br><br>Review of an untitled care plan dated September 6, 2012, indicated the resident was at risk for alteration in hydration related to open wounds. The listed interventions included to flush the g-tube with 200 cc's of water every eight hours.<br><br>Review of the, "Dietary Progress Notes", dated | F 327 | **Corrective Action(s) Specified to Resident(s) Identified**<br>The Attending Physician for Resident 4 was immediately notified of the Registered Dietician's recommendation to increase water flushes and a new order was received from the Physician.<br>**Corrective Action(s) for Potentially Affected Resident(s)**<br>All recommendations from the Registered Dietician from last month to present were reviewed to ensure that they have been followed and Physicians were informed.<br>**Systemic Corrective Action**<br>An annual in-service will be provided by the DON to all licensed nursing staff on the policy regarding following and completion of Registered Dietician's recommendations. The RN Supervisor will follow up with the Physicians on all Registered Dietician's recommendations within 7 days after being received.<br>**Monitoring Process**<br>The DON and Subacute Coordinator will review all recommendations of the Dietician every month to ensure that Physicians have been informed and the response of the Physician will be documented on the nurses notes. The DON will report all negative findings to the quarterly QA Committee meetings.<br>**Responsible Position(s)**<br>DON, Subacute Coordinator and RN Supervisor | 11-1-12 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055104 | A. BUILDING _____ B. WING _____ | 10/16/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUNSET MANOR CONV HOSP | 2720 NEVADA AVENUE EL MONTE, CA 91733 |

| (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 327 | Continued From page 13<br>October 2, 2012, indicated the RD recommended to increase the water flushes from 200 cc's every eight hours (three times a day) for a total of 600cc's per day, to 200cc's of water every six hours (four times a day) for a total of 800 cc's per day. There was no documented evidence the physician was notified of the RD's recommendation.<br><br>In an interview on October 11, 2012, at 11:25 a.m., the registered nurse coordinator (RNC) stated the licensed staff had received the recommendation from the RD to increase the water flushes. However, the staff had failed to notify the physician therefore the recommendation had not been carried out.<br><br>In another interview on October 12, 2012, at 11:05 a.m., the director of nursing (DON) stated the facility's policy is to notify a physician of any RD recommendations within seven days.<br><br>Review of the facility's policy titled, "Making a referral to the consultant dietician", dated May 2007, indicated the DON is responsible to institute action on recommendations. This may be delegated to the licensed nurses however, a time frame of seven days is to be specified to follow up on the recommendations. | F 327 | | |
| F 332 SS=E | 483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE<br><br>The facility must ensure that it is free of medication error rates of five percent or greater.<br><br>This REQUIREMENT is not met as evidenced | F 332 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055104 | A. BUILDING _____ B. WING _____ | 10/16/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUNSET MANOR CONV HOSP | 2720 NEVADA AVENUE EL MONTE, CA 91733 |

| (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 14<br>by:<br>Based on observation, interview, and record review, the facility failed to ensure that it was free of a medication error rate of five percent or greater. During the medication pass observation, six medication errors were observed out of 42 opportunities for errors, to yield a facility medication error rate of 14.28 percent.<br><br>Findings:<br><br>a. During a medication pass observation on October 11, 2012, at 8:26 a.m., licensed vocational nurse (LVN) 1 was observed as she prepared and administered the morning medications of Resident 7 via a gastrostomy tube (GT). LVN 1 poured 15 ml of Potassium Chloride (supplement) into a medication cup without diluting the medication with water or juice prior to administering it to the resident. The bottle label indicated "dilute with 4-8 ounces of water or juice." In addition, LVN 1 crushed and administered Cardizem 60 milligrams (mg) and Lopressor 25 mg to Resident 7 without checking the resident's heart rate before medication administration. The label on the Cardizem and Lopressor bubble pack indicated to hold the medication if the resident's heart is is less than 60. Furthermore, LVN 1 was observed administering two drops of artificial tears into the resident's left and right eye.<br><br>Upon reconciliation of the physician's orders, the physician's orders dated August 14, 2012, indicated to administer the following medications: Potassium Chloride 20 mEq liquid via GT daily for supplement, Cardizem 60 mg via GT for hypertension and hold for a heart rate (HR) of | F 332 | **Corrective Action(s) Specified to Resident(s) Identified**<br>The heart rate of Resident 7 was checked by the Licensed nurse using a stethoscope after the Surveyor's findings. In addition, upon the Surveyor's findings, the Licensed nurse administered Cipro antibiotic to resident via gastrostomy tube.<br>**Corrective Action(s) for Potentially Affected Resident(s)**<br>An in-service was provided by the DON to the Licensed nursing staff on 10/17/12 regarding guidelines for proper medication administration including 5 rights (right patient, right dose, right time, right drug, and right route) and policy regarding flushing of gastrostomy tubes.<br>In addition, the particular Licensed nurse involved was counseled by the DON and one on one teaching was provided with emphasis on proper medication passing procedures.<br>**Systemic Corrective Action**<br>An annual in-service will be provided by the DON on proper medication administration to all licensed nursing staff. Licensed nurses proficiency evaluation will be conducted by the DON annually to ensure that licensed nurses are maintaining proper/safe med-pass techniques.<br>**Monitoring Process**<br>The DON and Subacute Coordinator will conduct medication pass observation randomly every month. The Pharmacy Nurse Consultant will conduct med-pass observation every 3 months. The DON will report all negative findings at the quarterly QA Committee Meetings.<br>**Responsible Position(s)**<br>DON and Subacute Coordinator | 11-1-12 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055104 | A. BUILDING _____ B. WING _____ | 10/16/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUNSET MANOR CONV HOSP | 2720 NEVADA AVENUE EL MONTE, CA 91733 |

| (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 15<br>less than 60 and a systolic blood pressure (SBP) of less than 90, Lopressor 25 mg via GT twice a day for hypertension and hold for HR less than 60 or SBP less than 100, and artificial tears ophthalmic solution one drop to both eyes four times a day for eye dryness.<br><br>During an interview with LVN 1 on October 11, 2012, at 10:30 a.m., she stated that she should have administered one drop of artificial tears as ordered by the physician, instead of two drops. LVN 1 further stated that the resident's HR was 99 when she checked it while simultaneously measuring the resident's blood pressure using a manual blood pressure cuff.<br><br>During an interview with the director of nursing (DON) on October 12, 2012, at 3:15 p.m., she stated that the heart rate is not checked through the use of a manual blood pressure cuff. The DON further stated that LVN 1 probably just got nervous.<br><br>A review of the manufacturer's instructions for administration of potassium chloride oral liquid solution indicated that the medication must be mixed with a full glass (4-8 ounces) of cold water or juice before taking to prevent stomach upset.<br><br>The facility's policy and procedure titled "Guidelines for Medication Administration" dated January 2009, indicated that in the administration of all medications, the five rights which include right patient, right drug, right dose, right time, and right route must be observed. The label on the medication container must be read three times before administering the medication. | F 332 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055104 | A. BUILDING _____ B. WING _____ | 10/16/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUNSET MANOR CONV HOSP | 2720 NEVADA AVENUE EL MONTE, CA 91733 |

| (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 16 | F 332 | | |

b. During observation of a medication pass on October 12, 2012, at 8:10 a.m. licensed vocational nurse 2 (LVN 2) failed to flush the g-tube with water, as ordered by the physician, prior to the administration of the resident's medication as well as after finishing the medication administration. The LVN also failed to administer the antibiotic Ciprofloxacin ([Cipro] an antibiotic) as ordered by the physician.

The admission record indicated RSR 16 was admitted to the facility on August 11, 2009, and readmitted on June 24, 2012, with diagnoses that included dysphagia (difficulty swallowing), and a history of tongue cancer.

A Minimum Data Set (MDS), a standardized assessment and care screening tool, dated August 24, 2012, indicated the resident was sometimes understood and sometimes able to understand others. The resident was totally dependent on staff for eating, dressing, toilet use, and personal hygiene. According to the MDS the resident was receiving nutrition via g-tube.

Review of a physician's order dated June 24, 2012, indicated to flush the feeding tube with a minimum of 50 ml water before and after medication administration. Review of another physician's order dated October 6, 2012, indicated to administer Cipro 500 mg via g-tube for seven days for dysuria (pain with urination).

The Nurses Notes, dated October 6, 2012, indicated the resident complained of pain when voiding. The physician was notified and a new order was given for Cipro 500 mg to be

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055104 | A. BUILDING _____ B. WING _____ | 10/16/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUNSET MANOR CONV HOSP | 2720 NEVADA AVENUE EL MONTE, CA 91733 |

| (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 17<br>administered to the resident.<br><br>During an interview on October 12, 2012, at 8:45 a.m., the registered nurse coordinator (RNC) stated the Cipro should have been given during the medication pass however it had been missed by the licensed nurse.<br><br>In an interview on October 12, 2012 at 9 a.m., licensed vocational nurse 2 (LVN 2) stated she had missed giving the Cipro because the page of the medication administration record had been face down and she had missed it. When asked about the flushing of the g-tube the LVN stated she had flushed with approximately 5 cc's of water in between each medication. The LVN acknowledged she had not flushed the g-tube with 50 cc of water prior to and after medication administration, as ordered by the physician.<br><br>In another interview on October 12, 2012 at 10:10 a.m., the director of nursing (DON) stated the nurse should have informed the evaluator that she had missed giving the Cipro as soon as she realized her mistake. The DON also stated the purpose of flushing the g-tube with water before and after administering a medication is too ensure the tube stays patent.<br><br>Review of the facility's policy titled, "Administering Medications through an Enteral Tube", revised October 2010, indicated the purpose of the policy is to provide guidelines for the safe administration of medications through an enteral tube (feeding tube). The policy indicated that the g-tube should be flushed with at least 30 cc of warm water (or prescribed amount) prior to administering medications. The policy also indicated to flush | F 332 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055104 | A. BUILDING _____ B. WING _____ | 10/16/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUNSET MANOR CONV HOSP | 2720 NEVADA AVENUE EL MONTE, CA 91733 |

| (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 18<br>with at least 30 cc's of warm water (or prescribed amount) when the last medication begins to drain from the tubing. | F 332 | | |
| F 333 SS=D | 483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS<br><br>The facility must ensure that residents are free of any significant medication errors.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review the facility failed to ensure that it was free of any significant medication errors. The licensed staff failed to check the heart rate of Resident 7 prior to administering Cardizem (antihypertensive and anti-arrhythmia) and Lopressor (antihypertensive) as ordered by the physician. These medications have the potential to lower the resident's heart rate.<br>Findings:<br>a. During a medication pass observation on October 11, 2012, at 8:26 a.m., licensed vocational nurse (LVN) 1 was observed as she prepared and administered the morning medications of Resident 7 via gastrostomy tube (GT). LVN 1 was observed crushing and administering Cardizem (used to treat high blood pressure, chest pain, and heart rhythm disorders) 60 milligrams (mg) and Lopressor (antihypertensive) 25 mg to the resident without checking the resident's heart rate before administration. There was an instruction on the Cardizem and Lopressor bubble pack to hold the medication if the resident's heart is less than 60.<br><br>Upon reconciliation with the physician's orders, | F 333 | **Corrective Action(s) Specified to Resident(s) Identified**<br>After the Surveyor's findings, the heart rate of Resident 7 was checked using a stethoscope by the Licensed nurse.<br>**Corrective Action(s) for Potentially Affected Resident(s)**<br>An in-service was provided to the Licensed nursing staff by the DON on 10/17/12 regarding the policy for proper medication administration with emphasis on checking vital signs (i.e. blood pressure, heart rate based on parameters ordered by the Physician). The particular Licensed nurse involved was counseled by the DON and one on one teaching was provided emphasizing proper medication pass procedures.<br>**Systemic Corrective Action**<br>An annual in-service will be provided by the DON on proper medication administration. Also, Licensed nurses proficiency evaluation will be conducted by the DON and Subacute Coordinator to ensure that Licensed nurses are maintaining proper/safe medication pass techniques.<br>**Monitoring Processor**<br>The DON, Subacute Coordinator and RN Supervisor will conduct medication pass observation randomly every month. The Pharmacy Nurse Consultant will conduct medication pass observation every 3 months. The DON will report all negative findings to the quarterly QA Committee meetings.<br>**Responsible Position(s)**<br>DON, Subacute Coordinator, RN Supervisor | 11-1-12 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055104 | A. BUILDING _____ B. WING _____ | 10/16/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUNSET MANOR CONV HOSP | 2720 NEVADA AVENUE EL MONTE, CA 91733 |

| (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 333 | Continued From page 19<br>the physician's orders dated August 14, 2012, indicated to administer the following medications: Cardizem 60 mg via GT for hypertension and hold for a heart rate (HR) of less than 60 and a systolic blood pressure (SBP) of less than 90 and Lopressor 25 mg via GT twice a day for hypertension and hold for HR less than 60 or SBP less than 100.<br><br>During an interview with LVN 1 on October 11, 2012, at 10:30 a.m., she stated that the resident's HR was 99 when she checked it while simultaneously measuring the resident's blood pressure using a manual blood pressure cuff.<br><br>During an interview with the director of nursing (DON) on October 12, 2012, at 3:15 p.m., she stated that the heart rate is never checked using a manual blood pressure cuff. The DON further stated that LVN 1 probably just got nervous. The DON added that the blood pressure and heart rate should be taken prior to giving medication that has parameters on when to give or when to hold.<br><br>According to Lexi-Comp's Geriatric Dosage Handbook (2007), Cardizem and Lopressor can cause bradycardia (heart rate less than 60) and hypotension (low blood pressure). Monitoring parameters should include checking the resident's blood pressure and heart rate. The handbook further indicated to take the medication exactly as directed, take pulse (heart rate) daily prior to medication and follow the prescriber's instruction about holding medication. | F 333 | | |
| F 431 SS=D | 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS | F 431 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055104 | A. BUILDING _____ B. WING _____ | 10/16/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUNSET MANOR CONV HOSP | 2720 NEVADA AVENUE EL MONTE, CA 91733 |

| (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 431 | Continued From page 20<br>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.<br><br>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.<br><br>In accordance with State and Federal laws, the 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.<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, the facility failed to ensure that residents | F 431 | **Corrective Action(s) Specified to Resident(s) Identified**<br>None identified<br>**Corrective Action(s) for Potentially Affected Resident(s)**<br>An opened tuberculin (PPD) vial found inside the refrigerator without an "opened date" was immediately removed and discarded. An in-service was provided on 10/17/12 by the DON to all Licensed nursing staff regarding policy for medications "open date" procedures.<br>**Systemic Corrective Action**<br>An annual in-service will be provided by the DON on policy for medications "date opened" procedures. The RN Supervisor will check all medications inside the refrigerator weekly for medication expiration and to ensure all opened medications has an "opened date" written on the bottle/container.<br>**Monitoring Process**<br>The DON and Subacute Coordinator will conduct random checks on all medications in the med cart, medication room and medication inside the refrigerator to ensure that opened medications have "opened date" written on it. The DON will report all negative findings to the quarterly QA Committee Meetings.<br>**Responsible Position(s)**<br>DON, Subacute Coordinator and RN Supervisor | 11-1-12 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055104 | A. BUILDING _____ B. WING _____ | 10/16/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUNSET MANOR CONV HOSP | 2720 NEVADA AVENUE EL MONTE, CA 91733 |

| (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 431 | Continued From page 21<br>were not administered expired medications by failing to label previously opened and used multi-dose vials of Tuberculin Purified Protein Derivative (PPD- aid in the detection of infection with Mycobacterium tuberculosis), in accordance with the facility's policy and procedure. This deficient practice had the potential to result in inaccurate Tuberculosis skin test results or cause complications in an event that an expired medication is administered.<br><br>Findings:<br><br>During an inspection of the medication room in Station 2 on October 10, 2012, at 11:25 a.m., one open vial of PPD was observed without an open date label stored inside the medication refrigerator.<br><br>During an interview with the licensed staff on October 10, 2012, at 11:26 a.m., she inspected the vial of PPD and could not tell when the vial was first opened. She stated that the PPD vial should have been labeled with an open date.<br><br>The facility's policy and procedure titled "Date Open Procedures" dated January 2009, indicated that certain products have limited expiration dates after the product has been mixed or opened for the first time. The policy indicated that on containers that do not have a space to record the opening date on the manufacturers' label the pharmacy will affix a blank "Date Opened" sticker to the container. It will be the responsibility of the nursing staff to enter the opening date on all manufacturers' labels or blank pharmacy labels. According to Appendix D of the same policy, PPD vial expires 30 days after opening. | F 431 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055104 | A. BUILDING _____ B. WING _____ | 10/16/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUNSET MANOR CONV HOSP | 2720 NEVADA AVENUE EL MONTE, CA 91733 |

| (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 SS=D | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>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.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br>(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.<br>(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.<br><br>(c) Linens<br>Personnel must handle, store, process and transport linens so as to prevent the spread of infection. | F 441 | **Corrective Action(s) Specified to Resident(s) Identified**<br>The DON and DSD provided a verbal counseling and discussion to the C.N.A. involved regarding failure to follow infection control procedures.<br>**Corrective Action(s) for Potentially Affected Resident(s)**<br>An in-service was provided by the DSD on 10/18/12 to all CNAs regarding maintaining infection control during care of residents with emphasis on proper utilization of personal protective equipment ("PPE", I.e. gloves and frequency of changing PPE in between bed bath procedures).<br>**Systemic Corrective Action**<br>An annual in-service will be provided by the DSD to nursing staff on infection control and proper techniques on how to perform bed bath procedures, with return demonstration by each C.N.A.<br>**Monitoring Process**<br>The DON, DSD and Subacute Coordinator will conduct random checks of CNAs when giving bed bath to residents to ensure that proper techniques are used and infection control is maintained.<br>**Responsible Position(s)**<br>DON, Subacute Coordinator and DSD | 11-1-12 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055104 | A. BUILDING _____ B. WING _____ | 10/16/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUNSET MANOR CONV HOSP | 2720 NEVADA AVENUE EL MONTE, CA 91733 |

| (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 23<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, the facility failed to ensure that the staff wash their hands and changed their gloves after providing personal care for one sample resident (Resident 1) and failed to ensure that the tip of the eye drop medication bottle did not touch the bed linen for one sample resident ( 7). This deficiency had the potential to cause cross-contamination and spread infection.<br><br>Findings:<br><br>a. A review of the admission facesheet and admission information of Resident 3 indicated that the resident was originally admitted to the facility on November 6, 2011, and re-admitted on September 28, 2012, with diagnoses that included respiratory failure with tracheostomy ( a tracheostomy is a surgical procedure to create an opening through the neck into the trachea (windpipe). A tube is usually placed through this opening to provide an airway and to remove secretions from the lungs) and stroke.<br><br>The Minimum Data Set (MDS), a standardized assessment and care planning tool, dated October 5, 2012, indicated that the resident rarely or never understood others and rarely or never made self understood by others and required total assistance from the staff with all activities of daily living that includes dressing, toilet use and personal hygiene.<br><br>During an observation on October 11, 2012, at | F 441 | **Corrective Action(s) Specified to Resident(s) Identified**<br>Artificial Tears bottle was immediately removed and discarded and replaced with a new one.<br>**Corrective Action(s) for Potentially Affected Resident(s)**<br>An in-service was provided to Licensed nursing staff on 10/17/12 by the DON on maintaining infection control during medication administration.<br>**Systemic Corrective Action**<br>An annual in-service will be provided by the DON and DSD to Licensed nursing staff on maintaining infection control during medication administration.<br>**Monitoring Process**<br>The DON and Subacute Coordinator and RN Supervisor will conduct random medication pass observation every month. The Pharmacy Nurse Consultant will conduct medication pass observation every 3 months. The DON will report all negative findings at the quarterly QA Committee Meetings.<br>**Responsible Position(s)**<br>DON, Subacute Coordinator and RN Supervisor | 11-1-12 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055104 | A. BUILDING _____ B. WING _____ | 10/16/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUNSET MANOR CONV HOSP | 2720 NEVADA AVENUE EL MONTE, CA 91733 |

| (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 24<br>9:15 a.m., certified nursing assistant (CNA) 3 and CNA 4 were observed as they provided Resident 3 morning care and a bed bath. During the bed bath observation, CNA 4 was observed washing the resident's back, chest, arms, underarms, legs, feet, and perineal area using the same pair of gloves. Without changing her gloves, CNA 4 then proceeded to rinse and dry the resident and applied a new hospital gown. CNA 4 then changed the resident's bed linen using the same soiled pair of gloves. CNA 4 failed to change her gloves for the multiple tasks done during the bed bath procedure. In addition, during the same bed bath observation, CNA 4 touched the privacy curtain without removing the same soiled pair of gloves.<br><br>During an interview with CNA 4 on October 11, 2012, at 10:30 a.m., she acknowledged that she did not change her gloves between providing the resident a bed bath and changing to clean hospital gown and bed linens.<br><br>During an interview with the director of nursing (DON) and director of staff development (DSD) on October 11, 2012, 11 a.m., they stated that the CNA should have taken off the soiled pair of gloves after providing perineal care.<br><br>The facility's 2001 policy and procedure titled "Handwashing/Hand Hygiene," indicated that the employees must wash their hands after removing gloves and after handling items likely potentially contaminated with blood, body fluids or secretions."<br><br>b. During a medication pass observation on October 11, 2012, at 8:26 a.m., licensed | F 441 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055104 | A. BUILDING _____ B. WING _____ | 10/16/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUNSET MANOR CONV HOSP | 2720 NEVADA AVENUE EL MONTE, CA 91733 |

| (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 25<br>vocational nurse (LVN) 1 was observed as she administered artificial tears (lubricant eye drops) into the eyes of Resident 7. LVN 1 placed the cap and the uncovered artifical tears bottle on the resident's bed while she assisted the resident in opening his eyes. The tip of the artificial tears bottle was observed directly resting and touching the resident's blanket. LVN 1 then proceeded to administer another drop of artificial tears into the resident's eyes without cleaning the tip of the eye drop.<br><br>During an interview with LVN 1 on October 11, 2012, at 10 a.m., she acknowledged that the tip of the artifical tears bottle could be contaminated because it touched the resident's blanket and had the potential to cause infection to the resident's eyes. LVN 1 then discarded the medication bottle and stated she will get a new artificial tears for the resident. | F 441 | | |
| F 457 SS=B | 483.70(d)(1)(I) BEDROOMS ACCOMODATE NO MORE THAN 4 RESIDENTS<br><br>Bedrooms must accommodate no more than four residents.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and record review, the facility failed to ensure that resident bedrooms accommodated no more than four residents in 1 of 28 bedrooms. Room #44 had five beds inside the room.<br><br>Findings:<br><br>On October 10, 2012, between 10:20 a.m. and | F 457 | **Corrective Action(s) Specified to Resident(s) Identified**<br>n/a<br>**Corrective Action(s) for Potentially Affected Resident(s)**<br>A waiver has been requested for Room #44. The residents in these rooms have a reasonable amount of privacy as well as closet and storage space. The facility will ensure that the limited area in this room will not compromise with the provision of care and quality of life of the residents.<br>**Systemic Corrective Action**<br>n/a<br>**Monitoring Process**<br>n/a<br>**Responsible Position(s)**<br>n/a | 11-1-12 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055104 | A. BUILDING _____ B. WING _____ | 10/16/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUNSET MANOR CONV HOSP | 2720 NEVADA AVENUE EL MONTE, CA 91733 |

| (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 457 | Continued From page 26<br>11:15 a.m., during the initial tour, the evaluator observed that one of the 28 resident rooms (Room #44) had five resident beds Closer observation showed that Room #44 room had sufficient space for the beds, ventilators, tube feeding pumps and dressers. All the residents in this room were bed-bound and did not ambulate.<br><br>On October 10, 2012, at 11:20 a.m., an interview was conducted with the administrator regarding the five-bed room. The administrator stated that Room #44 had always had five beds and that the room did not present any problems with the provision of care to residents. The administrator also indicated that a room wavier would be submitted for this room.<br><br>On October 10, 2012, at 1:10 p.m., the administrator submitted a waiver for the five bed room. A review of the wavier indicated that Room #44 had sufficient room for provisions for nursing services and that the waiver would not adversely affect the residents' care, safety and security. | F 457 | | |
| F 458 SS=B | 483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT<br><br>Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and record review, the facility failed to ensure that 13 of 28 resident rooms (Room 16, 17, 19, 20, 21, 22, 23, 25, 26, 27, 32, 33 and 35) met the minimum requirement of 80 square feet (sq. ft.) per | F 458 | **Corrective Action(s) Specified to Resident(s) Identified**<br>n/a<br>**Corrective Action(s) for Potentially Affected Resident(s)**<br>A waiver has been requested for these 13 rooms. The residents in these rooms have a reasonable amount of privacy as well as closet and storage space. The facility will ensure that the limited area in this room will not compromise with the provision of care and quality of life of the residents.<br>**Systemic Corrective Action**<br>n/a<br>**Monitoring Process**<br>n/a<br>**Responsible Position(s)**<br>n/a | 11-1-12 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055104 | A. BUILDING _____ B. WING _____ | 10/16/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUNSET MANOR CONV HOSP | 2720 NEVADA AVENUE EL MONTE, CA 91733 |

| (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 458 | Continued From page 27<br>resident in multiple resident rooms. Seven of these rooms had two beds in each room and six other rooms had three beds each.<br><br>Findings:<br><br>On October 10, 2012, between 10:20 a.m. and 11:15 a.m., during a general observation, the evaluator observed that 13 of 28 resident rooms (noted above) did not meet the minimum requirement of 80 sq. ft. per resident in multiple resident rooms. The majority of the residents in these rooms were able to move freely around in their rooms and the other residents in these rooms were in wheelchairs to move around in their rooms. The evaluator also observed that the nursing staff had enough space to provide care to the residents, the privacy curtains provided privacy for each resident and the rooms had direct access to the corridors.<br><br>On October 10, 2012, at 11:23 a.m., the evaluator conducted an interview with the administrator regarding the 13 resident rooms that did not meet the minimum requirement of 80 sq. ft. per resident in multiple resident rooms. The administrator stated that a room wavier would be submitted for these 13 resident rooms.<br><br>On October 10, 2012, at 1:15 p.m., the evaluator reviewed the room waiver which stated that there was enough space for each resident's care, dignity and privacy. It also stated that these rooms were in accordance with the special needs of the residents and that the waiver would not adversely affect residents' health and safety.<br><br>The room waiver showed the following: | F 458 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055104 | A. BUILDING _____ B. WING _____ | 10/16/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUNSET MANOR CONV HOSP | 2720 NEVADA AVENUE EL MONTE, CA 91733 |

| (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 458 | Continued From page 28<br><br>Rm # / # of Beds / Sq. Ft.<br>16 / 2 / 140<br>17 / 2 / 155<br>19 / 3 / 216<br>20 / 2 / 149<br>21 / 3 / 218<br>22 / 2 / 146<br>23 / 3 / 230<br>25 / 2 / 147<br>26 / 2 / 135<br>27 / 2 / 142<br>32 / 3 / 235<br>33 / 3 / 232<br>35 / 3 / 231<br><br>The minimum square footage for a 2-bedroom is 160 sq. ft. and a 3-bed room is 240 sq. ft. | F 458 | | |
| F 465 SS=D | 483.70(h)<br>SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON<br><br>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview, the facility failed to<br>ensure that the shower drains were not unsecured. This had the potential to result in an unsafe environment and potential for a hazard.<br><br>Findings:<br><br>On October 15, 2012, at 9:30 a.m., during a | F 465 | **Corrective Action(s) Specified to Resident(s) Identified**<br>None identified<br>**Corrective Action(s) for Potentially Affected Resident(s)**<br>The unsecured shower room floor drain cover was immediately secured by the Maintenance Director.<br>**Systemic Corrective Action**<br>The Maintenance Director will conduct weekly rounds of the shower rooms and other areas to ensure that a safe environment is provided and to eliminate any potential hazards.<br>**Monitoring Process**<br>The Maintenance Director will immediately correct any hazards found and will report all negative findings at the quarterly QA Committee meetings.<br>**Responsible Position(s)**<br>Maintenance Director | 11-1-12 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055104 | A. BUILDING _____ B. WING _____ | 10/16/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUNSET MANOR CONV HOSP | 2720 NEVADA AVENUE EL MONTE, CA 91733 |

| (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 465 | Continued From page 29<br>general observation, the evaluator observed that the shower room next to Room 38 had one unsecured floor drain cover. and the shower drain cover measured 3-inches in diameter.<br><br>On October 15, 2012, at 9:33 a.m., the evaluator conducted an interview with the maintenance supervisor regarding the unsecured shower room floor drain cover. The evaluator mentioned that this unsecured floor drain cover was unsafe if residents are transported into the shower room, using a shower chair, a wheel might enter the unsecured floor drain that could cause the shower chair to tip over, and the resident could fall down and be injured. The maintenance staff stated he would secure the floor drain covers, immediately. | F 465 | **Corrective Action(s) Specified to Resident(s) Identified**<br>None identified<br>**Corrective Action(s) for Potentially Affected Resident(s)**<br>Upon finding the ants, the Maintenance Supervisor immediately removed and discarded the opened lunch bag and any other food that was attracting the ants. The lockers were removed from the employee break room and was cleaned. The employee break room was immediately cleaned by the housekeepers. The pest control company was also immediately called to come in and spray the area.<br>**Systemic Corrective Action**<br>An inservice was given to all personnel by the DSD regarding the proper storage of food in the facility and to clean up any spillage of food and drinks that may occur in order to prevent ants and other pests. They were also reminded that food cannot be stored overnight in the employee break room and they must discard or take their food home after their shift. Staff were also asked to report any ants that may be found to the Maintenance Director so that the area can be cleaned and the pest control company can be notified. Once per week, the housekeeper will clean out the refrigerator and discard of any foods that have not been properly labeled and/or stored.<br>**Monitoring Process**<br>The Maintenance Director and DSD will conduct daily rounds of the facility, including the employee break room, to make sure that food has been properly stored and pests aren't present. If pests are found, the pest control company will be called.<br>**Responsible Position(s)**<br>Maintenance Director and DSD | 11-1-12 |
| F 469 SS=E | 483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM<br><br>The facility must maintain an effective pest control program so that the facility is free of pests and rodents.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview, the facility failed to maintain an effective pest control program so that the facility is free of ants. Live ants were seen crawling on the employee break room wall.<br><br>Findings:<br><br>On October 15, 2012, between 8:30 a.m. and 10:30 a.m., the evaluator conducted a general | F 469 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055104 | A. BUILDING _____ B. WING _____ | 10/16/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUNSET MANOR CONV HOSP | 2720 NEVADA AVENUE EL MONTE, CA 91733 |

| (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 469 | Continued From page 30<br>observation accompanied by the maintenance supervisor. At 9:48 a.m., the evaluator noticed that between 190-200 live ants crawling (single file) on the walls of the employee break room. The ants crawled (5-feet) on one wall from the sliding glass doors to the second wall and then (15-feet) to the third wall and then (5-feet) to the employee lockers. The maintenance supervisor opened one of the lockers and found an opened lunch bag with ants on the bag. This employee break room was adjacent to the facility's kitchen.<br><br>On October 15, 2012, at 9:50 a.m., the evaluator conducted an interview with the maintenance supervisor regarding the ants. The maintenance supervisor stated he was unaware of the ants and that he would contact the pest control company to come to the facility and eliminate the ants, immediately. | F 469 | | |
| F 505 SS=D | 483.75(j)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS<br><br>The facility must promptly notify the attending physician of the findings.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review the facility failed to notify the physician of one of 15 sampled resident's (Resident 12) refusal to have lab work drawn. This failure had the potential of resulting in inappropriate care and services for the resident.<br><br>Findings:<br><br>The admission record indicated Resident 12 was | F 505 | **Corrective Action(s) Specified to Resident(s) Identified**<br>The attending Physician was immediately notified of resident's refusal of lab work to be drawn.<br>**Corrective Action(s) for Potentially Affected Resident(s)**<br>An in-service was provided by the DON to licensed nursing staff on 10/17/12 regarding promptness of notifying the Physician regarding refusal of any procedures ordered as per facility policy.<br>**Systemic Corrective Action**<br>An annual in-service will be provided by the DON to nursing staff regarding policy and procedure on notification of the Physician for any refusal of procedures.<br>**Monitoring Process**<br>.The RN Supervisor (11-7 and 7-3 shift) will continue to monitor lab tests on a daily basis to ensure scheduled lab tests are being carried out and refusals, if any, will be addressed and reported promptly to the Physician.<br>**Responsible Position(s)**<br>RN Supervisor, DON and Subacute Coordinator | 11-1-12 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055104 | A. BUILDING _____ B. WING _____ | 10/16/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUNSET MANOR CONV HOSP | 2720 NEVADA AVENUE EL MONTE, CA 91733 |

| (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 505 | Continued From page 31<br>admitted to the facility on June 1, 2012, and readmitted on June 21, 2012, with diagnoses that included respiratory failure and brain tumor.<br><br>A Minimum Data Set (MDS), a standardized comprehensive assessment and care screening tool, dated September 28, 2012, indicated the resident was able to make himself understood and able to understand others, and required extensive assistance with transfers, dressing, toilet use, and personal hygiene.<br><br>Review of a physician's order dated June 25, 2012, indicated to draw blood work for a basic metabolic panel ([BMP] blood tests used to measure levels of sugar, fluids and electrolyte levels in the blood) every three months (March, June, Sept, Dec) and a complete blood count ([CBC] measures the concentration of white blood cells, red blood cells, and platelets in the blood) every three months (March, June, Sept, Dec).<br><br>Review of an untitled care plan dated June 1, 2012, indicated the resident was prone to skin breakdown. Interventions included to monitor pertinent labs including BMP and CBC every three months and notify the physician of any abnormal values. Review of another care plan dated June 25, 2012, indicated the resident had the potential for a low hemoglobin (the molecule in red blood cells that carries oxygen) and hematocrit (blood test that measures the percentage of the volume of whole blood that is made up of red blood cells) due to anemia. Interventions included to draw laboratory blood work as ordered, including CBC every three months, and report the abnormal results to the | F 505 | | 11-1-12 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055104 | A. BUILDING _____ B. WING _____ | 10/16/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUNSET MANOR CONV HOSP | 2720 NEVADA AVENUE EL MONTE, CA 91733 |

| (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 505 | Continued From page 32<br>physician promptly.<br><br>In an interview on October 15, 2012 at 11 a.m., the registered nurse coordinator (RNC) stated the resident had episodes of refusing to allow blood work to be drawn. According to the RNC the resident was supposed to have a BMP and CBC done in September however the resident had refused. The RNC also stated there was no documentation indicating the resident had refused the blood work nor was the physician notified. According to the RNC the licensed staff should document when a resident refuses blood work to be drawn. The RNC also stated the physician should have been notified.<br><br>In an interview on October 16, 2012, at 9:45 a.m., the director of nursing (DON) stated when a resident refuses blood work to be drawn the staff should make three attempts at collecting the blood work. The DON also stated there should be documentation from the licensed staff indicating three attempts were made and the number of times the resident refused.<br><br>Review of the undated facility's policy titled, "Refusal of Medications and Treatment", indicated should a resident refuse his or her medications and/or treatments, appropriate documentation relative to such refusal must be recorded in the resident's medical record. According to the policy documentation pertaining to a resident's refusal of treatment shall include, as a minimum: date and time treatment was attempted, resident's response, that the resident was informed of the purpose of the treatment and the consequences of not receiving the medication/treatment, the date and time the | F 505 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055104 | A. BUILDING _____ B. WING _____ | 10/16/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUNSET MANOR CONV HOSP | 2720 NEVADA AVENUE EL MONTE, CA 91733 |

| (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 505 | Continued From page 33<br>physician was notified as well as the physician's response. | F 505 | | |