POC reviewed & accepted 7/27/15 #27785

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/QUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A428	A BUILDING B. WING	07/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEREY HEALTHCARE & WELLNESS CENTRE, LP	1287 SAN GABRIEL BLVE **ROSEMEAD, CA 91770**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the Department of Public Health during RECERTIFICATION and Abbreviated surveys. CA00439801-Substantiated with no regulatory violation CA00447639-Substantiated with no regulatory violation CA00442632-Substantiated with no regulatory violation CA00441312-Substantiated with no regulatory violation Representing the Department of Public Health: Surveyor ID: 27785 Surveyor ID: 11679 Surveyor ID: 18279 Total Resident Population: 72 Total Resident Sample: 15 Highest Scope and Severity: E	F 000	Monterey Healthcare and Wellness Center submits this response and Plan of Correction as part of the requirements under state and federal law. The plan of correction is submitted in accordance with specific regulatory requirements. It shall not be construed as admission of any alleged deficiency cited or any liability. The provider submits this plan of correction with the intention that it is inadmissible by any third party in any civil, criminal action or proceeding against the provider of its employee, agents, officers, directors, or shareholders. The provider reserves the right to challenge the cited finding if at any time the provider determines that the disputed findings are relied upon in a manner adverse to the interests of the provider either by the governmental agencies or third party.	
F 156 ssc	F 156 483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform **the** resident both orally and in writing in a language that the resident understands of his or her rights and **all** rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the	F 156		

2015 JUL 24 AM 4:50
LOS ANGELES COUNTY HEALTH FACILITIES DIVISION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X8) DATE

NHA — 7/24/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A428	A. BUILDING B. WING	07/0212015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEREY HEALTHCARE & WELLNESS CENTRE, LP	1267 SAN GABRIEL BLVE ROSEMEAD, CA 91770

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F 156	Continued From page 1 **notice** (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (6) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of	F 156	No residents were identified to be affected. Upon admission the Director of Admission or designee will review with resident and or responsible party on how to apply for and how to use Medicare and Medicaid benefits. The facility will post on the consumer board information on how to apply and use Medicare and Medicaid benefits. Admin or designee will monitor consumer board and keep current posting up to date. Admin or designee will report monthly to the QA committee any new posting for consumer board.	7/2/15

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F 156	Continued From page 2 institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit and a statement that the resident may file a 'complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. he facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by:	F 156		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDEPJSUPPLIERJCLIA IDENTIFICATION NUMBER;	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A428	A. BUILDING _____ B. WING _____	0710212015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEREY HEALTHCARE & WELLNESS CENTRE, LP	1267 SAN GABRIEL BINE ROSEMEAD, CA 91770

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156	Continued From page 3 benefits for the residents. This failure to post the Medicare and Medicaid benefit notice would not allow residents to contact these agencies for benefits. Findings: • On June 29, 2015, at 1:10 p.m., during the initial observation, it was observed that the facility's consumer information was posted at the front main office. Closer observation showed that the Medicare and Medicaid benefits notice was not posted at the consumer board. On June 30, 2015, at 7:10 a.m., during a second general observation, it was observed that the 'Medicare and Medicaid benefits notice was not posted, anywhere throughout the facility. On July 2, 2015, at 9:30 a.m., an interview was conducted with the administrator regarding the notice for Medicare and Medicaid benefits, which was not prominently posted. During this interview, the administrator stated she was unaware that the notice was not posted and *she* would post the notice, immediately.	F 156		
F 202 SS=D	483.12(a)(3) DOCUMENTATION FOR TRANSFER/DISCHARGE OF RES When the facility transfers or discharges a resident under any of the circumstances specified in paragraph (a)(2)(i) through (v) of this section, the residents clinical record must be documented. The documentation must be made by the resident's physician when transfer or 'discharge is necessary under paragraph (a)(2)(i) or paragraph (a)(2)(ii) of this section; and a physician when transfer or discharge is necessary:	F 202	DON completed a review of residents discharges in last 30 days and found no similar deficiency DON in-serviced the IDT and licensed nurses on 07/20/2015 regarding proper procedure of resident … (continued on next page)	7/20/15

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

PRINTED: 07/15/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A428	A. BUILDING _____ B. WING _____	07/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEREY HEALTHCARE & WELLNESS CENTRE, LP	1267 SAN GABRIEL BLVE ROSEMEAD, CA 91770

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F 202	Continued From page 4 under paragraph (a)(2)(iv) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to follow policy and procedure related to discharging a resident. As a result, nursing staff did not document the status and final disposition of a resident (12) after the resident's transfer to an acute care hospital. Findings: According to the Admission Face Sheet, Resident 12 was admitted to the facility on 10/03/09 and readmitted on 9/30/14 with diagnoses that included the following: paranoid schizophrenia (delusions and false beliefs), depressive disorder (feeling sadness and loss), and anxiety disorder (feelings of anxiety and fear). The resident was ambulatory, independent and able to make his needs known per the quarterly minimum data set used for assessments (MDS) dated 4/15/15. During a review of the clinical record for Resident 12 revealed the resident was discharged to another facility 6/29/15. The record also disclosed Resident 12 was discharged without proper discharge instruction. During an interview on 7/1/15 at 6:50 a.m. concurrent with clinical record review was conducted with Registered Nurse 1 (RN 1). She stated she remembered the resident and the incident. She further stated that she came into work one day and Resident 12 was discharged and did not know why there was no nursing discharge summary.	F 202	All residents with order for transfer/discharge will be reviewed by the IDT to ensure all notice requirements are met prior to discharge of the resident The MRD will complete an audit of the clinical record of resident with anticipated discharge order to assure that notice requirement are met prior to discharging resident. Findings will be reported to the administrator for follow-up. Administrator will report trend and analysis of finding to the monthly Q.I. committee meeting for further review and documentation.	7/20/15

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 202	Continued From page 5	F 202		

During a review of the residents nursing notes dated 6/29115 did not disclose a discharge note, assessment, or communication that the resident was being transferred to another skilled nursing facility (SNF). Also, there was no documentation there was a communication with the facility staff where the resident was going.

During an interview with the director of nursing (DON) on June 2, 2015 at 1:30 p.m., she stated the resident was discharged on the request of the conservator on the same day.

During an interview with the social service designee (SSD) on the same day at 1:55, he stated the resident was transferred to another facility with the approval of the assistant in training administrator (AIT). He further stated that the resident's discharge happened so quickly per the conservator.

Review of the facility's undated policy titled "Discharge and Transfer of Residents" states prior to discharge, Nursing staff will prepare a discharge summary and will document the summary in the resident's medical record. This was not done.

F 226 483.13(c) DEVELOP/IMPLMENT SS-E ABUSE/NEGLECT, ETC. POLICIES — F 226

The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

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F 226	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to train staff on its abuse policies and procedures that prohibit abuse of residents, regarding reporting incidents to the appropriate agencies within the appropriate tirneframe. One of six staff did not know that the facility must report any abuse, with serious bodily injury, to the California Department of Public Health (CDPH), the Ombudsman and the local law enforcement, within two hours and the administrator did not know all of the seven components of the abuse policy. The staffs' lack of knowledge of the abuse policy could lead to possible harm to residents who may have been abused. Findings: a. On June 30, 2015, at 7:10 am., a review of the facility's abuse policy and procedure, dated April 1, 2015, was conducted. The policy stated that for all alleged abuses, the facility will report by telephone, immediately, or as soon as practically possible but no later than 24 hours to the CDPH, the Ombudsman and the local law enforcement. It also stated that if a suspected abuse results in serious bodily injury, the facility must make a report by telephone immediately, and not later than two hours to the local law enforcement and file a written report, within two hours, to the CDPH, the Ombudsman and the local law enforcement. On June 30, 2015, at 8:05 a.m., a 7 a.m. to 3 p.m. shift Certified Nursing Assistant (CNA) was interviewed regarding the facility's abuse policy and procedure. During this interview, the CNA stated the facility had to report an abuse which	F 226	Staffs were in-serviced on 07/16/2015 regarding abuse policy and procedure of any suspected abuse resulting in serious bodily injury must be reported immediately no later than 2 hours by telephone to local law enforcement. Each month, the department heads will randomly ask the staff in their department about the time frames of reporting incidents to appropriate agencies. Department heads will report their findings to the administrator Trends will be reported to administrator at CQI committee monthly for discussion and review for further documentation.	7/16/15

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F 226	continued From page 7	F 226		

results in serious bodily injury, immediately or up to 24 hours to the CDPH, the Ombudsman and the local law enforcement.

On July 2, 2015, at 9:30 the administrator was interviewed regarding the staff interviews on the facility's abuse policy and procedure. The administrator was informed that six staff were interviewed for the abuse policy. Of the six staff, one of six staff did not know that the facility must report any abuse which results in serious bodily injury, within two hours, to the CDPH, the Ombudsman and the local law enforcement. The administrator stated all the staff would be in-serviced, as soon as possible, on the facility's abuse policy that any abuse which results in serious bodily injury, must be reported to the appropriate agencies within two hours.

b. On June 30, 2015, at 7:10 a.m., a review of the facility's abuse policy and procedure, dated April 1, 2015, was conducted, The policy listed the seven components of abuse, which consisted of screening, training, prevention, identification, **investigation,** protection, and reporting/response.

On July 2, 2015, at 9:30 a.m., the administrator was interviewed regarding the facility's abuse policy and procedure. During this interview, the administrator was asked to name the seven components required to be in the facility's abuse policy and procedure. After a few minutes, the administrator was only able to name two of the seven components. The administrator added that she would look up the other five components.

F 250 SS7-13	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE	F 250		

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

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEREY HEALTHCARE & WELLNESS CENTRE, LP	1267 SAN GABRIEL BLVE ROSEMEAD, CA 91770

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F 250	'Continued From page 8 The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide social services to assist one of nine alert and oriented residents who attended the group interview. The social services staff failed to assist Randomly Selected Residents 16 (RSR 16) with missing clothing items after it was reported to the staff. This had the potential to result to the deterioration of RSR 16's psychosocial well being. Findings: During the group interview on 6/30/16, at 9 AM, RSR 16 stated that he lost a jacket and a brand new shirt a couple of days ago (6/28/15). RSR 16 stated that he lost the jacket, which was important to him, and the shirt while he was in the shower room. RSR 16 said that he told his nurses the same day he lost the clothing items and was told that they would look for them but he stated that he haven't heard from them since. During an interview on 6/30/14, at 10:30 AM, the social services staff stated that he was not aware RSR 16 lost some clothing items. He stated that ' the nurses did not report the incident after RSR 16 told them about it. The social services staff stated that he would look into the incident now that it was brought to his attention.	F 250	An investigation was regarding (RSR 16) reported lost jacket and shirt. Staff searched RSR16's bedside and both the jacket and shirt were found and given to RSR 16 who showed satisfaction with the resolution of this reported loss of clothing items. On 07/23/2015, the SSD in-serviced nursing staff on timely communication and documentation of reported loss of resident personal property to SSD for prompt investigation and resolution. No other residents were identified to be affected. Staff in-service completed 07/22/2015 by social services. Staff to report missing items timely when reported by residents. Inventory to be completed upon admission and discharge. Medical records will audit resident charts for inventory completion and report finding to admin and DON. 07/22/15	07/23/2015

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MONTEREY HEALTHCARE & WELLNESS CENTRE, LP	**1267 SAN GABRIEL EWE** **ROSEMEAD, CA 91770**

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F 250	Continued From page 9 A review of RSR 16's clinical record indicated that there was no documentation regarding the incident after RSR 16 reported it to his nurses and no documented evidence that the resident was assisted in any way before surveyor brought it to their attention. The facility's policy and procedure titled "Resident Rights - Personal Property," dated revised on 1/1/12, indicated that the facility promptly Investigates any complaints of misappropriation, theft, or mistreatment of resident property. Another policy and procedure of the facility titled "Theft Prevention," dated revised on 7/1/12, indicated that the Facility documents reports of lost and stolen resident property on the "Lost **and** Stolen Property Log" for items with a value of 25 dollars or more or of particular value to the resident,	F 250		
F 257	483,15(h)(6) COMFORTABLE & SAFE SS=E **TEMPERATURE** LEVELS 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 This REQUIREMENT is not met as evidenced *by*. Based on observation, interviews **and** record review, the facility failed to maintain comfortable and safe temperature levels ranging between 71-81 degrees Fahrenheit **(F),** In areas where the residents reside. Three common areas inside the facility were at or above 84.5 degrees **F.** This improper maintenance of the room temperatures for the residents could lead to dehydration or heat	F 257	No residents were identified to be affected. The Maintenance Supervisor will monitor the facility temperatures daily in areas where residents reside and maintain a log. Maintenance will install weather strips on 10 facility doors to help maintain the temperature levels between 71-81 degrees Fahrenheit (F). Maintenance Sup or designee will monitor weather stripes effectiveness, and report to Admin.	8/14/15

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MONTEREY HEALTHCARE & WELLNESS CENTRE, LP	1287 SAN GABRIEL BLVE ROSEMEAD, CA 91770

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F 257	Continued From page 10	F 257		

stroke.

Findings:

On June 30, 2015, at 9:30 am., a group interview was conducted with nine alert and oriented residents. During this group interview, four of the nine residents stated that it is too hot inside the facility.

On June 30, 2015, at 2:15 p.m., it was observed that the outside temperature was 97.2 degrees F.

Between 2:20 p.m. and 2:40 p.m., a general observation was conducted and ambient temperatures were taken at three common areas where the residents were at. The following temperatures were taken at the three enclosed areas:

Location	_F_
East TV area	84,5
. Breezeway	85,5
West TV area	88.5

On July 1, 2015, at 1:45 p.m., an interview was conducted with the administrator regarding the room temperatures which were above 81 degrees F. The administrator said she knew the room temperatures should be between 7181 degrees F, but was unaware that these areas were that hot. The administrator was informed that this Could affect the residents by causing dehydration (excessive loss of body water) or heat stroke (a severe heat illness with a body temperature greater than 105.1 degrees F due to environmental heat exposure). At the end of the interview, the administrator stated she would have the maintenance staff check the air

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MONTEREY HEALTHCARE & WELLNESS CENTRE, LP	1267 SAN GABRIEL BLVE ROSEMEAD, CA 91770

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F 257	Continued From page 11 conditioning units, this same day, and make sure they are working properly. On July 2, 2015, at 10:15 a.m., a review of the facility's resident room and environment policy and procedure, dated January 1, 2012, was conducted. This policy stated that the facility will maintain a homelike atmosphere with comfortable temperatures.	F 257		
F 371 SS-D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and -(2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to protect food under sanitary conditions, regarding one refrigerator not in service. This improper maintenance of the kitchen equipment could lead to possible food contamination and/or foodborne illness. Findings: On July 1, 2015, between 6:25 a.m. and 8:15 am., a kitchen observation was conducted at the facility's kitchen. There were four refrigeration units throughout the kitchen. Upon closer	F371	No residents were identified to be affected. On 7/2/15 the non-working refrigerator was removed from the facility. The facility has since ordered a new refrigerator and will be delivered to the facility on 7/27/15. The DDS along with Maintenance will monitor all dietary appliance's and schedule repairs as needed. If unable to repair the facility will make determinations on need for replacements and coordinate according.	7/27/15

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	05A428	A BUILDING B. WING	07/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEREY HEALTHCARE & WELLNESS CENTRE, LP	12B7 SAN GABRIEL RLVE ROSEMEAD, CA 91770

(X4) ID PREFIX TAO	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 371 Continued From page 12

observation, it was observed that the Traulsen 2-door refrigerator had an "Out of Service" sign taped on the door. The refrigerator was unplugged, empty and not in use.

At 8:15 a.m., a review of the refrigeration unit temperature log showed that this refrigerator had been "broken" since April 1, 2015.

On July 1, 2015, at 8;25 a.m., an interview was conducted with the dietary supervisor regarding this out of service refrigerator. During this interview, the dietary supervisor stated that this refrigerator had been malfunctioning for a few days. The dietary supervisor added that the administrator was made aware of it and had not decided if the facility was going to replace it or remove it. The dietary supervisor mentioned that this refrigerator was too old to be repaired.

F 371

F 457 483.70(d)(1)(1) BEDROOMS ACCOMMODATE SS-13. NO MORE THAN 4 RESIDENTS

F 457

Bedrooms must accommodate no more than four residents.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to ensure that 6 of 28 resident rooms (Rooms 1, 5, 20, 26, 44 and 45) must accommodate no more than four residents in each room. Rooms 1, 20, and 45 had 12 beds inside; Rooms 5 and 26 had 8 beds inside; and Room 44 had 5 beds inside. These rooms are overcrowded and could affect the residents quality of life.

On 6/30/15 the Admin submitted a waiver for the following six bedrooms that accommodate more than 4 beds to a room. # 1,5,20,26,44 and 45.

Administrator and Maintenance Supervisor checked all other bedrooms for square footage and bed count and no other room accommodates more then 4 beds.

Maintenance Supervisor will periodically check the bed count of

7/24/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/OLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A428	A. BUILDING B. WING	07102/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEREY HEALTHCARE & WELLNESS CENTRE, LP	1287 SAN GABRIEL BLVE ROSEMEAD, CA 91770

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSO 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 13 Findings: On June 29, 2015, between 1:10 p.m. and 2:15 p.m., during the initial tour, it was observed **that** that some of the resident rooms had **five** or **more** beds inside, at the east wing, south wing and west wing. These rooms were Rooms 1, 5, 20, 26, 44 and 45. It was noticed that the residents on the east wing and west wing were ambulatory. The entire south wing (which included Rooms 44 and 45) was vacant and no residents were there. Closer observation showed that there were no residents admitted in the following beds: 1F, 5A, 20E, 201, 20K **and** 26B. On June 29, 2015, at 2:30 p.m., an **interview** was conducted with the administrator regarding Rooms 1, 5, 20, 26, 44 and 45. The administrator indicated that a room waver would be submitted for these six resident rooms which had five or more beds in each of the rooms. At the end of the interview, the administrator stated that all the rooms on the south wing (which included Rooms 44 and 45) were vacant and the facility had not determined what would be done with these rooms. On June 30, 2015, at 9:05 a.m., a review of the room waiver, dated June 30, 2015, was conducted. This room waiver indicated that there was adequate space for each resident's care, and the health and safety of the residents in these rooms. It also mentioned that these rooms were in accordance with the special needs of the residents, and would not have an adverse effect on the residents' health and safety or impedes the ability of any resident in the rooms to attain his or her highest practicable well-being. The room waiver showed the following:	F 457	each room. Maintenance Supervisor will report any bedroom with more than 4 beds not included in the wavier to the monthly CQI committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(V) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER!	(x2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A428	A. BUILDING B. WING	0710212015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEREY HEALTHCARE & WELLNESS CENTRE, LP	1237 SAN GABRIEL BLVE ROSEMEAD, CA 91770

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID Pi=tF X TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION SATE

F 457 Continued From page 14

F 457

Rm #	# Beds
1	12
5	8
20	12
26	8
44	5
45	12

F 458 483.70(d)(1)(ii) BEDROOMS MEASURE AT ssiB LEAST 80 SQ FT/RESIDENT

F 458

Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to ensure that 20 of 28 resident rooms (Rooms 2, 3, 4, 5, 6, 7, 8, 9, 21, 22, 23, 24, 25, 26, 27, 28, 29, 40, 41 and 44) met the square footage of 80 square feet (sq. ft.) per residents in multiple resident rooms, and at least 100 square feet in single resident rooms. These rooms could lead to possible inadequate nursing care to the residents.

Findings:

On June 29, 2015, between 1:10 p.m. and 2:15 p.m., during the initial tour, it was observed that some of the resident rooms did not meet the minimum requirement of 80 sq. ft. per resident in multiple resident rooms and the single resident rooms to be at least 100 sq. ft., at the east wing, south wing and west wing. These rooms were Rooms 2, **3, 4, 5, 6,** 7, 8, 9, 21, 22, 23, 24, 25, 26,

On 6/30/15 Administrator submitted a waiver for the square footage of the following rooms: 2,3,4,5,6,7,8,9,21 22,23,24,25,26,27,28,29,40,41,44

Administrator and Maintenance Supervisor measured all other rooms to ensure the square footage meets regulations.

Maintenance Supervisor will report to QA committee monthly

7/24/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIERICLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A428	A BUILDING B, WING	07/0212015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEREY HEALTHCARE & WELLNESS CENTRE, LP	**1267 SAN GABRIEL BLVE** **ROSEMEAD, CA 91770**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST 8E 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 15	F 458'		

27, 28, 29, 40, 41 and 44. It was noticed that the residents on the east wing and west wing were ambulatory. The entire south wing (which included Rooms 40, 41 and 44) was vacant and no residents were there. Closer observation showed that there were no residents admitted in the following beds: 3A, 5A, 9A, 21B, 21C, 22A, 26B, 28A, and 29B.

On June 29, 2015, at 2:33 p.m., an interview was conducted with the administrator regarding Rooms 2, 3, 4, 5, 6, 7, 8, 9, 21, 22, 23, 24, 25, 26, 27, 28, 29, 40, 41 and 44. The administrator indicated that a room wavier would be submitted for these 20 resident rooms which did not meet the minimum requirement of 80 sq. fk. per residents in multiple resident rooms and the single resident rooms to be at a minimum of 100 sq. ft. During this interview, it was mentioned to the administrator that a client accommodations analysis (a form which shows the room measurements, floor area [square footage] and bed capacity for each room) would need to be completed with the room waiver. At the end of the interview, the administrator mentioned that all the rooms on the south wing (which included Rooms 40, 41 and 44) were vacant and the facility had not determined what would be done with these **rooms.**

On June 30, 2015, at 9:10 am, a review of the room waiver, dated June 30, 2015, was conducted. This room waiver indicated that there was adequate space for each resident's care, and the health and safety of the residents in these rooms. It also mentioned that these rooms were in accordance with the special needs of the residents, and would not have an adverse effect on the residents' health and safety or impedes the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
05A428	A. BUILDING _____ B. WING _____	07/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEREY HEALTHCARE & WELLNESS CENTRE, LP	**1287 SAM GABRIEL BLVE ROSEMEAD, CA 91770**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSO IDENTIFYING INFORMATION)	ID — PREF X 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 16	F 458		

ability of any resident in the rooms to attain his or her highest practicable well-being. The room waiver showed the following:

Rm #	# Beds	Sq. Ft.
2	2	132
3	2	132
4	2	132
5	8	550
6	2	147
7	2	154
8	1	96
9	2	150
21	4	276
22	2	120
23	2	108
24	2	108
25	2	120
26	8	562.5
27	2	154
28	4	306
29	2	114
40	2	143
41	1	99
44	5	379.5

The minimum square footage for a 1-bed room is 100 sq. ft., a 2-bed room is 160 sq. ft., a 4-bed room is 320 sq. ft., a 5-bed room is 400 sq. ft., and an 8-bed room is 640 sq. ft.

F 465 SS-E 483.70(h) SAFE/FUNCTIONAUSANITARY/COMFORTABL E ENVIRON — F46[illegible]

The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDERJSUPPLIER1CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A428	A. BUILDING B. WING	07102/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEREY HEALTHCARE & WELLNESS CENTRE, LP	**1267 SAN GABRIEL BLVE ROSEMEAD, CA** 91770

9(4) 10 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 SE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETION DATE
F 465	F 465 Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide a safe environment for residents and staff, regarding the three dryers in the laundry room. Two of the three dryers were allowing lint to pass through the exhaust tubes, and deposit on the roof. This improper maintenance of the equipment could increase the risk of a fire hazard. Findings: On July 1, 2015, between 9:45 a.m. and 1:30 p.m., a general observation was conducted with the maintenance supervisor. At 1:15 p.m., it was observed that there was lint deposited on the roofs ledge, outside of the laundry room. The dryer exhaust tubes were at the roof, directly above the laundry room, At 1:16 p.m., upon entering the laundry room, it was observed that there were three dryers. Upon closer observation, it was noticed that all three dryer lint screens were 16-mesh screen (A 16-mesh screen consists of 16 rows and 16 columns equaling 256 squares, per every square inch of the screen.) and there were not tears on these screens. At 1:18 p.m., an observation was conducted with a maintenance staff, upon the roof of *the* laundry room. It was observed that two of the three exhaust tubes had lint build inside. At 1:20 p.m., an interview was conducted with the maintenance supervisor and the administrator	F 465	The exhaust tubes in laundry room were immediately cleaned by the laundry staff on 07/01/2015 and any lint build-up was removed. The maintenance director educated staff on proper maintenance of the exhaust tubes to minimize risk of fire hazard on 07/01/2015. The laundry staff will check the exhaust tubes monthly for any lint build-up. The maintenance director will randomly check monthly and any findings to be reported to administrator. The QA committee will review findings monthly.	07/01/20 15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A428	A. BUILDING B. WING	D7102/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEREY HEALTHCARE & WELLNESS CENTRE, LP	1267 SAN GABRIEL BLVE ROSEMEAD, CA 91770

(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 18

F 465

regarding the lint deposit on the roof and the lint build up inside the exhaust tubes. The maintenance supervisor stated that he was unaware of the facility the lint build up and the lint deposit on the roof. During this interview, the maintenance supervisor was informed that this lint deposit means that lint travels to the inside of the dryer exhaust tubes and possibly accumulate inside the exhaust tubes. If the lint accumulates and builds up, this lint build up could be a possible fire hazard. At the end of the interview, the maintenance supervisor stated that he would have the maintenance staff clean the exhaust tubes, immediately.

F 492 48315(b) COMPLY WITH 88=D FEDERAL/STATE/LOCAL LAWS/PROF STD

F 492

The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to operate in compliance with all applicable State regulations with accepted professional standards and principles that apply to professionals providing services, regarding facility's administrator and the operation managers. These unaccepted professional standards and principles are non-compliant with State regulations, which could lead to inappropriate operating services.

7/6/15

The administrator reviewed with AIT his job description on 07/06/2015 on AITs responsibility outlined in the assistant administrator job description.

ON 07/06/2015 the Admin and SSD was given education of discharge policy with focus on accepted professional standard and principles that apply to providing services in the facility.

The DON reviewed all discharges in the last 30 days and found no similar findings.

Any request for resident discharge will be reviewed by the IDT for a written order for discharge by physician

The SSD on a monthly basis, will randomly review at least 2 discharged resident records for completion and report findings to administrator.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A428	A BUILDING 13, WING	0710212015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEREY HEALTHCARE & WELLNESS CENTRE, LP	1267 SAN GABRIEL BLVE ROSEMEAD, CA 91770

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREF X TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 492	Continued From page 19 Findings: According to the Admission Face Sheet, Resident 12 was admitted to the facility on 10/03/09 and readmitted on 9/30/14 with diagnoses that included the following: paranoid schizophrenia (delusions and false beliefs), depressive disorder (feeling sadness and loss), and anxiety disorder (feelings of anxiety and fear). The resident was ambulatory, independent and able to make his needs known per the quarterly minimum data set used for assessments (MDS) dated 4115115. On 7/2/15, at 1:30 p.m., during an interview, the social service designee (SSD) stated he was given orders to discharge Resident 14 from the facility by the assistant in training (AIT). He further stated the resident was discharged on the same day to another facility. Review of the assistant administrators undated job descriptions discloses the following, "The Assistant administrator is responsible for orienting and learning the day to day activities for all facility departments with an emphasis on profit and loss management and state compliance to state and federal regulations. On 7/2/15, at 1:40 p.m., during an interview, the AIT stated that he gave the SSD directives to discharge Resident 14 to another facility. He further stated the, resident was discharged because the conservator wanted him transferred. The AIT asked if he was allowed to discharge a resident. It was mentioned that there was no	F 492		

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

PRINTED: 07/15/2015
FORM **APPROVED**
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(xi) pRovioEFuSuPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A428	A. BUILDING B. WING	07/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEREY HEALTHCARE & WELLNESS CENTRE, LP	**1287 SAN GABRIEL raLvE ROSEMEAD, CA 91770**

(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 492.	Continued From page 20 documentation anywhere that showed the administrator in training (AFT) had authorization to discharge or transfer residents to another facility or had the authorization to sign any forms in lieu of the administrator. (The California Code of Regulations, Title 22, Licensing and Certification of Health Facilities, Section 72513 (a) (3) states the administrator shall designate a responsible adult who is knowledgeable in the policies and procedures of the licensee in each facility to be responsible for Carrying out the policies of the licensee in the administrator's absence.)	F 492		
: 507	483.75(j)(2)(iv) LAB REPORTS IN RECORD - SS=D LAB NAME/ADDRESS The facility must file in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure laboratory test report was filed in the clinical record for one (Resident 5) of 15 sampled residents. Resident 5 had a physician's order for a laboratory test for thyroid stimulating hormone and thyroxine (TSH & T4, tests used to help evaluate **thyroid** function and diagnose thyroid diseases) level every year, howeVer, the latest laboratory report for these tests were not filed in the resident's clinical record. This had the potential to result in a delay for appropriate actions, if indicated, to meet the resident's	F 507	Resident #5 laboratory test TSH and T4 result was immediately filed back to resident clinical record Review of other residents clinical record completed made sure all lab results are available. In-service given to licensed nurses and medical record designee on 07/17/2015 regarding policy and procedure in laboratory services. Licensed nurses will check availability of lab results in resident clinical record on a weekly basis during completion of weekly summary	

PRINTED: 07/15/2015
FORM APPROVED
OMB. NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(xi) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(x2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A428	A. BUILDING B. WING	07102/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEREY HEALTHCARE & WELLNESS CENTRE, LP	1267 SAN GABRIEL EINE ROSEMEAD, CA 91770

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 507	F 507 Continued From page 21 well-being. Findings: 'A review of the admission record for Resident indicated resident was admitted to.the facility on 7/19/12, with diagnosis that included paranoid schizophrenia (a form of schizophrenia in which the patient has delusions or false beliefs that a person or some individuals are plotting against them or members of their family), hypertension (high blood pressure), and hyperlipidemia (abnormally high concentration of fats or lipids in the blood). The latest minimum data set (MDS, a standardized assessment and care planning tool), . dated 6/16/15, indicated Resident 5 had the ability to make self understood and understand others, and had behavioral symptoms not directed toward others. MDS also indicated that Resident 5 was independent in performing Activities of daily living and was continent of bowel and bladder. A review of a physician's order dated 7/19/12, indicated to do a laboratory test for a TSH & T4 level determination every year. However, further review of Resident 2's clinical record revealed that the latest laboratory report for this test was not in the resident's active clinical record for use as reference in the resident's care.	F 507	MRD will audit clinical record (weekly summary) to ensure lab results are available. Tread identified will be reported by the DON and will be discussed at the facility CQI committee monthly for further review and recommendation.	07/17/2015

During an interview on 7/1/15, at 10 AM, the director of nursing (DON) stated that the TSH & T4 ordered by the physician for Resident 5 was done but the laboratory report was removed from the clinical record when it was thinned out.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA420	A. BUILDING _____ B. WING _____	07/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEREY HEALTHCARE & WELLNESS CENTRE, LP	1287 SAN GABRIEL BLVE ROSEMEAD, CA 91770

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	483.75(l)(1) RES ss=D RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the residents assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the licensed nursing staff failed to maintain clinical records in accordance with accepted professional standards and practices that are accurate. This was evidenced by inaccurate and illegible medication administration record (MAR) for one of 12 sampled residents (4). Findings: According to the admission record, Resident 4 was admitted to the facility on 6/3/14, with diagnoses that included paranoid schizophrenia (delusions and false beliefs) and esophageal reflux (acid coming from the stomach). During the morning pass on 7/1/15 at 6:15 a.m., Residents 4's MAR times were observed scribbled over in black pen and illegible.	F514	DON immediately reviewed other resident clinical records In-service given to licensed nurses and medical records on 07/17/2015 regarding accepted professional standards and practices including accurate documentation, will focus on proper correcting and error MRD will complete an audit of residents clinical record to assure that documentation are accurate and within accordance with professional standard and practice. Tread identified will be reported by the DON and will be discussed at facility CQI committee meeting monthly for further discussion and recommendation.	07/17/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDERISUPPLIERICLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A428	A. BUILDING B, WING	07/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEREY HEALTHCARE & WELLNESS CENTRE, LP	1287 SAN GAsRIEL BLVE ROSEMEAD, CA 91770

(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)	(7(5) COMPLETION DATE

F 514 Continued From page 23

F 514

On 7/1/15 at 7:20 a.m., during observation, interview and record review, the RN supervisor was observed giving insulin (medication to regulate blood sugar) to a resident. The resident said, "I always get my insulin at 9 a.m." The MAR time was observed scribbled over in pen with an illegible time change.

On 7/1/15 at 7:30 a.m., the registered nurse (RN 1) was asked why someone would scribble over the medication times on the residents MAR. RN 1 said that she did not scribble over the times and did not know who did it.

During an interview with the director of nursing (DON), on 7/2/15, at 1:25 p.m., she stated that the facility does not have a policy on legible writing. She further stated staff should have drawn a single line through the time and initialed the changes.

F 517 463.75(m)(1) WRITTEN PLANS TO MEET EMERGENCIES/DISASTERS
ss=c

F517

The facility must have detailed written plans and procedures to meet all potential emergencies and disasters, such as fire, severe weather, and missing residents.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to have detailed written policy and procedures to meet all potential emergencies, including accurate information. The facility's disaster manual had inaccurate information,

The emergency telephone disaster manual was updated on 07/06/2015 to include current names and telephone numbers of department supervisors.

No other emergency telephone list with inaccurate information was available in the facility.

The MRD will update the emergency contact list as needed to keep information up-to-date .

The emergency contact list in the disaster manual will be reviewed by the department supervisor for accuracy of information monthly in QA meeting.

07/06/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A428	A. BUILDING B. WING	07)0212015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEREY HEALTHCARE & WELLNESS CENTRE, LP	1267 SAN GABRIEL BLVE ROSEMEAD, CA 91770

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSO IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 517	Continued From page 24 regarding emergency telephone numbers for some of the department supervisors. This inaccurate information may delay the staffs' emergency response time that could lead to possible harm to residents, staff and visitors. Findings: On June 29, 2015, at 3:05 p.m., a review of the facility disaster manual was conducted. This manual was reviewed and approved by the quality assurance committee, on January 26, 2015. Further review showed that this manual had an inaccurate emergency telephone list for some of the department supervisors, including the administrator. The emergency telephone listing had the former administrator, the former business office manager, the former social service designee, and the former medical records director, On July 2, 2015, at 9:10 am., an interview was conducted with the administrator, regarding the disaster manual. During the interview, it was mentioned the disaster manual had an inaccurate emergency telephone list. At the end of this interview, the administrator stated that this emergency telephone list would be updated, as soon as possible	F 517		
F 518	483 75(m)(2) TRAIN ALL STAFF-EMERGENCY **ssr-E** PROCEDURES/DRILLS The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures.	F 518	Staff were in-serviced on 07/16/2015 regarding emergency procedure and preparedness including review of locations of water and gas shut-off locations and how to use fire extinguisher and procedure when a resident goes missing.	7/16/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A428	A. BUILDING _____ B. WING _____	07/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEREY HEALTHCARE & WELLNESS CENTRE, LP	1267 SAN GABRIEL SINE ROSEMEAD, CA 91770

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATOR'? OR LSC IDENTIFYING INFORMATION)	ID PREF X TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(x5) COMPLETION DATE
F 518	F 518 Continued From page 25 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to train the staff on the facility's emergency preparedness procedures. Four (CNA1, CNA2, RN1, SSD1) of six staff did not know the location of the gas shut-off valve, the location of the water shut-off valve, how to use a fire extinguisher, the fire code, the location of the emergency water, and the missing person code. The staffs' lack of emergency preparedness procedures may delay their response time which could lead to possible harm to residents, visitors and other staff. Findings: On June 29, 2015, at 3:05 p.m., a review the facility's disaster manual was conducted. This manual indicated that the gas shut-off valve was located behind the kitchen, the water shut-off valve was located at the front facility parking lot, the instructions on how to use the fire extinguisher was PASS (Pull the pin, Aim the hose at the base of the fire, Squeeze the handle and Sweep *the* hose), the fire code was "Dr, Red," the location of the emergency water inside the cabinets outside of the dining room, and there was no code for a missing person. On June 30, 2015, at 7:45 a.m., a 7 a.m. to 3 p.m. shift Certified Nursing Assistant (CNA) was interviewed regarding the facility's emergency policies and procedures. During this interview, the CNA stated the gas shut-off valve was located at the front, the water shut-off valve was located behind the kitchen, and only knew the fire extinguisher instructions were pull the pin and aim the hose at the fire.	F 518	Each quarter the DSD will review emergency preparedness and procedures to all staffs. Each month the department heads will ask the staff in their department about locations of water and gas shut-offs and the different emergency codes Department heads will report their findings to the administrator. Treads will be reported by the administrator at CQI committee monthly for discussion and review for further recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A428	A. BUILDING _____ B. WING _____	07/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEREY HEALTHCARE & WELLNESS CENTRE, LP	1267 SAN GABRIEL BLVE ROSEMEAD, CA 91770

(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 518	.Continued From page 26	F 518		

On June 30, 2015, at 8:20 a.m., a 7 a.m. to 3 p.m. shift CNA was interviewed regarding the facility' s emergency policies and procedures. During this interview, the CNA stated the fire code was "Code Red."

On June 30, 2015, at 1:45 p.m., the social service designee was interviewed regarding the facility's emergency policies and procedures. During this interview, the social service designee stated the emergency bottle water was located in the kitchen and the missing person code was "Code Blue" ("Code Blue" is the code for medical emergency.).

On June 30, 2015, at 4:10 p.m., a 3 p.m. to 11 p.m. shift Registered Nurse (RN) was interviewed regarding the facility's emergency policies and procedures. During this interview, the RN stated that the missing code was "Code Green" ("Code Green" is the code for residents fighting.).

On July 2, 2015, at 9:15 a.m., an interview was conducted with the administrator regarding the staff interviews. During this interview, the administrator was informed that four of six staff did not know some of the emergency procedures. The administrator stated that all the staff would be in-serviced on the facility's emergency procedures, as soon as possible.