17:19 Admissions Coordinator 02/14/2018

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| DEPARTME | ENT OF HEALTH AN | D HUMAN SERVICES | | 2/26/18 | OMB NO. | |
|---|--|--|------------------|--|---------------------------------|--------------------|
| CENTERS FOR MEDICARE & ! TAYEMENT OF DEFICIENCIES ND PLAN OF CORRECTION | | (X1) PROVIDERS PROTECTION OF D | (X2) MOLTIPLE CO | NETRUCTION | (X3) DATE SURVEY COMPLETED C | |
| NU PLAN OF C | ONNEOTION | a di mila i ni | 1.1011 | | 1 | /2018 |
| | | BHOFEB 23 AL | BONINGS | | 02/02 | 72010 |
| | | TOTAL CO A | STR | EET ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF PRO | OVIDER OR SUPPLIER | RECEIVE | | THIRD STREET | | |
| FIRESIDE C | ONVALESCENT HOSE | PITAL | 8AI | NTA MONICA, CA 90403 | | |
| | | | I ID I | PROVIDER'S PLAN OF CORRECTIVE ACTION SHO | TION | (XI) COMPLETION |
| (X4) ID PREFIX TAG | WARL BEELDIEN | TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTION OF CROSS-REFERENCED TO THE APPLICATION OF CROSS-REFERENCY) | ROPRIATE | DATE |
| | INITIAL COMMENTS | | F 000 | Submission of this Plan of Correction is not legal admission that a deficiency exists or that this statement of deficiency was | | |
| | The following reflect | cts the findings of the Ic Health (DPH) during a | | correctly cited and is also construed as an admission | of interests | |
| | complaint investigation. | | | against the facility, the adm any employees, agents, or of | her individual | |
| | Complaint number: | | | who may be discussed in this | n, preparation | 8 |
| | Representing the D Nurse: 34178 RN | PH: Health Facilities Evaluator | | and submission of this plan | or correction | ja is |
| | The inspection was | limited to the specific | | agreement of any kind by the truth of any facts alleged or t | the correctness | 1 |
| | complaint investiga | ated and does not represent Il Inspection of the facility. | | of any conclusions set forth | by the survey of the plan of | |
| | One deficiency wa | s written as a result of | | correction within the time in | construed as | |
| F 441 | | 522549. TROL, PREVENT SPREAD, | F 441 | compliance of admissions | by the facility. | |
| \$\$=E | CFR(s): 483.80(a) | (1)(2)(4)(e)(f) | | This plan of correction shall | of compliance | |
| | (a) Infection preve | ention and control program. | и и | as outlined by Section California Health and Safety | 1280 of the | |
| | and control progra | establish an infection prevention am (IPCP) that must include, at illowing elements: | | , . | | |
| | (1) A system for p | preventing, identifying, reporting, identifying and | F441 | F441 | | |
| | communicable di volunteers, visito | seases for all residents, staff, rs, and other individuals | 1.441 | How the corrective act | esidents found | 1 |
| | providing service | s under a contractual ed upon the facility assessment | | to have been affected by | y the delicien | it |
| | conducted accordance implementation is | ding to §483.70(a) and following al standards (facility assessment s Phase 2); | | a) The facility performed an the nurses regarding infect proper hand washing te | ion control an | a |
| | (2) Written stand | lards, policies, and procedures | | providing bedside care. b) The facility performed an | n in-service wit | th |

LABORATORY GIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S BIGNATURE Any deficiency statement ending with an asteriak (*) denotes a deficiency which the inelitation 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 of 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 evallable to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued approximate and deficiency participation. program participation.

FORM CMS-2587(02-99) Previous Versions Obsolste

for the program, which must include, but are not

the nurses regarding g-tube and catheter

TITLE

(XX) DATE

2-14-18

elefoedO-enclast/ exchant (69-digition-enc) segon

(e) Linens. Personnel must handle, store,

be implemented, and the corrective ections taken by the facility. seum naiq eint boniateus bas bovoides evideonce out base 4041 sVillest ord tebru el notivorrice that that correction is befilinebi atnebioni gnibrocen roi mateye A (4) are sustained. The facility must develop enotinies that orne salam of sonamvolvaq Lostroo trasitest toetle in beviown trasident. How the facility plans to monitor its bewelled ad as unbecord ensigy it brisit off (IV) babaan es sunitmos. bris ;essestb orti firmensu (liw testnee od qu wollot bas gaining readua? ,boton contact with residents or their feed, if direct Of Nursing if there are deficient practices oideolummos e diby essergime bididorq isum fosulo moti snoissi nits belasini essesalo rico reported to the Administrator and Dir. at least three consecutive months until (v) The circumstances under which the facility treatment of wounds, g-tubes, and catheters. These sudits shall be ongoing for droumskinoes. erli rebru tresbizon erti tot didiazog evitotdem tar erit ed blucris miksket erit tarit imamariuper A (B) galus bewellot galed one seedment lonines bna ,bavlovni noticedani terit has exelq ai ere coupliniest mainagro ro kraga auctocher in unqu gribnaqab rendom to ensure that proper hand washing ,notheriori ent to incliant brus eqt eriT (A) periodically no less than monthly, at designees, shall follow the vestment number to) betimil for ted gributori probise practice does not recur-in facility infection Control Muse or a tol beau ed bivorts notisiosi worl bas nariW (vi) insialish sait that orners of salam renotice the bearing and process of control what systematic changes will the facility anolluseriq bessid-noiselmensit bins bisbrist8 (iii) What measures will be put into piace, or reported; -compooning ed bluode enclosist to esseeb eldesimmenco bus estotion Villess ant or sonstiquios To atnotioni eldissoq morter ot brus norter (II) owens of senod-ni stroked its rot wound cere, g-tube cere, and catheter cere percus gual care ebreaq to cause become pu gre anibivorq eserum eth this essitoring lorinos enoticeini to essessib eldesirummoo eldisedq The facility reviewed the proper infection Vilinabl of barquest somelitevius to metays A (I) and what corrective action will be taken. affected by the same deficient practice of ballnul ed of latinatog sab galvad atachisor f ageq mort beunihoo. How the facility will identify other MATERIAL STATES CHANGE OF THE MATTER TO THE STATE OF THE STA SVO. PROVEERS PLAN OF CORRECTION BE CONTRACTION BY CONTRACTION BY CALL OF CORRECTION BY CALL OF Q (900 92/9 (92/21/2000) PIREBIDE CONVALESCENT HOSPITAL SCHOOL AD ADMOM ATMAS MAINE OF PROVIDER OR SUPPLEM THUMB CHAIL TAG STREET ADDRESS, CITY, STATE, 2P CODE 620999 ENUA 'E 03/03/20/8 STATEMENT OF DEFICERORS MOTTERFIELD TO MALT DIA ON) PROVIDENSIVENERUS. NOTIFIED CONSTRUCTION CENTERS FOR MEDICARE A MEDICAID SERVICES VEVAUS BIAQ (EQ DEPARTMENT OF HEALTH AND HUMAN SERVICES ONE ICO, 0938-039 CEVORATE METOR 810514150 PRINTED: 02/02/2018

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POC is integrated into the OA system

action evaluated for its effectiveness. The

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17:20 Admissions Coordinator 02/14/2018

OMB NO. 0988-0391 DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICALD SERVICES (CO) DATE SURVEY OCH MULTIPLE CONSTRUCTION (XI) PROVIDERSUPPLERICLIA IDENTIFICATION NUMBER: COLUNITED STATEMENT OF DEFICIENCES A. BUILDING WO PLAN OF CORRECTION 02/02/2018 686039 STREET ADDRESS. CITY, STATE, ZIP CORE NAME OF PROVIDER OR SUPPLIER SAT THIRD STREET Banta Monica ca 90403 FIRESIDE CONVALUSCENT KOSPITAL PROVIDERS PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE CONTRACTION (CD) SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAS (EACH DEPICIENCY MUST SE PRECEDED BY PULL REGULATORY OR LEG IDENTPYNO HIFOTLATICK) (XX) ID PREFEX and F 441 Continued From page 2 This plan of correction is integrated into the process, and transport linens so as to prevent the monthly quality assurance and performance enneri of infection. improvement and shall be reviewed by the (f) Annual review. The facility will conduct an quality assurance (QA) committee monthly for three (3) months, or until compliance is annual review of its IPCP and undata thair program, as necessary. determined to be complete. This REQUIREMENT is not met as evidenced Include dates when corrective actions by: Based on observation, interview and record will be completed. The corrective action review, the facility staff falled to wash hunds completion dates must be acceptable to before and after the dressing changes for surgical wound, gastrostorny tubing elle, and suprepuble the State Agency. catheter alte for two of three campled residents 2/21/18 (Resident 2 and 3). (G-tubs, is an opening into the stamach from the ebdominal wall, made surgically for the introduction of food, and suprepuble catheter site is a urine drainage calinater which is inserted into the bladder so that urine can be drained out, al entry with 1st tuo view lumnor entre entry visuous blocked. Instead of being passed up through the urethra as is usual, the supra public catheter is inserted through the abdominal wall just shove the pubic bone and into the bladder). This deficient practice had the potential for cross contamination and spread of infection to other residents. Findings: a. On 2/22/17, et 8:15 a.m., during an unannounced complaint visit, it was observed that the Rosnaed vocational nurse (LVN 1) performed wound treatment for Resident 2. LVN 1 gloved hand hold 4×4 gause, type, normal saline cup. LVN 1 placed 4 x 4 gauze, tape, hydrogen

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FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES <u>18 NO. 0938-035</u> (A) DATE GURVEY COMPLETED CENTERS FOR MEDICARE & MEDICAID SERVICES (C) NULTIFLE CONSTRUCTION ON) PROVIDERIGIPOLIERICLIA IDENTIFICATION MAGERI STATEMENT OF DEFICIENCES AND PLAN OF CORRECTION A. BUILDING. C 02/02/2018 S. WING EE5039 STREET ADDRESS, CITY, STATE, ZP CODE NAME OF PROVIDER OR SUPPLIER 947 THURD STREET BANTA HONICA, CA 80403 FIRESIDE CONVALESCENT KOSPITAL PROVIDERS PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BY
CROSS-REPERBICED TO THE APPROPRIATE ONE CONSTELLOR (VII) SUMMARY STATEMENT OF DEFICIENCIES PREFEK (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LEG IDENTIFYING BIFORMATION) (X4) ID PREFIX TAG OFFICENCY) F 441 Centimied From page 3 F 441 bed side table had breakfast tray. LVN 1 removed solled dressing at right and last enterior hips post-op surgical wounds. LVN 1 cleansed the right and left enterior hip, pet dried, wrapped around surgical wound and tapes. LVN 1 did not change gloved and or wash hand from the beginning of to the and of procedures. Resident 2's admission record indicated the resident was admitted to the facility on 12/29/16, with diagnoses that included difficulty in walking. and hypertension (high blood pressure). A Minimum Date Set (MDS) to a standardized resident essessment care screening tool, dated 2/8/17, indicated resident's countilve skills for delly decision making was intact and required limited to extensive assistance from the staff with activities of daily living with foot surgicel wounds ogra. A review Resident 2's Discharge Summary from general acute care hospital (GACH) dated 12/29/16, indicated post-op ortho follow up with a history of right excess pelvic fracture in fixation device. The resident was admitted to the skills nursing facility for ortho follow-up pelvic of opened reduction internal flustion (ORIF) and also raduction of the right tib-fib fracture. Resident 2 had a physician order dated 2/6/17 for left enterior hip and right anterior hip status post CRIF, cleanse with hydrogan percodde 3% solution - apply Bestroben 2% to alles, pat dry and cover with dry dressing treatment daily at 7 -3 shift for 14 days then re-evaluate. b. On 2/22/17, at 8:25 a.m., during a treatment

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PRINTED: 02/02/2018 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0838-0381 CENTERS FOR MEDICARE & MEDICAID SERVICES OCHPLETED (X2) MULTIPLE CONSTRUCTION (M) PROVIDERSUPPLIESCLIA IDENTIFICATION MAKEER: STATEMENT OF DEFICIENCIES A BUILDING NO FLAN OF CORRECTION 02/02/2018 R. WOLD **685039** STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER OAT THURD STREET Banta Horica, ca 90403 PIRESIDE CONVALESCENT HOSPITAL PROVIDERS FLAN OF CORRECTION CONTRIBUTION (BACH CORRECTIVE AUTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE SUMMARY STATEMENT OF DEFICIENCIES (M)D PREFX (EACH DEPOSERRY MUST BE PRECEDED BY FULL RESULATORY OR LCC (DENTIFYING BEFORMATION) DEFICIENCY) TAG F 441 F 441 Continued From page 4 gauzo, messure tape, ectasor, cup of normal seline with gauze inside on the resident's bad side table. the bedside table were a pair of socks and dark blue Foley dignity bag (urine collecting beg). LVN 1 put gloves on, removed solled dressing from G-tube site, with the same gloved hand LVN 1 cleaned G-tube alte with normal saline gauze, pet dry, and wrapped 4 x 4 gauze around G-tube, covered 4 x 4 gauze dry dressing. LVN 1 changed new gloves, and proceeded to remove soiled dressing from suprepublo catheter site, cleaned area with normal caline gauze with the same gloved hand, 4 x 4 gauze wrapped around suprepuble eatheter. LVN 1 asked the certified nurse assistant (CNA 2) to hold Resident 3's hand. Then LVN 1 covered suprepublic cetheter with 4 x 4 gause. LVN 1 picked up dark blue Poley dignity bug on bed side table and handed it to CNA 2. CNA 2 verbalized "I forgot to put the eignity bag on the foley bag" while putting on to dignity beg to cover folloy beg. LVN 1 continued to out two with subsor and secured tope to supreputite eatheter. LVN 1 did not wash hands after removed solled dressing and before proceeding to a second dressing change. Resident 3's admission record indicated the regident was re-admitted to the facility on 2/17/17. with diagnosed that included urinary tract infection and dyspinetia (difficulty in swallowing).

FORM CMS-ESSTETS-SSI Providus Versione Charlete

A Minimum Data Set (MDS) to a standardized resident assessment care screening tool, dated 1/31/17, indicated resident's cognitive skills for daily decision making was severely impaired and required extensive to total assistance from the

staff with activities of daily living.

The Resident 3 had a physician order dated Event ID: NR1211

Facility (Dr. CAR10000058

Yourdoustion sheet Page 5 of 7

Meating" no dated, indicated the principle of The facility policy and procedure, filled "Hand nobootni bns ossosib to noissimensut bns tramquiaveb erti traverq qiori et mata bras atrablasa toi treamnonivrio eldatromoco bra viatinas, estas a ebiverq Centrol Program" no deted, indicated the feelily octables on infection control program designed to noticeins' betti ,erubecorq bre yollog Villast erff es gateseth yiqqA .berebre il sottoidine pair of cierca disposable gloves. Apply topicel wen nob bus ebresh riself , sevolg eldesoqalb evenness, thereton as stratch or distract, Remove 1960Bole brauw to entire famon ritiw brauew erth with blood, or other body fulld is thely. Cleanse the only necessary if solling of your skin or clauting and dry hands theroughly. Put on gloves. A gown supplies so they can be easily reached. Wesh erill egnernA. . bleft russto erit no erubecorq erit enfrub besu ed of amed its coals. (etsupoba et resident's overbed table (a clean, dry paper towel on Teers, Abrazione and Miror Skin Brazion on the ert on the action of the control of the contro The facility policy and procedure titled, "Care of "Inamiser refig briari ym riastw ot fogrof i "griasarib bio beworiari tests ,friendsort gritub brisil yin rissw jon hib i .brisi ym fiesw bris geoveg erry hend. I did phonis (.bie) eithers event fon bib (.tnormeinpe LVN 1, who stated "I should have a tray for my rilly welvisiri as gailub "m. 8 &+:8 is ,Trissis ao Anemiseri Viisb elis oktuanque sellne, epply dry dressing delly, and parl-cere st edists larmon rithe edit-@ estracto not VINTING Continued From page 5 Fttl SECULATION OR LES INSERTORS DESCRIPOR ON PRODUCTION (CALCHES DES TRACTORS DES PRODUCTION) DES DESCRIPOR DE PRODUCTION (CALCHES DES PRODUCTION) DE CALCHES DE PRODUCTION (CALCHES DE PRODUCTION (CALCHES DE PRODUCTION) DE CALCHES DE PRODUCTION (CALCHES DE PRODUC (ionantiad MOTIORESO TO MAIG STRUMORY ES CAUDIS MOTION ENTREMISO HOAS STAINGORYN BYT OT CENTREMENS CECAS STAINGORYN BYT OT CENTREMENS CECAS CI XPTERPY SAST d (M) (CO) MOTTENS HOO BISIG PREBIDE CONVALERCENT KOSPITAL SANTA MOMCA, CA 92403 MALIE OF PERVISORS OR SUPPLIES BINGET ADDRESS, CITY, STATE, 27º CODE 620229 B. VIENG 810sisote0 AND PLAN OF CORRECTION ALISABILISABSEBRIVONS (NO FEBRUM MONTACETIVED) COMBIELED DIAE EDHAEA HOSTOLISTERS SEVERILLING (SOC) CENTERS FOR MEDICARE & MEDICALD SERVICES DEPARTAENT OF HEALTH AND HUMAN SERVICES CMB NO. 0858-0281 FORM APPROVED

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| ENTERS | ENT OF HEALTH AI FOR MEDICARE & CORRECTION | MEDICAID SERVICES MEDICAID SERVICES ON) PROVIDENCUPLIERICLA IDENTIFICATION NUMBER: | OCI) MULTIPLE CONSTRUCTION A. BUILDING | | | OMB NO | FORM APPROVED OMB NO. 0988-0891 (03) DATE SURVEY COMPLETED C 02/02/2018 | |
|--|--|--|---|---|----------------|--------|---|--|
| AME OF PROVIDER OR SUPPLIER TRESIDE CONVALESCENT HOSPITAL | | | | STREET ABORESS, CITY, STATE, ZIP COUR 947 THERD STREET | | | | |
| OKO 10 PREFIX TAG | SULBARY STATEMENT OF DEPOSENCES (EACH DEPICIENCY MUST BE PRECEDED BY FULL RESIDATORY OR LEC EXEMPTING SUFGRAATION) | | ID PREF | | | | OTION OLLD BE ROPRIATE | CONTRACTION (CONTRACTION CONTRACTION CONTR |
| F 441 | of machanical remo microorganisms. H at the appropriate t a duty; before and each resident; before | technique is the primarily that well of dirt and landwashing should be done lime, such as before and after after physical contact with re and after use of gloves; stions; handling soiled | F | 441 | | | | |
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