STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555787	A. BUILDING _____ B. WING _____	07/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOCTORS CONVALESCENT HOSPITAL	7926 S PAINTER AVE WHITTIER, CA 90602

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the Department of Public Health during a re-certification survey. Representing the Department of Public Health: [redacted], RN - HFEN [redacted] - HFEN [redacted], REHS - HFE I Total Resident Population: 30 Total Resident Sample Size: 10 Highest Scope and Severity: E	F 000	THIS PLAN OF CORRECTION CONSTITUTE OUR WRITTEN CREDIBLE ALLEGATION OF COMPLIANCE FOR THE DEFICIENCES NOTED.	
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a physical restraint is only used to treat the resident's medical symptoms for one of 10 sample residents (10). Resident 10 had a right hand mitten without a physician's order, without an initial and an ongoing assessment to justify the need of the restraint, and without less restrictive measures attempted prior to the application of the right hand mitten. This deficient practice has the potential to result in the resident's decline in functioning.	F 221		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X8) DATE
	Administrator	8/12/11

8/10/11

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

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F 221	Continued From page 1 Findings: On 7/20/11, at 9 a.m., during the initial tour, Resident 10 was observed lying in bed wearing a right hand mitten. The resident was unable to participate in an interview due to confusion. A review of the medical record indicated the resident was admitted to the facility on 9/30/10, and readmitted on 6/6/11, with diagnoses that included bullous dermatoses (a skin disorder), dysphagia (difficulty swallowing), and gastrostomy tube feeding. The admission Minimum Data Set (MDS - standardized assessment and care planning tool) dated 6/19/11, indicated the resident was moderately impaired in cognitive skills for daily decision making, was rarely/never able to make himself understood, did not walk, and was totally dependent on staff for activities of daily living (ADLs). The clinical record had no physician's order for the use of the hand mitten and no interdisciplinary team assessment to justify the need of the restraint. According to the undated facility's policy and procedure titled "Restraint Devices, Physical," for all restraint devices include assessing the resident's need for restraint device use, obtaining informed consent, and obtaining physician's order for restraint device. On 7/22/11, at 10 a.m., during an interview and after reviewing the medical record, the director of nursing (DON) acknowledged the lack of physician's order for the use of the restraint and	F 221	F221 -Charge nurse secured orders for hand mittens together with transfer orders on 7/20/11, so as to prevent pulling of GT while in transit to hosp. Although resident came in the facility with hand mitten, resident did not use hand mitten until transfer back to hosp. Inservice to all charge nurses by DON On 7/25/11 re: securing MD orders for any therapeutic device after justi fication of necessity. -DON to identify all other residents with therapeutic devices like hand mittens during admission, quarterly, annually and change of condition assessments . -DON to monitor all identified residents to have MD orders and justification for therapeutic devices during daily rounds, and daily chart review. -Immediate corrective action for any findings by evaluating justification, offer ing least restrictive measures first, then	8/12/11

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F 221	Continued From page 2 the lack of assessment. The DON explained the hand mitten was applied to prevent the resident from scratching himself and from pulling out the feeding tube. The DON stated the resident was already wearing the mitten when he was re-admitted back to the facility.	F 221	F221 cont obtaining physician orders for therapeutic device. -All findings to be addressed in monthly nurses QA and evaluated for effectiveness in quarterly QA.	
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to implement policies and procedures to prevent abuse by not screening potential employees for history of abuse. The criminal background was not checked during the hiring process for five of five employee personnel files reviewed. Findings: On 7/21/11, and 7/22/11, a review of the files of five recently hired employees, conducted with licensed vocational nurse 1 (LVN 1), who was also the business office manager, revealed the following information: - For Employee 1, a LVN hired on 6/22/11, there was no evidence of a criminal background check in the employee file. When asked for documentation that a background check had been done, LVN 1 obtained information online	F 226		8/12/11

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F 226	Continued From page 3 from the Board of Vocational Nursing dated 7/22/11, and stated it was the first time he had requested information on the employee. - For Employee 2, a certified nursing assistant (CNA) hired on 3/10/11, there was no evidence a criminal background check had been completed prior to, or during the hiring process. When asked for documentation of a background check, LVN 1 obtained online information from the California Department of Public Health Licensing and Certification Verification dated 7/21/11. - For Employee 3, a CNA hired on 9/7/10, there was no evidence a criminal background check had been completed prior to or during the hiring process. When asked for documentation, LVN 1 obtained online information from the California Department of Public Health Licensing and Certification Verification dated 7/21/11. - For Employee 4, a housekeeper hired on 12/6/10, there was no evidence a criminal background check was conducted prior to or during the hiring process. On the Application for Employment form, the question of whether the employee had ever been convicted by a court of a felony or crime other than a minor traffic violation, was left blank. LVN 1 obtained information from a background screening service agency dated 7/21/11, and verified that was the first time he had obtained the information. - For Employee 5, a dietary worker hired on 6/14/10, there was no evidence a criminal background check had been completed prior to, or during the hiring process, no personal references were obtained. Documentation of a	F 226	F226 -Criminal background check , including verification of licenses and certifications with DHS on all employee files reviewed and completed by DSD on 7/29/11. Inservice by DON to DSD on 7/22/11 re completing of Federal and State requirements in hiring process for prevention of abuse of residents. -DSD to develop a logging form to identify all employees new and old, due dates for criminal background and updating all credential in a timely manner. -DSD to monitor identified staff for due criminal background check by reviewing new employee file for completeness before start of employment. -Immediate corrective action by DSD completing all criminal background and credential updates upon weekly review of employee log. -All findings to be addressed in quarterly QA for evaluation of effectiveness.	8/12/11

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F 226	Continued From page 4 background check was dated 7/22/11. The facility's undated policy and procedure titled "Personnel Records," indicated personnel records must be kept current and complete to comply with Title 19, Title 22, and with Abuse and Prevention regulations. The policy further stipulated that screening of employees for licensed and certified employees can be done through the Department of Health Services website, and for non-licensed or non-certified employees will be done through references and recommendations. On 7/22/11, at 1:10 p.m., during an interview with LVN 1, he stated he was the staff member responsible for obtaining criminal background checks instead of the director of staff development (DSD) because he had computer access. He further indicated that criminal background checks should be done within two weeks of hire, but he was very busy with running the business office and was unable to conduct the checks. On 7/22/11, at 4:35 p.m. during the exit conference, the administrator stated the DSD had repeatedly asked LVN 1 for the background checks, but he had not given the DSD the information.	F 226	This page intentionally Left blank	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY 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.	F 241		8/12/11

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F 241	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to promote care for residents in a manner that maintained or enhanced each resident's dignity and respect for one of 10 sample resident (8). Restorative nursing assistant 1 (RNA 1) spoke roughly and acted in an impatient manner with Resident 8 during dining. This deficient practice had the potential to result in the resident feeling disrespected and embarrassed. Findings: On 7/20/11, at 12:20 p.m., during a lunch meal observation, 10 residents and RNA 1 were in the dining room. Resident 8 was observed picking up a small dish of ice cream and attempting to place a spoon in the bowl, but the dish was covered with plastic wrap. RNA 1 approached the resident, then grabbed the bowl out of the resident's hand, loudly stating, "No". The RNA then proceeded to feed the resident her lunch in a hurried and impatient manner while standing next to the resident. When the resident attempted to pick up a fork, RNA 1 again stated, "No" loudly, and grabbed the fork from the resident's hands. Additionally, while the resident was still chewing, RNA 1 fed the resident another spoonful of food. At one point, RNA 1 was feeding the resident chopped salad in such a hurry, pieces of salad were observed falling into the resident's lap. Approximately five minutes after starting to feed the resident, RNA 1 obtained a chair but did not sit down. After a total of 10 minutes, RNA 1 sat in the chair and continued to feed the resident.	F 241	F241 -RNA immediately inserviced by DON on 7/20/11 re: addressing resident in a manner to promote dignity and respect. -DON to identify all staff for same deficient practice by observing staff's manner of addressing residents during patient care daily. -SSD to identify any staff with concerns of dignity and respect through grievance session in resident council meeting every month. -DON to monitor identified staffs for addressing all residents with respect and dignity during daily rounds -Immediate corrective action by one on one inservice and issuance of warning. -All results of corrective action to be Addressed in monthly nurses QA and Evaluated in quarterly QA.	8/12/11

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F 241	Continued From page 6 The resident was unable to participate in an interview due to confusion and inability to communicate her needs. A review of the clinical record revealed the resident was admitted to the facility on 6/9/09, with diagnoses which included failure to thrive, Alzheimer's Disease, and dementia. The Minimum Data Set (MDS - standardized assessment and care planning tool) dated 6/22/11, indicated the resident was severely cognitively impaired, was incontinent of bowel and bladder, and required extensive assistance with all activities of daily living (ADLs) including eating. A physician's order dated 5/3/11, indicated RNA feeding program for breakfast and lunch five times a week. The resident's ordered diet was mechanical soft diet with finely chopped meats and vegetables. On 7/20/11, at 1:45 p.m., during an interview, RNA 1 stated she was not aware she had been gruff and impatient with the resident. RNA 1 also stated she should be seated at eye level when feeding a resident in order to put the resident at ease.	F 241	This page intentionally Left blank	
F 250 SS=E	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE 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	F 250		8/12/11

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F 250	Continued From page 7 by: Based on observation, interview, and record review, the facility failed to provide medically-related social services to meet the resident's needs of independence, socialization, and comfort for 1 of 10 sample residents (7). Resident 7, who was quadriplegic (paralyzed from the neck down), did not get assistance from the social services staff to have a broken electric wheelchair repaired. The resident could not wheel herself around the facility. This deficient practice resulted in the resident experiencing feelings of frustration, increased time spent in bed, and lack of independence in locomotion. Findings: On 7/22/11, at 10:50 a.m., during an interview, Resident 7 stated she felt frustrated because the electric wheelchair she owned was broken for over a year and nobody helped her with having it repaired. The resident, who was sitting in regular wheelchair, stated she was unable to move her arms to propel the wheelchair and needed her electric wheelchair. The resident stated she was saddened she no longer wheel herself around her room and the facility. The resident added the wheelchair she was using was uncomfortable and she could only tolerate an hour or two sitting in the wheelchair and had to go back to bed. According to a clinical record review, the resident was admitted to the facility on 2/23/10, with diagnoses which included history of multiple sclerosis with quadriplegia, depressive disorder, and diabetes. The quarterly Minimum Data Set (MDS -	F 250	F250 -Faxed letter to the facility from ATG Rehab Co on 6/22/11 stating " approval for repairs and/or modification to patient owned equipment is only for patients who get out of the facility into the community". An activity log show ing that the resident regularly goes out into the community was needed to justify necessity of the electric wheel chair. SSD & DON spoke with daughter, Katie, & stated in the previous place, the resident visited a family member the facility, but even then, the resident would get stuck in the middle of the street and run over people's toes since resident's motor functions is progres sively deteriorating due to MS. -SSD documented results of assistance given for repair of electric WC to resident on 7/25/11.	8/12/11

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F 250	Continued From page 8 standardized assessment and care planning tool) dated 5/27/11, indicated the resident was alert, oriented, able to make her needs known, and was totally dependent on staff for all activities of daily living (ADLs). The resident had a suprapubic urinary catheter (tube inserted into the bladder through the abdomen in order to drain the urine) due to neurogenic bladder. On 7/22/11, at 11:50 a.m., during an interview, the social service designee (DSS)/activity director stated the resident was admitted from another skilled nursing facility and brought an electric wheelchair with her. However, the wheelchair was not functioning upon the resident's admission. The SSD further indicated the maintenance director tried but was unable to fix the wheelchair. The SSD then stated she was unaware of the current status of the resident's wheelchair. The SSD was unable to provide documentation the resident was assisted in making arrangements for obtaining repair of the wheelchair since the facility's maintenance staff was unable to repair the wheelchair. On 7/22/11, at 12:05 p.m., during an interview, the maintenance director stated a technician from the wheelchair manufacturer visited the facility approximately two to three months ago and informed him the wheelchair required a part which was not approved by Medicare. The maintenance director did not hear back from the wheelchair company since the technician's visit. On 7/22/11, at 12:15 p.m., during an interview, the director of nursing (DON) stated the wheelchair technician had informed her the battery was unable to hold a charge, and the	F 250	F250 cont Inservice by Social Service Consultant to SSD on 7/25/11 on proper and timely documentation of all assistance in medical-related social service provided to any resident.	8/12/11

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F 250	Continued From page 9 company needed approval from Medicare for the repair. The DON was unable to provide documentation regarding the technician visit, the evaluation of the wheelchair, and the status of the approval request. There was no documentation that the facility was finding options to meet the resident's need to go around the facility independently. There was no evidence that additional information was provided to Medicate for an approval. On 7/22/11, at 4:30 p.m. during the exit conference, the administrator stated the facility could not afford to repair the resident's electric wheelchair, and that the resident did not need one. The administrator also stated there was not a physician's order for an electric wheelchair.	F 250	F253 -Dangling light fixture in room 11 fixed On 7/21/11 Placed no smoking sign on door of O2 room on 7/20/11. Broken hot water pedal faucet in room 1 fixed on 8/4/11. -All staff inserviced by DON on 7/25/11 re: timely reporting of any equipment or fixture that needs repair by maintenance supervisor will be entered into the maintenance log book and scheduled for repairs. Maintenance supervisor to identify any equipment and fixture that needs repair during morning rounds. -ADM to monitor maintenance log book daily for repairs to are performed at a reasonable time frame. -Immediate corrective action by sche duling any needed repairs with MS. -All results of findings and corrective action to be addressed in monthly dept	
F 253 SS=B	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. There was a broken hot water pedal underneath the hand wash sink in Room 21. A dangling light fixture was observed in Room 11. A "No Smoking" sign was missing outside the oxygen storage room door. Findings:	F 253		8/15/11

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F 253	Continued From page 10 On 7/20/11, at 2 p.m., and on 7/21/11, at 11 a.m., during the general observation of the facility, in the presence of the maintenance supervisor, the following was observed: 1. A broken hot water faucet pedal underneath the hand wash sink in the bathroom located in Room 21. At the time of the observation, the maintenance supervisor stated he was not aware of the broken pedal. 2. Room 11 had a dangling light fixture above the head board of the resident in Bed D. 3. A "No Smoking" sign was not posted outside the door of oxygen storage room located near Room 28 In an interview, on 7/21/11, at 11:10 a.m., the maintenance supervisor stated the "No Smoking" sign was missing and would be replaced.	F 253	F253 Cont head meeting and evaluated in quarter ly QA. -All results of findings and corrective action to be addressed in monthly dept. head meeting and evaluated in quarter ly QA.	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition	F 329		8/5/11

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F 329	Continued From page 11 as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to monitor drug levels as ordered for one randomly selected resident (12). For Resident 12, the blood levels of Tegretol (anti-seizure medication) was not done monthly as ordered by the physician. This deficient practice had the potential to result in unidentified abnormal blood levels of the medication and lack of prompt interventions. Findings: On 7/22/11, a clinical record review revealed Resident 12 was readmitted to the facility on 12/1/10, with diagnoses that included history of grand mal seizures and history of stroke with hemiplegia (weakness on one side of the body). A physician's order dated 12/1/10, indicated Tegretol level every month. The current physician's order for Tegretol was dated 12/30/10, an indicated to give Tegretol 500 milligrams (mg) orally every morning. A review of the laboratory tests revealed no Tegretol blood level results for the months of 12/2010, and 2/2011.	F 329	F329 -Lab results for 12/10 & 2/11 refaxed by laboratory on 7/22/11. Inservice to all charge nurses by DON on 7/25/11 re: proper lab procedure from requisition, documentation of collection of specimen, to relaying of results to MD within 24 hour time frame. Laboratory company set-up to receive results of lab work on line for easier & faster access. -Charge nurse to identify all residents due for lab work for the day on a daily basis. All identified residents will be entered in laboratory log book docu mented as blood drawn or refused. charge nurse to mark all results received with a check and relay results to MD. -Medical Records to monitor that all results marked with a check are relayed to MD and filed in chart. quarterly QA for evaluation.	8/12/11

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DOCTORS CONVALESCENT HOSPITAL	7926 S PAINTER AVE WHITTIER, CA 90602

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F 329	Continued From page 12 On 7/22/11, at 10 a.m., during interview and after reviewing the clinical record review, the director of nursing (DON) stated she could not find the laboratory test results for the months of 12/2010, and 2/2011, and could not explain the lack of monthly monitoring of the Tegretol level as ordered by the physician.	F 329	F329 - -Immediate corrective action by Medical records designee by following up any results w/o a check mark with laboratory company by afternoon. --All findings to be discussed in monthly nurse QA and addressed in quarterly QA for evaluation of effectiveness	
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure it was free of medication error rate of five percent or greater, as evidenced by the identification of three medication errors, out of 42 opportunities for error, to yield a cumulative medication error rate of 7.1 for one of 10 sample residents (4) and one randomly selected resident (11). For Resident 11, Procell (protein supplement) and a multivitamin were not administered as ordered. For Resident 4 an incorrect number of eye drops was administered. This deficient practice resulted in the residents not receiving prescribed medications as ordered by the physician. Findings: 1. On 7/22/11, at 7:30 a.m., during the morning medication pass observation, Medication Nurse 2	F 332		8/10/11

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F 332	Continued From page 13 administered Resident 11's morning medications. At the end of the medication pass, at 9:30 a.m., during reconciliation of the medication administered with the physician's orders, it was noted that two medications ordered on 5/19/10, were not administered to the resident: - Procell two scoops three times daily, mix with 120 cubic centimeters (cc) of juice/water with med pass - Multivitamins one tablet orally daily. According to the medication administration record (MAR), the two medications were scheduled to be given at 8 a.m. On 7/22/11, at 9:30 a.m. during an interview, Medication Nurse 2 stated she had overlooked the Procell and the multivitamin orders written in the MAR. The facility's undated policy and procedure on Medication Administration, indicated medications were to be administered within 60 minutes of the scheduled time (1 hour before and 1 hour after), and routine medications were to be administered according to the established medication administration schedule for the facility. 2. On 7/21/11, at 8:15 a.m., during a medication pass observation, Medication Nurse 1 pulled Resident 4's right lower eyelid down with a finger and placed three drops of Timolol 0.5%. A review of the medical record indicated Resident 4 was admitted to the facility on 6/4/02, and readmitted on 7/15/06, with diagnoses that included glaucoma (eye disorder marked by	F 332	F332 1,2 -MD notified of missed medication for Resident 11, with orders to still administer Procell 2 scoops and give Multivitamins on 7/22/11. MD notified of medication error for Resident 4, monitor for untoward effects with 72 hours. Medication error incident report completed for both. report completed on 7/22/11. Inservice to all charge nurses by DON/ Pharmacy Consultant on 7/25/11 re: proper medication administration, including infection control measures. -DON to identify licensed staff with Medication errors including observation of infection control measures by periodic observation of med pass during DON's daily rounds., at different shifts. Pharmacy consultant to identify Licensed staff with mediation error during monthly drug regimen review and med pass review.	8/12/11

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F 332	Continued From page 14 unusually high pressure within the eyeball), hypertension, and osteoporosis. A physician's order dated 7/2/08, indicated to administer Timolol 0.5%, (ophthalmic solution to reduce the intraocular pressure within the eyeball) one drop on both eyes twice a day for glaucoma On 7/21/11, at 8:20 a.m., during an interview, Medication Nurse 1 stated the ophthalmic medication was for glaucoma and he should have placed only one drop of the medication into the resident's right eye.	F 332	F332 cont 1, 2 -DON to monitor identified license staff and all other license staff on proper Medication administration including observation of infection control measures during daily med pass at random shifts. Pharmacy consultant to monitor Licensed staff for medication error during med pass review monthly. -Immediate corrective action by DON/ Pharmacy Consultant on any findings by notification of physician of medication error, monitoring of patient for untoward effects of medication error, completing an incident report for medication error and further inservices. -All findings to be addressed in monthly nurses QA log and evaluated in Quarterly QA for effectiveness.	
F 371 SS=E	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 store, prepare, and distribute food under sanitary conditions. Food items in the refrigerator and freezer were prepared/opened and not labeled to identify content and date. A dietary worker did not wash hands before opening food containers. The dishwasher machine chemical sanitation did not meet the manufacture's requirement. The food in the tray line did not hold safe temperatures. This	F 371		8/12/11

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F 371	Continued From page 15 deficient practice may result in preventable foodborne illness. Findings: 1. On 7/20/11, at 8:10 a.m., during the initial kitchen inspection, with the presence of Dietary Aide 1, the following was observed: 1a. The reach-in refrigerator contained six glasses of juice that were not labeled to indicate the type of juice and the date of preparation. There were nine glasses with milk that were not identified as to whether they were regular, nonfat, or lowfat. There were two other glasses that were marked with an "X", which Dietary Aide 1 identified as regular milk. A gallon container of barbecue sauce was opened and undated. 1b. The reach-in freezer had three dishes of ice cream that had no date when they were prepared. At the time of the observation, Dietary Aide 1 stated each item in the refrigerator and freezer should be labeled with the contents and open date in order to prevent contamination. 1c. Dietary Aide 1 was observed sweeping the dried food storage room, then proceeded to open three small bins containing packets of salt, pepper, sugar and artificial sweeteners, three dried food bins which contained flour, rice, and sugar, without first washing her hands. During a concurrent interview, Dietary Aide 1 stated she should have washed her hands immediately after using the broom to prevent contamination.	F 371	F371 1 a -6 glasses of juice labeled with date opened and type of juice on 7/20/11. Nine glasses of milk identified to be non-fat with date prepared on 7/20/11. Two glasses marked with X identifies as regular milk and marked with date prepared on 7/20/11. Gallon of barbecue sauce dated with date opened on7/20/11. 1 b Three dishes of ice cream in freezer dated with date prepared on 7/20/11. 1 a, b, c, d, 2, 3 Inservice by Registered Dietary Consultant to all dietary staff on 7/20/11 re: handwashing and usage of gloves as a measure of infection Control, before handling any clean food, condiments and kitchen items. Maintaining sanitary conditions in storage, preparation and	8/19/11

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F 371	Continued From page 16 The facility's undated policy and procedure on Safety and Sanitation: Handwashing, stipulated hands will be washed after handling or removing trash. 1d. The low-temperature dishwasher chlorine test strip (testing method to ensure adequate final rinse chemical sanitation) had a reading of 10 parts per million (ppm) of chlorine on two separate cycles. Dietary Aide 1 stated the strip should read between 50-100 ppm, and that it usually took to run the dishwasher three times before the chlorine test strip indicated 50 - 100 ppm. At 10:15 a.m., during an interview, the registered dietitian (RD) stated the dishwasher had to be run two to three times in order to obtain a chlorine reading that was between 50 -100 ppm. At 10:40 a.m. during an interview with a dishwasher technician, he indicated the chlorine strip should read 50 -100 ppm after the first run. The technician further indicated the chlorine priming pump needed to be repaired. The undated facility's policy titled "Dishwashing Machine With Sanitizing Agent," stipulated the sanitizer must be dispersed at the rate of no less than 50 ppm and no higher than 100 ppm. This must be monitored on a daily basis. 2. On 7/20/11, at 2 p.m. and at 2:15 p.m., Dietary Aide 2 was observed slicing potatoes without gloves then placing the slices in a bowl of water, occasionally stirring the potato slices with her hand.	F 371	F371 serving of food as required by Federal and State laws, including maintaining proper temperature of food and proper range of chlorine test results. to include date opened and date prepared for every item in refrigerator and freezer. Sanitary preparation of food to include wearing of gloves during food preparation. 1 d Authochlor .immediately notified for service after initial reading of chlorine test strip read 10ppm. Lunch served on disposable utensils and paper plates. Dishwasher up and running with chlorine test reading 75 ppm within 30 mins. Authochlor report submitted to surveyors, indicating repair of chlorine priming pump done. Inservice by Registered Dietary consultant to all dietary staff on 7/20/11 re: procedure to notify Auto Chlor for chlorine test not within range of 50ppm-100ppm. Disposable	8/12/11

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F 371	Continued From page 17 At 2:15 p.m., she was observed slicing oranges without wearing gloves. At the time of the observation, an interview with Dietary Aide 2 revealed she was aware she should be wearing gloves in order to prevent food contamination. The facility's undated policy on Safety and Sanitation: Glove Use, stipulated gloves must be worn when direct skin contact with food occurs. 3. On 7/22/11, at 11:55 a.m., during observation of the lunch tray line, in the presence of the dietary service supervisor (DSS), the following food temperatures were obtained: -Chicken fried steak: 110 degrees Fahrenheit (F) -Pureed spinach: 120 degrees F -Pureed chicken fried steak: 120 degrees F -Glass of whole milk: 45 degrees F During an interview with the DSS at 1 p.m., she stated that due to the small size of the facility, the kitchen was not equipped with a steam table to maintain food temperature between 140 to 160 degrees F. The DSS stated the kitchen staff attempts to maintain the hot food temperatures by placing the food items over a low flame on the stove. The facility's undated policy and procedure on Food Production - Food Temperatures, stipulated temperatures for hot products should be no less than 140 degrees F, and cold products shall reach temperatures no greater than 40 degrees F. The policy also indicated that foods failing to register these temperatures must be reheated/chilled until acceptable temperatures are reached.	F 371	F371 paper plates and utensils to be used in the event chlorine test results fall out of range. Daily testing of chlorine levels on first cycle to be maintained in 50-100 ppm range. 3. Chicken fried steak, pureed spinach, pureed chicken fried steak reheated to acceptable temperature of 140 F. Glass of whole milk discarded and prepared another glass from refrigerator with temp of 36 F -Dietary supervisor to identify deficient practice of kitchen staff in maintaining sanitary conditions during storage, preparation and distribution of food, including maintaining chlorine test levels and maintaining hot foods hot and cold food cold, during daily work schedule. Steam pans to be used during tray line and cold liquids to be pulled out of refrigerator as last item to maintain cold temp. -	8/24

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F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure accurate dispensing and administering of medications for for one randomly selected resident (12). The medication nurse failed to sign off Resident 12's medications on the medication administration record (MAR) immediately after administering them, as per facility policy. This deficient practice may result in medication errors. Findings:	F 425	F371 Cont -DSS/ADM to monitor during daily work schedule and tray line observation, that all Federal and State requirements for sanitary conditions in storage, preparation and distribution of food be maintained. -Immediate corrective action by DSS/ADM through continuous inservices of any findings noted. - All results of corrective action to be addressed in monthly department QA for further management and evaluated in quarterly QA.	8/12/11

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F 425	Continued From page 19 On 7/22/11, at 7:35 a.m., a morning medication pass for Resident 12 was conducted with Medication Nurse 2. After administering the medications to the resident, Medication Nurse 2 returned to the medication cart, sanitized her hands, then proceeded to prepare medications for Resident 11. At 9:30 a.m., the same morning, a review of the MAR with Medication Nurse 2 revealed the administration of the resident's medications was not yet documented. After it was brought to her attention, Medication Nurse 2 began initialing the medications on the MAR. When asked why she did not sign the medications off immediately after administering them to the resident, Medication Nurse 2 stated she had forgotten. The facility's undated Medication Administration Policy, stipulated the purpose of the policy was to administer the ordered medications in a safe and accurate manner. The procedure indicated individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given.	F 425	F425 -Charge nurse initialed MAR on 7/22/11 at 930 am for medication administered to resident 12. -Inservice by DON to staff concern on 7/20/11 re: proper procedure for medication administration and documentation. Inservice to all charge nurses by Pharmacy Consultant on 7/25/11 re: proper medication administration to avoid medication errors, including infection control measures. -DON to identify licensed staff with Medication errors including observation of infection control measures by periodic observation of med pass during DON's daily rounds., at different shifts. Pharmacy consultant to identify licensed staff with medication error during monthly drug regimen review and med pass review.	8/12/11
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections	F 441		

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F 441	Continued From page 20 in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide a safe, sanitary environment for two of 10 sample residents. Medication Nurse 2 failed to wash or sanitize her hands after coughing into her hand prior to take Resident 9's blood pressure. Medication Nurse 1 failed to wear gloves during administration of Resident 4's eye drops. This deficient practice had the potential to result in the	F 441	F425 cont -DON to monitor all licensed staff for timely documentation of medication administered during daily med pass at random shifts. Pharmacy consultant to monitor licensed staff for documentation of medication administration during monthly med pass review. -Immediate corrective action by DON/Pharmacy consultant by further inservices upon findings. -All findings to be addressed in monthly nurses QA and evaluated in QA quarterly for further management.	8/12/11

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F 441	Continued From page 21 spread of infections. Findings: 1. On 7/22/11, at 7:15 a.m., during observation of the morning medication pass, as Medication Nurse 2 was preparing to administer medications to Resident 9, she was observed coughing into her hand. Medication Nurse 2 then poured juice from a pitcher into a disposable cup, picked up a blood pressure cuff, and obtained the resident's blood pressure. Medication Nurse 2 returned to the medication cart, then obtained hand sanitizer from a dispenser located on the medication cart, rubbed her hands together twice, then wiped her hands with a paper towel. On the same day, at 9:30 a.m., during an interview, Medication Nurse 2 stated she was unaware she had coughed into her hand. Medication Nurse 2 also stated when using the hand sanitizer, she should have rubbed her hands together several times, then allowed her hands to air-dry, prior to continuing with the medication pass. The instructions on the bottle of the hand sanitizer indicated to place a thumbnail size amount in the palms and rub hands together briskly until dry. 2. On 7/21/11, at 8:15 a.m., during a medication pass observation, Medication Nurse 1 pulled Resident 4's right lower eyelid down with a finger and placed three drops of Timolol 0.5% (an	F 441	F441 1 -Inservice to all charge nurses by DON/Pharmacy consultant on 7/25/11 re: proper medication administration including infection control measures. Resident 9 observed for any cross contamination due to charge nurse coughing times 3 days, none noted. -DON to identify deficient practice during daily med pass on different shift. -DON to monitor daily during her rounds the deficient practice of charge nurses coughing in hands during med pass -Immediate corrective action by DON inservices licensed staff to wash hands or sanitize hands before resuming med pass. -All results of corrective action to be addressed in nurse monthly QA and evaluated in quarterly QA	8/12/11

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F 441	Continued From page 22 ophthalmic medication for glaucoma), without wearing gloves. At 8:20 a.m., during an interview, Medication Nurse 1 stated he does not wear gloves when administering medicated eye drops to the resident. A review of the medical record indicated Resident 4 was admitted to the facility on 6/4/02, and readmitted on 7/15/06, with diagnoses that included glaucoma (an eye disorder marked by unusually high pressure within the eyeball) and hypertension. According to the Centers for Disease Control (CDC) infection prevention includes to wear gloves when in contact with mucous membrane. Encyclopedia Britannica (2011) retrieved from http://www.britannica.com/EBchecked/topic/395887/mucous-membrane, noted that mucous membrane line many structures in the body, including the eyelids.	F 441	F441 cont 2 -Inservice to all charge nurses by DON/Pharmacy consultant on 7/25/11 re: proper medication administration including infection control measures in eye instillation treatments. Resident 4 observed for any cross contamination during eye drop instillation. According to Encyclopedia Britannica (2011) the mucous membrane **line** (inside) many structures in the body including eyelids which primarily consist of skin and muscle that acts as a protective epithelial cell covering. -Charge nurses will wear gloves if contact with mucous membrane is imminent Charge nurses will continue to hand wash before and after eye drop administration where no contact with mucous membrane or eye drainage occurs. -DON to identify and monitor during her daily rounds at time of med pass handwashing for eye drop instillation and use of gloves for draining eyes and mucous membrane contact. -Immediate corrective action by DON by inservicing licensed staff on infection control policy in eye instillation treatments. -All results of corrective action to be addressed in nurse monthly QA and evaluated in quarterly QA	
F 458 SS=B	483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT 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 and record review, the facility failed to provide at least 80 square feet per resident in multiple resident bedrooms. Finding:	F 458		8/12/11

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F 458	Continued From page 23 Rooms 1, 2, 3, 4, 5, 6, 7, 8, 10, 12, 13, 14, 15, and 16 accommodate two residents. Rooms 2, 4, 5, 7, and 15 had each one resident and one unoccupied bed. The space available for the resident is sufficient to provide access and freedom of movement. ROOMS SQUARE FEET 1 146.52 2 146.52 3 143.88 4 143.88 5 149.16 6 141.21 7 147.84 8 133.32 10 147.84 12 147.84 13 147.84 14 133.32 15 147.84 16 147.84	F 458	F458 -Waiver was requested for rooms below the 80 square footage required per resident On 7/22/11. -The present space available for residents and their care is sufficient to provide comfortable access and freedom of movement. -ADM/DON to monitor that access and freedom of movement for resident and their care is maintained. -Periodic evaluation to provide sufficient access and freedom of movement will be addressed in quarterly QA.	
F 469 SS=D	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation,interview, and record review, the facility failed to ensure an effective pest control program to maintain the facility free	F 469		8/12/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555787	A. BUILDING _____ B. WING _____	07/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOCTORS CONVALESCENT HOSPITAL	7926 S PAINTER AVE WHITTIER, CA 90602

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F 469	Continued From page 24 of pests. There were adult cockroaches and nymphs in the employee lounge room. This deficient practice had potential to spread germs in the environment. Findings: On 7/20/11, at 2 p.m., during the general observation of the facility, in the presence of the maintenance supervisor and a charge nurse, live adult cockroaches and nymphs were observed in the employee lounge. The cockroaches and the nymphs were active and were crawling on the walls and floors A review of the facility's pest preventive service report from the pest control company dated 7/18/11, indicated roaches were found in break areas and three resident's rooms. In an interview, on 7/20/11, at 2:30 p.m., the maintenance supervisor stated the facility had a pest control service but was not able to state the reason why adult cockroaches and nymphs were still present after the pest control company already treated the facility.	F 469	F469 -Inservice to all staff by DON on 7/25/11 re: continued reporting of any presence of pest and rodents by informing Maintenance sup and documenting report on maintenance log book. Pest control treated employee lounge with gas spray inside crevices along base boards. It was followed with boric acid powder and meant to burn tentacles of roaches. The burning is what makes them active Although the surveyors indicated they saw 3 roaches in the lounge room this was 2 days after the pest control, and no roaches has been seen since that time. Pest control in place every month with Stanley Pest Control. -All staff to monitor and report any pest or rodents to charge nurse and or Maintenance supervisor and document in maintenance log book. -Immediate corrective action by maintenance supervisor notification of pest control company. -All findings to be addressed in monthly department head meeting and evaluated in quarterly QA.	8/12/11
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to promptly obtain laboratory test result and	F 502		

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F 502	Continued From page 25 inform the physician of the results in a timely manner for one of 10 sample residents (9). Resident 9's valproic acid level was last drawn on 3/8/11, but the result was requested and reported to the physician on 7/21/11, four months after the test was done. This deficient practice may result in delayed interventions. Findings: A review of the medical record indicated Resident 9 was admitted to the facility on 9/7/07, and readmitted on 6/22/09, with diagnoses that included bipolar disorder, diabetes mellitus, and hypertension. The annual assessment Minimum Data Set (MDS - standardized assessment and care planning tool) dated 6/19/11, indicated the resident was able to communicate, did not walk, and required extensive assistance with transfer, dressing, and personal hygiene. A physician's order dated 6/22/09, indicated Depakote (valproic acid) ER (extended release) 500 milligram (mg) every day at night. Another order dated 9/8/09, indicated Depakote level every 6 months. The clinical record did not contain the most recent valproic acid level result, due on 3/2011. On 7/21/11, at 4:30 p.m., after requesting the laboratory test result, the director of nursing (DON) submitted a report printed on 7/21/11, indicating the valproic acid level was taken on 3/8/11. The report was printed four months after the test was done. The report indicated the reference range was 50-100 microgram per milliliter (mcg/ml), and the resident's level was 26.3 mcg/ml (below the reference range).	F 502	F502 -Notification of lab results for resident 9 to MD done on 7/21/11. No new orders given by MD. No untoward effects noted with resident 9. Inservice to all charge nurses by DON on 7/25/11 re: proper lab procedure from requisition , collecting of specimen, receiving results to relaying results to MD on a timely manner. Laboratory company setting up on line access of laboratory results for easier access by next month. -Medical records designee to identify residents with lab works for the day by auditing lab lo daily. -Medical records designee to monitor daily all lab work done for day to have results in by afternoon, during daily lab audit. -Immediate corrective action by MR for any findings by retrieving results from on line or notification of lab co to fax results. -All results of corrective actions to be addressed in monthly nurses QA and evaluated in quarterly QA.	8/12/11

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F 502	Continued From page 26 A handwritten note on the laboratory report indicated the physician was notified on 7/21/11, at 4:20 p.m. and gave no new orders. At 4:35 p.m., during an interview, the DON stated the morning shift charge nurse was supposed to ensure the laboratory result was obtained at the end of the day. The DON also stated the physician is to be informed of abnormal test results immediately.	F 502	This page intentionally Left blank	8/12/11