HIGHLAND CARE CENTER OF REDLANDS

700 EAST HIGHLAND AVE.,
REDLANDS, CA. 92374

Phone: (909) 793-2678
Fax: (909) 793-7390

FAX

To: CDPH-POC Coordinator	**From: Manijeh Forouzan, Administrator**
Fax: 916-636-6051	**Pages: 9**
Phone:	**Date: 06/24/2021**
Re: DHPPD-POC	**cc:**

Comments:

Please see the attached.
Original will be mailed today as well.

Thank you

HIGHLAND CARE
CENTER OF REDLANDS

06/24/2021

California Department of Public Health
Licensing and Re-Certification
Staffing Audit Section
ATTN: POC Coordinator
1615 Capital Ave., Room 73.630
P.O.BOX 997377, MS 3203
Sacramento, CA. 95899-7377

Dear POC Coordinator

Please see the attached facility's signed Plan of Correction for DHPPD Staffing Audit completed on 04/20/2020. Please note that 2567 dated 04/20/2020 was received by the facility on 06/22/2021.

Please do not hesitate to contact this office, should you have any questions or concerns.

Respectfully,
M Forouzan
Manijeh Forouzan, NHA
Administrator
Ext. 214

State of California—Health and Human Services Agency
California Department of Public Health

TOMÁS J. ARAGÓN, MD, DRPH
Director and State Public Health Officer

GAVIN NEWSOM
Governor

Notice of Intent to Issue an Administrative Penalty And Notice to Correct a Violation

The Director of the California Department of Public Health, through the Deputy Director of the Center for Health Care Quality, Licensing and Certification Program, has reasonable cause to determine that an alleged violation of the California Health and Safety Code §1276.5 or 1276.65 has occurred, which will result in the issuance of an Administrative Penalty.

SECTIONS VIOLATED

- HSC §1276.5 3.2 DHPPD
  or
- HSC §1276.65 3.5 DHPPD and/or 2.4 CNA DHPPD

Action to correct this violation(s) must commence immediately and be addressed in the facility Plan of Correction (POC).

This notice issued to **Highland Care Center of Redlands** on **06/18/2021**.

By: Debra Gonzales
Section Chief, Staffing Audits Section

Debra Gonzales Digitally signed by Debra Gonzales Date: 2021.06.18 10:15:53 -07'00'
Signature

I acknowledge receipt of this Notice 06/22/2021
Month/Day/Year

By: Manijeh Forouzan
Designee name

M Forouzan
Signature

TOMÁS J. ARAGÓN, MD, DRPH
Director and State Public Health Officer

GAVIN NEWSOM
Governor

COMPONENTS OF AN ACCEPTABLE PLAN OF CORRECTION

CERTIFIED MAIL

June 18, 2021

Manijeh Forouzan
Highland Care Center Of Redlands
700 E Highland Ave
Redlands, CA 92374-6233

Dear Manijeh Forouzan:

Facility ID: 240000020

Enclosed please find a Statement of Deficiencies and Plan of Correction form. Staff of the Licensing and Certification Program identified the deficient practice during a visit to your facility. Please prepare a Plan of Correction, sign and date the document, and, within 10 days, return the original to:

California Department of Public Health
Licensing and Certification, Staffing Audits Section
ATTN: POC Coordinator
1615 Capitol Avenue, Room 73.630
PO BOX 997377, MS 3203
Sacramento CA 95899-7377

The Plan of Correction must be implemented, corrective action evaluated for its effectiveness, and it must be integrated into the quality assurance system. The Plan of Correction for each deficiency must contain the following:

a) What immediate measures and systemic changes will be put into place to ensure that the deficient practice does not recur.
b) A description of the monitoring process and positions of persons responsible for monitoring (i.e., Administrator, Director of Nursing, or other responsible supervisory personnel) as well as how the facility plans to monitor its performance to ensure corrections are achieved and sustained.
c) Dates when corrective action will be completed. The corrective action completion date must be acceptable to the Department. The deficient practice should be corrected immediately. This date shall be no more than 30 calendar days from the date the facility was notified of the non-compliance.

The previous list includes those components that must be included in every Plan of Correction. Please retain a copy of the completed Statement of Deficiencies and Plan of Correction form for your file.

A rebuttal of the deficiency is not a Plan of Correction. California Health and Safety Code, Section 1280, requires a Plan of Correction for all deficiencies. By providing a Plan of Correction, a licensee or designee does not necessarily admit guilt of any violation nor does this interfere with the right to contest or appeal any alleged violation.

If your Plan of Correction is unacceptable to the Department, you will be notified in writing. You are ultimately accountable for compliance and responsibility is not alleviated when notification of the acceptability of the Plan of Correction is not timely. Your Plan of Correction will serve as the facility's allegation of compliance. The original signed Plan of Correction must be maintained at the facility for a minimum of three years.

If you have any questions regarding this notice, you may contact me via email at LNCStaffingAudits@cdph.ca.gov.

Respectfully,

Debra Gonzales Digitally signed by Debra Gonzales Date: 2021.06.18 10:16:33 -07'00'

Section Chief, Staffing Audits Section

Enclosures: Statement of Deficiencies and Plan of Correction Form
Final Facility Audit Dates and NHPPD Summary Report
Final Facility NHPPD Non-Compliant Days Summary Report
Notice of Intent

cc: AG Redlands, LLC
6300 Wilshire Blvd., Suite 1800
Los Angeles, CA 90048

Kara Read-Spangler, Office of Legal Services
California Department of Public Health
1415 L Street, Suite 500
Sacramento, CA 95814-3964

M Forouzan
Signature of Facility Representative Receiving Letter

06/24/2021
Date Letter Returned With Plan of Correction

Manijeh Forouzan
Complete, Printed Name of Facility Representative Receiving Letter

Note: Sign, date, and return this letter with the Plan of Correction

PRINTED: 06/18/2021
FORM APPROVED

California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA240000020	A. BUILDING: _____ B. WING _____	04/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND CARE CENTER OF REDLANDS	700 EAST HIGHLAND AVENUE REDLANDS, CA 92374

(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) COMPLETE DATE
A 000	Initial Comments The following reflects the findings of the California Department of Public Health during a staffing audit visit for 24 randomly selected days from 10/01/2019 to 12/31/2019. Representing the Department: W.E, Associate Governmental Program Analyst. Welfare and Institutions (W&I) Code section 14126.022 sets forth the Department's authority to conduct audits of direct caregiver nursing services provided to residents of skilled nursing facilities, and to establish procedures for conducting such audits through All Facility Letters (AFLs). <http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14126.022.&lawCode=WIC> AFL 19-16, setting forth the audit process and guidelines for facilities is available through the following link: <https://www.cdph.ca.gov/Programs/CHCQ/LCP/CDPH%20Document%20Library/AFL-19-16.pdf> Health and Safety Code (HSC) 1337-1338.5, sets forth the requirements for Certified Nurse Assistants is available through the following link: <https://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?division=2.&chapter=2.&lawCode=HSC&article=9> W&I section 14126.022 requires the Department to assess an administrative penalty to a SNF if the Department determines that the SNF fails to meet the DHPPD requirements pursuant to HSC sections 1276.5 or 1276.65. The Department shall assess an Administrative penalty to any facility that fails to meet the applicable standard	A 000	**Please accept our plan of correction as our credible allegation of compliance with the regulations identified below. This plan of correction does not denote an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of the deficiency. The plan of correction is prepared and/or executed solely as it is required by the provisions of Federal and State law.**	

Licensing and Certification Division

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE M Forouzan TITLE Administrator (X6) DATE 6/29/2021

California Department of Public Health

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A 000	Continued From page 1 for staffing requirements on any given day. The applicable standard is 3.5 DHPPD and 2.4 DHPPD (CNA), unless an approved Workforce Shortage or Patient Needs Waiver is granted. Final Audit Result: Total Distinct Non-Compliant Day(s) = 10	A 000		
A 200	HSC 1276.65(c)(1)(B) SAS - 3.5 Standard (B) Effective July 1, 2018, skilled nursing facilities, except those skilled nursing facilities that are a distinct part of a general acute care facility or a state-owned hospital or developmental center, shall have a minimum number of direct care services hours of 3.5 per patient day, except as set forth in Section 1276.9. This Statute is not met as evidenced by: Facility failed to meet 3.5 direct care service hours per patient day (DHPPD), pursuant to HSC 1276.65(c)(1)(B) for 2 of 24 days. The statute was not met as evidenced by the following findings: The total number of actual nursing hours performed by direct caregivers per patient day divided by the average census during the patient day failed to meet 3.5 Nursing Hours per Patient Day (NHPPD) per AFL 19-16, Section 1(A). Payroll records were incomplete, illegible or inaccurate [AFL 19-16, section II, A]. Time spent providing nursing services could not be verified. Failure to provide the information has resulted in the exclusion of all service hours for such	A 200	A 200 Facility will ensure to make every attempt to have a minimum number of direct care services hours of 3.5 per patient day. Director of Staff Development and Human Resources Representative conducted an audit of employee's personnel files and no other deficiency was identified. There was no ill effect to any resident from this deficient practice. Administrator will re-educate Payroll Coordinator on keeping complete, legible, and accurate payroll records. She will be re-educated on the importance of accurate records keeping process so time spent providing nursing services could be verified and counted as direct patient care. Administrator will re-educate Director of Staff Development on the facility's established policy and procedure regarding employee's personnel files. She will be re-educated to ensure all personnel files are maintained current, complete, and accurate. Administrator will re-educate Director of Staff Development to exhaust all efforts to replace a nursing staff that did not work as scheduled. She will be re-educated to ensure to schedule enough nursing staff to meet the minimum staffing requirements. Director of Staff Development and Director of Nurses will continue to employ additional nurses to ensure patients receive nursing care based on their needs.	

California Department of Public Health

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A 200	Continued From page 2 employees. Facility failed to maintain current, complete and accurate personnel and payroll records for all employees in accordance with CCR Title 22, section 72533 and per AFL 19-16, section II, A. Time spent providing direct care could not be verified. Failure to provide the information has resulted in the exclusion of all service hours for such employees. Facility failed to replace staff that did not work as scheduled, and/or did not schedule to meet the minimum staffing requirements. Review of the documentation provided for audited day(s) resulted in the following Non-Compliant DHPPD result: DATE 3.5 DHPPD 11/16/2019 1.73 11/17/2019 3.36	A 200	Director of Nurses and/or Administrator will monitor the process through audit process of employee personnel records to ensure they are complete and accurate. Any identified non-compliance with this requirement will immediately be addressed and additional training will be provided if needed. Director of Nurses and/or Administrator will monitor DHPPD staffing requirement of 3.5/2.4 hours per patient day by discussing this daily during the morning meeting. This process will ensure enough staff are scheduled to meet the minimum requirement. DSD and/or DON will make all efforts to find a replacement for any nursing staff that has called off. Any identified non-compliance with this requirement will immediately be addressed and additional training will be provided if needed. DSD Consult/Resource will provide additional monitoring during her visit to the facility by reviewing employees' personnel files and DHPPD records to ensure compliance. Any identified non-compliance with this requirement will be reported to the Director of Nurses and/or Administrator for corrective actions and additional training if needed.	
A 205	HSC 1276.65(c)(1)(C) SAS - 2.4 Standard (C) Skilled nursing facilities shall have a minimum of 2.4 hours per patient day for certified nurse assistants in order to meet the requirements in subparagraph (B). This Statute is not met as evidenced by: Facility failed to meet 2.4 direct care service hours per patient day (DHPPD), performed by certified nurse assistants, pursuant to HSC 1276.65(c)(1)(C) for 10 out of 24 days.	A 205	Director of Nurses and/or Director of Staff Development will report any non-compliance with this requirement to Quality Assurance Committee and all identified concerns and proposed corrective actions shall be documented in the quarterly committee meeting minutes. Completion Date: **07/18/2021** **A 205** Facility will comply with the requirement of having a minimum of 2.4 hours per patient day for Certified Nurse Assistant.	07/18/21

PRINTED: 06/18/2021
FORM APPROVED

California Department of Public Health

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A 205	Continued From page 3 The statute was not met as evidenced by the following findings: The total number of actual nursing hours performed by direct caregivers per patient day divided by the average census during the patient day failed to meet 2.4 Nursing Hours per Patient Day (NHPPD) per AFL 19-16, Section 1(A). Facility failed to replace staff that did not work as scheduled, and/or did not schedule to meet the minimum staffing requirements. Review of the documentation provided for audited day(s) resulted in the following Non-Compliant DHPPD result: DATE 2.4 CNA DHPPD 10/01/2019 2.39 10/04/2019 3.12 10/08/2019 2.38 10/14/2019 2.33 10/19/2019 2.31 10/25/2019 2.26 11/16/2019 0.90 11/17/2019 2.12 11/18/2019 2.28 11/28/2019 2.32	A 205	There was no ill effect to any resident from this deficient practice. Administrator will re-educate Director of Staff Development to exhaust all efforts to replace a nursing staff that did not work as scheduled. She will be re-educated to ensure to schedule enough nursing staff to meet the minimum staffing requirements. Director of Staff Development and Director of Nurses will continue to employ additional nurses to ensure patients receive nursing care based on their needs. Director of Staff Development will be re-educated to anticipate the nursing needs in advance and contact the contracted staffing agency to provide additional nursing staff for any shift in need. Director of Nurses and/or Administrator will monitor DHPPD staffing requirement of 3.5/2.4 hours per patient day by discussing this daily during the morning meeting. This process will ensure enough staff are scheduled to meet the minimum requirement. Any identified non-compliance with this requirement will immediately be addressed and additional training will be provided if needed. Director of Nurses and/or Director of Staff Development will report any non-compliance with this requirement to Quality Assurance Committee and all identified concerns and proposed corrective actions shall be documented in the quarterly committee meeting minutes. Completion Date: **07/18/2021**	07/18/21