page 3

Arcepted SA7-8/13/15

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

PRINTED: 07/30/2015 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			74. 00.251110		C
		555039	B. WING		07/30/2015
NAME OF	PROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY: STATE, ZIP CODE	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
			9	47 THIRD STREET	
FIRESIDE CONVALESCENT HOSPITAL			S	SANTA MONICA, CA 90403	
(X4) ID		TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	
PREFIX TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	RIATE DATE
				Submission of this Plan of Corre	
F 000	INITIAL COMMENT	⁻ S	F 000		ency
!			} ! !	exists or that this statement of	
	The following reflect	ts the findings of the		deficiency was correctly cited an	d is
!		ic Health during a Complaint		also not to be construed as an	
	investigation.	-		admission of interests against the	Е
				facility, the administrator, or any employees, agents, or other indi	vidual
	Complaint number:	CA00449895 - Substantiated.		who may be discussed in this re-	
	There was one defin	ionaviaguad E 444 on a		and plan of correction. In addition	
	result of complaint #	ciency issued F 441 as a		preparation and submission of th	
-	result or complaint #	0, (30,143,000)		of correction does not constitute	an
į	Highest severity and	i scope (S/S)-E.		admission or an agreement of ar	
†	_			by the facility of the truth of any f	
!		limited to the specific		alleged or the correctness of any	
		es not represent the findings		conclusions set forth by the surv	
	of a full inspection of	f the facility.		agency. The submission of the	
!				correction within the time frame sin no way be considered or cons	
1	Representing the De	epartment of Public Health:	1	as agreement with the allegation	
	representing the Be	paramonit or radine reduction.		non-compliance of admissions b	
1	Surveyor ID#: 1404:	2, HFEN, RN		facility. This plan of correction si	
F 441	483.65 INFECTION	CONTROL, PREVENT	F 441	constitute this facilities credible	
SS=E	SPREAD, LINENS		j	allegation of compliance as outling	ned by
			TO THE WHILE	Section 1280 of the California He	ealth
		ablish and maintain an	ì	and Safety Code.	
	Infection Control Program designed to provide a safe, sanitary and comfortable environment and				
				(=) Immodiate Competion	
	to help prevent the development and transmission of disease and infection.		į	(a.) Immediate Correction Resident 1 was discharged	
				against medical advised (AMA) f	
	(a) Infection Control Program			the facility on 7/7/2015 and Resi	
		ablish an Infection Control		was discharged to home on 6/30	
	Program under which			On July 13, 2015, the Direct	
- f	() investigates, cont in the facility;	trols, and prevents infections		Nursing provided an in-service to	
		cedures, such as isolation,		Licensed Nurses regarding MDR	
		an individual resident; and		Deficile infection control care and	
		d of incidents and corrective	į	management with emphasis on	
	actions related to infe		i	residents co-horting requirement	ts.
CODATORY	DIRECTORIS OF POSTARS	P/SLIPBLIER DEPRESENTATIVE'S SIGNA	~	TITLE	(X6) DATE

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.

FORM CMS-2567(02-99) Previous Versions Obsolete

Eveni ID: Q9NB11

Facility ID: CA910000038

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NT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
	555039	B. WING _		1	C 30/2015
			947 THIRD STREET		30/2015
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETION DATE
(b) Preventing Sp (1) When the Infe determines that a prevent the sprea isolate the resider (2) The facility mu communicable disfrom direct contact will (3) The facility mu hands after each chand washing is in professional pract (c) Linens Personnel must ha	read of Infection ction Control Program resident needs isolation to d of infection, the facility must at, st prohibit employees with a rease or infected skin lesions at with residents or their food, if transmit the disease, st require staff to wash their direct resident contact for which adicated by accepted ice.	F 44	can be affected with the Practice: No other residents are the deficient practice. Measures that was put in ensure deficient practice recur: The new Director (DON) on 8/5/15, provided a follow-to Licensed nurses facility policy and page and manager residents with MDI infections with emhorting requirement	Deficient affected by nto place to does not of Nurses 8/6/2015 up in-service regarding procedure on ment of RO/C-deficile phasis on co- nts. Another	
by: Based on observareview, the facility who had symptom: [(C-diff)-a spore for present in the stooranging from diarrhoramping, to life-th colon] would not be resident (9) who will colon to the cleanse the floor in carpeted areas and proper disinfectant spread of infection,	ation, interview, and record failed to ensure the resident (1) is of clostridium difficile raining bacterium which is that can cause symptoms nea, abdominal pain, and reatening inflammation of the ecohorted in the room with the as not diagnosed with the of its symptoms, and failed to the laundry room, hallways if a lobby furniture with the a solution to prevent possible and failed to ensure the		shall review reside comprehensively proom changes to a residents room chappropriate and coresidents are compinfection control res/management. DON and RN supereview residents wo ficondition daily to any trends of symplyinfection to ensure	ents record prior to any ensure that anges are phorting of patible per quirement ervisor shall ith a change of determine ptoms e appropriate	
	PROVIDER OR SUPPLIE E CONVALESCENT SUMMARY S (EACH DEFICIEN REGULATORY OR SUMMARY OR REGULATORY OR SUMMARY OR SUMARY OR SUMMARY OR SUMMARY OR SUMMARY OR SUMMARY OR SUMMARY OR SUMMARY OR SU	PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 (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	PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 Continued From page 1 Continued From page 1 (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 ensure the resident (1) who had symptoms of clostridium difficile [(C-diff)-a spore forming bacterium which is present in the stool that can cause symptoms ranging from diarrhea, abdominal pain, and cramping, to life-threatening inflammation of the colon] would not be cohorted in the room with the resident (9) who was not diagnosed with the C-diff and was free of its symptoms, and failed to cleanse the floor in the laundry room, hallways carpeted areas and a lobby furniture with the a proper disinfectant solution to prevent possible spread of infection, and failed to ensure the	PROWDER OR SUPPLIER E CONVALESCENT HOSPITAL SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR USC IDENTIFYING INFORMATION) Continued From page 1 Continued From page 1 Continued From page 1 (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 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: This REQUIREMENT is not met as evidenced by: This Requirement in the stool that can cause symptoms and gained to ensure the resident; (1) who had symptoms of clostridium difficile (1C-diff)—a spore forming bacterium which is present in the stool that can cause symptoms ranging from diarrhea, abdominal pain, and cramping, to life-threatening inflammation of the colon) would not be cohorted in the room with the resident (9) who was not diagnosed with the resident of picton, and failed to ensure the spread of lifection and lobby furniture with the a proper disinfectant solution to prevent possible spread of lifection, and failed to ensure the spread of lifection and failed to ensure the possible spread of lifection to ensure the spread of lifection and failed to ensure the possible spread of lifection.	PROVIDER OR SUPPLIER 555039 **ROWDER OR SUPPLIER **CONVALESCENT HOSPITAL SUMMARY STATEMENT OF DEFICIENCIES (ACHO DEFOCIENCING MATERIAL PROVIDERS PLAN OF DORRECT ON PROVIDER PLAN OF DORRECT ON PROVIDE PLAN OF DORRECT ON PROVIDER PLAN OF DORRECT ON PROVIDE PLAN OF DORRECT ON PROVIDED PROVIDE PLAN OF DORRECT ON PROVIDED PROVIDED PROVIDED PROVIDED PROVIDE PROVIDED

facility policy and procedure on Infection Control

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION		E SURVEY
	555039					C 30/2015
NAME OF	PROVIDER OR SUPPLIER		'	STREET AODRESS, CITY, STATE,		30/2013
			- 1	947 THIRD STREET		
FIRESID	E CONVALESCENT H	IOSPITAL		SANTA MONICA, CA 90403		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE CY)	(XS) COMPLETION DATE
				residents if ne	cessary.	
F 441	preparation of blea Center for Disease (CDC).	ige 2 Irate information on the characteristics with control and Prevention in accordance with Control and Prevention ice had the potential to spread	F4	DSD shall mai going line listi residents adm MDRO/C-deficincluding a list	ng log of itted with tile infections	<u>.</u>
	the infection throughout the facility and placed the residents in the facility at risk of contracting C-diff infection. Findings: On July 10, 2015, at 1 p.m., unannounced visit was made to the facility to investigate a complaint allegation the facility had an outbreak of C-diff. During an interview the director of nursing (DON) presented a line list of the residents who developed diarrhea as one of the major symptoms of gastrointestinal illness (C-diff), According to the list Resident 1, 2, 3, 4, 5, 6, 7, and 8, were having diarrhea. According to the presented documents tree out of eight listed residents were diagnosed positive for C-diff. The DON stated residents Resident 2, 4 and 5 were			who develop M infection in the appropriate co	IDRO/C-Deficile facility to ensure -horting and	
				the facility if no DON/DSD sha going in-service nurses on a quas needed reg	all provide an on- te to Licensed parterly basis and arding care and of residents with sile infection to ance.	
	tested positive for C-diff infection. Based on information from a line list and interview with the DON the facility had a potential to have an outbreak of communicable illness of C-diff. a. According to the admission record Resident 1 was admitted to the facility on June 18, 2015, with diagnoses which included infection of right lower extremity.			condition, residuring facility of compliance wirequirements. issues shall be to the DON for follow-up and its conditions.	dents on isolation visit to ensure the co-horting Any identified communicated immediate resolution.	
	The Minimum Data assessment and cal 25, 2015, indicated in	Set (MDS) - a standardized re screening tool, dated June Resident 1 was alert and ktensive assistance from staff		Monitoring Put in Pla Compliance is sustai Director of Nu ensure that above production and any trends identified	ned: Irses shall cess is on-going	

	T OF DEFICIENCIES OF CORRECTION	(OFNITIFICATION NUMBER)		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		555039	B. WING		0.	C 7/30/2015		
NAME OF	PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		73072013	
FIRESIDE CONVALESCENT HOSPITAL				THIRD STREET NTA MONICA, CA 90403				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETION DATE	
F 441	hygiene, but neede showering. The resicontrol) of bowel are A review of the licer 29, 2015, at 3:06 p. monitored for chills, lower abdominal are There was a physica 2015, for Flagyl (an orally three time a castool sample for of C-diff. According to the lab 29, 2015, Resident infection. A review of the licer 29, 2015, at 11:18 p continued to have to dated June 29, 2015 from his room to Re A review of Resident indicated the resident other signs and symba could an infection.	d total assistance for Ident was continent (had adder functions. Insed nurses notes dated June m., indicated Resident 1 was shivering and pain in the ea. Ident was continent (had added functions. Insed nurses notes dated June m., indicated Resident 1 was shivering and pain in the ea. Ident dated June 29, tibiotic) 500 milligram (mg) lay for 14 days, and to collect liagnostic test to rule out Ident of the for C-diff function for the earth of the earth	F 4	41 C C P	reported to the QA and A conserview and further plan of act Date of Compliance: 8/7/20 (b.) Immediate Correction The use of Sanisol for disinfecting was immereplaced with bleach solution as per the EF approved label guidel C. Diff spores. The housekeeping staff was serviced on 7/10/2015 regarding the updated requirements. Further and disinfecting will on recommendations by EPA approved manufaguidelines, and specifinstruction from the LA Health Department Nutlentification of Other Residan be affected with the Definance: No other residents we affected by the deficie practice. Iterative deficient practice documents of the practice deficient practice documents.	ediately pased pas		
* and the law is the l	while he was exhibit stools indicating he	ed to Resident 9's room ng abdominal pain and loose was still contagious. The ent 1 and Resident 9 together		The state of the s	 The Administrator, DS Housekeeping Superv conducted in-service or 	sor		

PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETED.)			,				CIVID AC	7, 0300- 033
NAME OF PROVIDER OR SUPPLIER FIRESIDE CONVALESCENT HOSPITAL SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCIES SANTA MONICA, CA 90403 (K41)D SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) FIRESIDE CONVALESCENT HOSPITAL SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY CASH DOUGLES PREFIX TAG) (EACH DEFICIENCY OR LSC IDENTIFYING INFORMATION) FREINT TAG T/14/2015 with housekeeping staff to review cleaning/disinfecting procedures of resident rooms high contact areas and the laundry room as per the EPA approved manufacturer's label. CDC and LA County Health Department Nurse. On June 30, 2015, there was a physician order to place Resident 1 on contact isolation for C-cliff, to discontinue Flagyl 500 mg and to start Vancomicyn 250 mg one tablet four times a day for 17 days for C-cliff infection. A review of the County of Los Angeles Department of Public Health Acute Communicable Disease Control Program (Guidelines for prevention and control of multi-drug resistant organisms and clostridium difficile in nursing care facilities) dated May 26, 2009, indicated the resident who was tested positive for C-diff should be place in an								
FIRESIDE CONVALESCENT HOSPITAL XX1 ID SUMMARY STATEMENT OF DEFICIENCIES TAG SUMMARY STATEMENT OF DEFICIENCIES TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PROVIDER'S PLAN OF CORRECTION CEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY DATE OF THE APPROPRIATE DEFICIENCY TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY DATE OF THE APPROPRIATE COMMENT DATE OF THE APPROPRIATE DEFICIENCY DATE OF THE APPROPRIATE COMMENT DATE OF THE APPROPRIATE DEFICIENCY DATE OF THE APPROP			555039	B. WING				
FREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 441 Continued From page 4 even though Resident 9 was never diagnosed with C-diff infection. On July 10, 2015, at 11 a.m., the DON confirmed the facility did not document the clinical rational to cohort both residents together. The DON stated Resident 1 requested to be moved to another room because of personal issues with his previous roommate. On June 30, 2015, there was a physician order to place Resident 1 on contact isolation for C-diff, to discontinue Flagyl 500 mg and to start Vancomicyn 250 mg one tablet four times a day for 17 days for C-diff infection. A review of the County of Los Angeles Department of Public Health Acute Communicable Disease Control Program (Guidelines for prevention and control of multi-drug resistant organisms and clostridium difficile in nursing care facilities) dated May 26, 2009, indicated the resident who was tested positive for C-diff should be place in an			IOSPITAL	<u> </u>	947 T	HIRD STREET		100/2010
F 441 Continued From page 4 even though Resident 9 was never diagnosed with C-diff infection. On July 10, 2015, at 11 a.m., the DON confirmed the facility did not document the clinical rational to cohort both residents together. The DON stated Resident 1 requested to be moved to another room because of personal issues with his previous roommate. On June 30, 2015, there was a physician order to place Resident 1 on contact isolation for C-diff, to discontinue Flagyl 500 mg and to start Vancomicyn 250 mg one tablet four times a day for 17 days for C-diff infection. A review of the County of Los Angeles Department of Public Health Acute Communicable Disease Control Program (Guidelines for prevention and control of multi-drug resistant organisms and clostridium difficile in nursing care facilities) dated May 26, 2009, indicated the resident who was tested positive for C-diff should be place in an	PREFIX	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREF	ıx	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	OULD BE	(X5) COMPLETION DATE
room is not available, the resident could be cohort with another resident who has a C-diff infection. During an interview with the DON on July 10, 2015, at 11 a.m., confirmed Resident 1 should not infection free. The DON also confirmed by cohorting infected Resident 1 with non-infected Resident 9 placed Resident 9 at risk to develop a C-diff infection. The facility Infection Control Committee will track and trend nosocomial C. Diff infection rates. The data will be reviewed, analyzed and further action plans developed by the Infection Control Committee. Rates to be reported to the facility QAA Committee. B. On July 10, 2015, at 1:20 p.m., during		even though Reside with C-diff infection. On July 10, 2015, a the facility did not do cohort both resident. Resident 1 requester room because of perevious roommate. On June 30, 2015, in place Resident 1 or discontinue Flagyl 5. Vancomicyn 250 mg for 17 days for C-diff A review of the Counderstand Communicable Dise (Guidelines for previous for C-diff shisolation/private room is not available with another resident During an interview 2015, at 11 a.m., conave been cohort with infection free. The Discohorting infected Resident 9 placed Resident 9 p	ent 9 was never diagnosed It 11 a.m., the DON confirmed occument the clinical rational to test together. The DON stated and to be moved to another ersonal issues with his there was a physician order to a contact isolation for C-diff, to 60 mg and to start gone tablet four times a day if infection. Into of Los Angeles ic Health Acute ease Control Program ention and control of organisms and clostridium are facilities) dated May 26, resident who was tested ould be place in an m. When an isolation/private e., the resident could be cohort to who has a C-diff infection. With the DON on July 10, infirmed Resident 1 should not the Resident 9 who was C-diff ON also confirmed by esident 1 with non-infected esident 9 at risk to develop a	F	Mc	staff to review cleaning/disinfecting procedures of residen high contact areas an laundry room as per ti approved manufactur CDC and LA County is Department Nurse. The Policy and Proce were updated to reflet recommendations of the EPA approved bleach manufacturer, and LA Health Department Ni policy to be approved Medical Director, the Control Committee an QAA Committee. In facility Infection Committee will track a nosocomial C. Diff inforates. The data will be reviewed, analyzed an action plans develope Infection Control Com Rates to be reported to facility QAA Committee Housekeeping staff co	nt rooms, and the he EPA rer's label. Health dures of the the CDC, and County was. The label infection and the control and trend ection end further and by the inmittee, to the ee. compliance	

NAME OF PROVIDER OR SUPPLIER FIRESIDE CONVALESCENT HOSPITAL STREET ADDRESS. CITY. STATE, ZIP CODE 947 THIRD STREET SANTA MONICA, CA 90403 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 441 Continued From page 5 observation of facility environment, accompanied by the maintenance/laundry supervisor and the administrator, both confirmed the use of regular commercial cleaning solution Neutral Sanisol to mop the laundry floor and to clean front lobby furniture (high touched surfaces). A review of Neutral Sanisol bottle manufactured's and other action plans will be	AND PLAN OF CORRECTION IDENTIFICATION NUMBER		1	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER FIRESIDE CONVALESCENT HOSPITAL SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 441 Continued From page 5 observation of facility environment, accompanied by the maintenance/laundry supervisor and the administrator, both confirmed the use of regular commercial cleaning solution Neutral Sanisol to mop the laundry floor and to clean front lobby furniture (high touched surfaces). A review of Neutral Sanisol bottle manufacturer's STREET ADDRESS. CITY, STATE, ZIP CODE 947 THIRD STREET SANTA MONICA, CA 90403 PROVIDER'S PLAN OF CORRECTION (XS) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) monitored by the Maintenance supervisor, DSD, and Administrator. Results to be reported to the facility QAA for a minimum of 3 months or until compliance threshold is achieved. Routine in-services and other action plans will be						С	
FIRESIDE CONVALESCENT HOSPITAL SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 441 Continued From page 5 observation of facility environment, accompanied by the maintenance/laundry supervisor and the administrator, both confirmed the use of regular commercial cleaning solution Neutral Sanisol to mop the laundry floor and to clean front lobby furniture (high touched surfaces). A review of Neutral Sanisol bottle mapufacturer's SANTA MONICA, CA 90403 (x5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLET CACHON SHOULD BE COMPLET SANISOL THE APPROPRIATE DEFICIENCY) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE ACTION SHOULD BE COMPLETE ACTION SHOULD BE COMPLETE CACHON SHOULD BE COMPLETE CACHON SHOULD BE COMPLETE ACTION SHOULD			555039	B. WING		07/30/2015	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 441 Continued From page 5 observation of facility environment, accompanied by the maintenance/laundry supervisor and the administrator, both confirmed the use of regular commercial cleaning solution Neutral Sanisol to mop the laundry floor and to clean front lobby furniture (high touched surfaces). A review of Neutral Sanisol bottle manufacturer's PREFIX TAG PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) monitored by the Maintenance supervisor, DSD, and Administrator. Results to be reported to the facility QAA for a minimum of 3 months or until compliance threshold is achieved. Routine in-services and other action plans will be					947 THIRD STREET		
F 441 Continued From page 5 observation of facility environment, accompanied by the maintenance/laundry supervisor and the administrator, both confirmed the use of regular commercial cleaning solution Neutral Sanisol to mop the laundry floor and to clean front lobby furniture (high touched surfaces). A review of Neutral Sanisol bottle manufacturer's	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE COMPLETION	
label indicated the solution would not kill C-diff spores (a protective covering adopted by a bacterial cell for survive in adverse conditions for extended period of time). The maintenance/laundry supervisor stated he cleaned the carpeted area by using hot water from the palio mixed with Carpet Cleaner cleaning solution. A review of the Carpet Cleaner bottle manufacturer's label indicated it would not kill C-diff spores. The C-diff. spores can survive on the surfaces for several months and are present in the stool which can be spread from person to person through a contaminated (infected) environment while at the facility (CDC guidelines, 2010). A review of an undated facility's policy and procedure titled "Infection Control", indicated due to spore-forming nature of Clostridium difficile and its ability to survive on dry environment surfaces for many months, the disinfectant solution recommended for cleaning the environment is a bleach solution with dilution of 1.8 (one part of bleach to eight parts of water).	obsiby to admic continuous furmant in the clear from clear from clear from clear facility. A respond to spand surfacility and surfacility and surfacility and surfacility and surfacility.	servation of facility the maintenance ministrator, both in mercial cleaning p the laundry floor inture (high touch eview of Neutral el indicated the stores (a protective exterial cell to survended period of the maintenance/late and the carpeten the pation mixed and the carpeten the pation. Eview of the Carpeten the pation is labely iff spores. EC-dif. spores caleral months and be spread from taminated (infect lity (CDC guideling) wiew of an undate can be spore-forming national its ability to survente for many matter the part of blead one part of blead one part of blead in the part of blead one part of blead in the part of blead one part of blead in the pore-forming nation recommend is a blead one part of blead one part of blead in the part of blead one part of blead in the part of blead one part of blead in the part of blead one part of blead in the part of blead one part of blead in the part of b	ty environment, accompanied //laundry supervisor and the confirmed the use of regular g solution Neutral Sanisol to or and to clean front lobby ned surfaces). Sanisol bottle manufacturer's colution would not kill C-difficovering adopted by a rive in adverse conditions for time). undry supervisor stated he d area by using hot water d with Carpet Cleaner set Cleaner bottle I indicated it would not kill an survive on the surfaces for are present in the stool which person to person through a rived) environment while at the nes, 2010). sed facility's policy and section Control", indicated due rure of Clostridium difficile rive on dry environment onths, the disinfectant ed for cleaning the ach solution with dilution of the to eight parts of water).	F 441	supervisor, DSD, and Administrator. Results to reported to the facility QA a minimum of 3 months o compliance threshold is achieved. Routine in-serv and other action plans will developed to ensure compliance. Administrator and DSD will conduct random observat housekeeping staff cleani procedures on isolation rowant issues identified shall address promptly with the and further in-services shaprovided if needed.	be A for r until ices I be ill ion of ng poms. I be staff	

1	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	i	555039	B. WING_		į .	30/ 2015	
NAME OF PROVIDER OR SUPPLIER FIRESIDE CONVALESCENT HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 947 THIRD STREET SANTA MONICA, CA 90403				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 441	duties at the facility confirmed that a cui policy did not reflect bleach solution. DON confirmed the policy was not in accordang to the CD solution recommend disinfecting the envi part of bleach to 9 p	inted DON who started his on July 30, 2015, he rent facility's Infection Control acceptable preparation of current Infection Control cordance with CDC guidelines each solution to disinfect ces to kill C-diff spores. OC guidelines the bleach ded for cleaning and ronment should be 1:10 (one	F 44				