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

PRINTED: 12/04/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555065	A. BUILDING _____ B. WING _____	11/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAREMONT MANOR CARE CENTER	621 BONITA AVE CLAREMONT, CA 91711

(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 California Department of Public Health during a Recertification survey. Representing the Department of Public Health: Surveyor ID: 31331 Surveyor ID: 31335 Surveyor ID: 07598 Total Resident Census: 51 Total Resident Sample: 13 Highest Scope/Severity: E	F 000		
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to resolve issues brought up by residents in a timely manner. During the group interview 4 of 8 residents complained of call lights not being answered promptly. This concern was brought up during the previous resident council meeting held on November 2012, but was not resolved. This deficient practice was also noted during the prior re-certification survey. This has a potential to result in the residents needs not being met. Findings:	F 166	483.10(f)(2) Corrective Action for Affected Residents: All call lights were checked to make sure they were in good working order. The telephone call light answering machines were changed to insure that staff answer call lights in person and not allow the call lights to be answered or turned off at the station. Identifying Other Potential Residents: Department managers and administrative staff have been assigned a section	12/17/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	ADMIN.	12/14/12

* 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.

of rooms to monitor and interview residents daily for call light respnse times. A log will be kept of resident responses.

Systemic Change to Prevent Recurrence:

Staff have been inserviced on the need to answer call lights timely. In addition, bids have been received for a new call light system after a previous company was unable to complete the job. OSHPD approval for the new system will be obtained.

Monitoring and Evaluation of Plan:

Administrative staff or their designee will meet with the resident council each month to discuss the call light response times and results of the daily logs that have been kept. Findings will be reviewed by the QA Committee for further analysis and recommendations. monthly.

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F 166	Continued From page 1 On 9/17/12, a review of the Resident Council Meeting minutes for the month of November 2012 and on the prior re-certification survey dated 8/17/11 indicated that the residents brought up the concern regarding the call lights not being answered promptly.	F 166		
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. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure staff speaks a language that residents can understand while providing care for 3 out of 8 residents in the group interview, which bothered them because they said they don't know if they staff were talking about them and it made them feel very uncomfortable. Finding: During a group interview on 11/17/12 at 10:30 a.m., 3 out of 8 residents who attended the meeting stated that some of the staff speaks in different languages other than English. The residents stated that when two staff are in the room providing care it really brothers them when the staff speak another language. The residents stated that they are never sure if the residents were talking or making fun of them. One resident stated that she has told some of the staff to stop but they persisted. The resident further stated that they noticed a slight drop off of this practice	F 241	483.15(a) Corrective Action for Affected Residents: The issue of resident dignity and respect has been inserviced with staff members along with giving each staff member a copy of the Work Place Language policy. Identifying Other Potential Residents: All residents in the community are potentially affected. Systemic Change to Prevent Recurrence: The issue of resident dignity and respect has been inserviced with staff members along with giving each staff member a copy of the Work Place Language policy. Charge nurses and managers have also	12/17/12

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F 241	Continued From page 2 since the last survey but the practice still continues every day. A review of the facility ' s policy titled " Work Place Language Policy " updated July 2010, indicated it is understood that the residents can become confused and disturbed when they cannot understand what is happening around them. The policy further indicated that only English language is to be used in Care Center, residents ' rooms/apartments, sitting rooms and common rooms used by the residents and all other residents ' areas and hallways. During an interview with the DON on 11/17/12 at 2:00 p.m. she stated that the staff are not supposed to speak any language that the residents would not be able to understand, especially while providing care to the residents. The DON further stated that all employees had received information regarding this policy when hired and in further in-services throughout the year.	F 241	been inserviced to observe for other languages spoken during direct care if they are not the same language as the resident. Monitoring and Evaluation of Plan: Charge nurses and dept. managers will be responsible to observe that staff members are speaking an appropriate language in resident care areas. Staff members noted to be out of compliance will be corrected immeidately and have their supervisor notified. Management staff will meet with the resident council (see next page)	
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced	F 328	483.25(k) Corrective Action for Affected Residents: Resident #7 had their orders reviewed and their concentrator checked to insure that the oxygen was infusing at the correct rate. Resident #8 had their orders reviewed and their concentrator checked to insure that oxygen was infusing at the	12/17/12

each month to discuss issues with speaking languages not understood by the resident during resident care. Findings will be presented to the QA Committee for further action as needed by the committee.

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F 328	Continued From page 3 by: Based on observations, interviews, and record review, the facility failed to ensure that two of 13 sample residents who were receiving oxygen therapy received proper treatment and care for the use of oxygen for Resident 7 and 8. Resident 7 was observed receiving oxygen at 3 liters/minute (L/min) however, the Physician order was to administer oxygen at 2 L/min. Resident 8 was observed receiving oxygen therapy at 3.5 L/min however, the physician order was for the resident to receive oxygen at 3 L/min. This condition may place the residents' breathing centers at risk for oxygen dependency and decrease their drive to breathe without mechanical assistance. Findings: a. During an initial observation tour, on November 15, 2012, at 7:20 p.m., accompanied by the director of nursing (DON), Resident 7 was observed on 3 L/min of oxygen via a nasal cannula. A review of the admission face-sheet for Resident 7 indicated the resident was originally admitted to the facility on May 10, 2007, and re-admitted on January 21, 2011, with diagnoses that included diabetes mellitus (high sugar in the blood), muscle weakness, cellulitis (skin infection). The Minimum Data Sets (MDS), a standardized assessment and care screening tool, dated September 14, 2012, indicated that the resident could understand and was able to understand others. Further review of the resident's medical records indicated a physician's order on February 27,	F 328	Identifying Other Potential Residents: Residents charts were reviewed to assure all residents with oxygen orders were receiving oxygen at the correct rate. Charge nurses will monitor oxygen use every shift and document on the MAR that the oxygen is infusing at the ordered rate. Residents were educated on proper oxygen treatment and care. Systemic Change to Prevent Recurrence: Staff have been inserviced to monitor resident's oxygen treatment and care. A sticker with the ordered oxygen treatment rate will be placed on each resident's concentrator to insure the proper oxygen treatment. Residents receiving oxygen have education on the need for proper oxygen rates and to identify nursing if they feel their oxygen rate needs to be changed. Monitoring and Evlauation of Plan:	

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F 328	Continued From page 4 2012, to administer oxygen at two liters a minute through the nasal cannula as needed for shortness of breath. The respiratory care plan, dated May 15, 2008, indicated that the oxygen should be administered as ordered. b. During an initial observation tour, on November 15, 2012, at 8:10 p.m., accompanied by the director of nursing (DON), Resident 8 was observed on 3.5 L/min of oxygen via a nasal cannula. A review of the admission face-sheet for Resident 8 indicated the resident was originally admitted to the facility on December 7, 2010, and re-admitted on January 24, 2012, with diagnoses that included diabetes mellitus (high sugar in the blood), pneumonia (lung infection), and chronic airway obstruction. The Minimum Data Sets (MDS), a standardized assessment and care-screening tool, dated September 14, 2012, indicated that the resident could understand and was able to understand others. Further review of the resident's medical records indicated a physician's order dated February 24, 2012, revealed to administer oxygen at three liters a minute through the nasal cannula continuously for shortness of breath. Both the cardiovascular and respiratory care plan, dated January 25 and 24, 2012, respectively, indicated to administer oxygen as ordered above. A review of the facility's policy and procedure titled "Oxygen Therapy" dated August 2009,	F 328	Charge nurses are responsible to monitor and insure that residents are receiving the proper oxygen treatment and care. The DON and DSD will do random monthly audits of oxygen administration rates to monitor for compliance. Negative findings will be discussed at the monthly QA meeting with further action as deemed necessary by the committee.	

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F 328	Continued From page 5 indicated oxygen therapy should be administered by a licensed nurse as ordered by the physician.	F 328		
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 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 ensure that one of 13 sampled residents (Resident 5) on antidepressant therapy had an adequate indication for the use of the regimen. This placed the resident at risk for the possible	F 329	483.25(1) Corrective Action for Affected Resident: Pharmacy recommendation note to physician was re-faxed to MD's office requesting documentation of indication for need for multpile antidepressant medications. Identifying Other Potential Residents: Charts were reviewed for residents with multiple antidepressant medications to insure that documentation was present justifying medical need. Systemic Change to Prevent Recurrence: An inservice by the Pharmacist was scheduled for the licensed staff on the need to avoid duplicate unnecessary medication. Monitoring and Evaluation of Plan:	12/17/12

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F 329	Continued From page 6 side effects of the psychoactive medications. Findings: A Consultant Pharmacist ' s Medication Regimen Review document, dated September 18, 2012, indicated that the resident was currently on Paxil (medication used to treat depression) 20 milligrams (mg) once a day and Wellbutrin (medication used to treat depression) 150 mg once a day. Furthermore, it indicated that the used of two or more antidepressants simultaneously required documentation of the expected benefits because the use of duplicate therapy may increase the risk of side effects. The form did not specify if the medication was to be continued, adjusted, or some type of other action. During an interview with the director of nursing (DON), on November 16, 2012, at 8:50 p.m., she stated that there was no documentation in the resident ' s clinical record to indicate the need to continue with the current regimen. A review of the admission face-sheet for Resident 5 indicated that the resident was originally admitted to the facility on April 2, 2012, and re-admitted on May 15, 2012, with diagnoses that included vascular dementia (subtly progressive worsening of memory and other cognitive functions due to chronic, reduced blood flow in the brain), trauma bone fracture, and hypertension (high blood pressure). The Minimum Data Sets (MDS), a standardized assessment and care-screening tool, dated November 14, 2012, indicated that the resident understood and was able to understands others. A review of the facility's policy and procedure titled "Psychotherapeutic Medication Use" dated	F 329	Charge nurses will be responsible to ensure that residents' drug regimen must be free from unnecessary drugs and to contact the physician if documentation is needed to clarify the jsutification for duplicate therapy. Each resident's medications will be reviewed monthly by the pharmacist and quarterly by the ID Team to insure that the physician documents justification for duplicate therapy. The DON will monitor the pharmacy recommendations monthly to insure that appropriate responses are received back from the physicians. Findings will be discussed at the monthly QA meeting with further action as deemed necessary by the committee.	

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F 329	Continued From page 7 June, 2011, indicated the need for the medication should be care planned.	F 329		
F 368 SS=E	483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure that 4 of 8 anonymous residents who attended a quality of life (QOL) group meeting were offered a bedtime snack. This deficient practice had the potential for the residents to be hungry during the night. Findings: During the residents ' QOL group interview conducted, on November 17, 2012, at 10:30 a.m., with the eight residents, four alert and oriented	F 368	483.35(f) Corrective Action for Affected Residents and Identifying Other Potential Residents: Staff have been inserviced on the importance to insure that all residents are offerred a bedtime snack each evening. Systemic Change to Prevent Recurrence: Staff have been inserviced on the importance of giving bedtime snacks and how to document for each resident whether they received the snack, refused the snack or were sleeping. Management staff or their designee will meet with the resident council each month to discuss whether or not the residents have been receiving their evening snacks. Monitoring and Evaluation of Plan:	12/17/12

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F 368	Continued From page 8 residents stated that they are not offered bedtime snacks and they were occasionally hungry at night. The residents did not suffer any weight loss. A review of the clinical record, on November 17, 2012, titled "ADL Scoring Data- Evening Shift" dated November 2012, indicated that four of the residents in group did not receive a bedtime snack from November 1 through 16, 2012.	F 368	The charge nurses and CNA's are responsible to insure that residents are given bedtime snacks daily. Medical Records Coordinator will complete weekly audits to insure that bedtime snacks are documented daily on the ADL flowsheets. Negative findings will be reported to the staff and DSD for further action as needed. Audits results will be discussed at the monthly QA meeting with further action as deemed necessary by the committee.	
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 and interview, the dietary staff failed to ensure that the coffee beverage dispenser drain pipe in the main kitchen had an air gap between the water supply inlet and the flood level rim of the plumbing fixture, that was at least twice the diameter of the water supply inlet and not less than 1 inch. Findings: During the initial kitchen tour on November 15, 2012, at 7:00 p.m., a drain pipe in the kitchen was observed extending from the coffee beverage dispenser into a floor-sink. The end of the pipe	F 371	483.35(i) 12/17/12 Corrective Action for Affected Resident and Identifying Other Potential Residents: The drain pipe identified in the Plan of Correction has been shortened so that it no longer extends beyond the rim of the floor sink. Systemic Change to Prevent Recurrence: The Director of Environ-	

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F 371	Continued From page 9 went past the rim and reached the bottom of the floor-sink thereby leaving no air gap between the pipe and the floor-sink. An interview with the dietary aide revealed that it was an over-sight on their part as he was aware of the necessity of an air gap or the potential for back siphonage or back-pressure. During an interview with the facility dietician the following evening on November 16, 2012, she stated the drain pipe for the coffee dispenser had been cut off so that it did not extend beyond the rim of the floor sink anymore.	F 371	mental Services and/or the Director of Dining Services will both monitor for compliance on a routine basis at least quarterly that the proper air gap is maintained for all drain pipes. Monitoring and Evaluation of Plan: The Director of Environmental Services will review the findings of the routine rounds and provide the information to the QA Committee at least quarterly. The QA Committee will make recommendations as needed.	

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A 000	Initial Comments The following reflects the findings of the California Department of Public Health during a Recertification survey. Representing the Department of Public Health: Surveyor ID: 31331 Surveyor ID: 31335 Surveyor ID: 07598 Total Resident Census: 51 Total Resident Sample: 13	A 000		
A 147	T22 DIV5 CH3 ART3-72303(b)(6) Physician Services--General Requirements (b) Physician services shall include but are not limited to: (6) Health record progress notes and other appropriate entries in the patient's health records. This Statute is not met as evidenced by: Rosa, Please review, revise and re-submit. Based on interviews and records review, the facility failed to ensure 1 of 1 patient (Patient 8) was seen by a physician every 30 days. Patient 1 stated during a Quality of Life Assessment Resident Interview that she had not seen her physician for almost a year. This failure had the potential to have an adverse effect on the patient's care and treatment. Findings:	A 147	T22 Div5 CH3 Art3-72303(b)(6) Corrective Action for Affected Resident: The physician for Resident #8 was notified to visit his resident every 30 days. Identifying other Potential Residents: The Medical Records Coordinator will audit all charts each month to ensure that physician visits are tinely. Systemic Change to Prevent Recurrence: Medical Records staff has received an inservice on the need for physican	12/17/12

Licensing and Certification Division

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE ADMIN. — (X6) DATE 12/14/12

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAREMONT MANOR CARE CENTER	621 BONITA AVE CLAREMONT, CA 91711

(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 147	Continued From page 1 On November 17, 2012, a review of Patient 8 ' s admission Face Sheet indicated that the patient was admitted to the facility on January 24, 2012. The patient ' s diagnoses included diabetes mellitus (high sugar in the blood), pneumonia (lung infection), and chronic airway obstruction. The Minimum Data Sets (MDS), a standardized assessment and care-screening tool, dated September 14, 2012, indicated that the resident could understand and was able to understand others. A further review of Patient 8's medical record indicated that there were no physician's visit for the month of September. The last physician visit was dated July 31, 2012 and the subsequent visit was dated October 31, 2012. ßE Please indicate the date of the initial and last resident's physician's visit (if any) On November 17, 2012, at 9:50 a.m., during an interview and a review of the resident ' s record, the MDS director stated there was no physician ' s visit for September and stated there was no other place it could be found. A review of the facility ' s policy, dated April 5, 2006, titled, " Health Information/ Record Manual, " indicated the physician visit at least every 30 days.	A 147	visits monthly. When a physician has not completed his visit timely, the Medical Records Coordniator will notify the physician's office to see the resident within 48 hours. If the physician has not responded the Director of Nursing will be notified to make a follow up call to require a visit. If there continues to not be a response by the physician, the Administrator will follow-up to insure that the resident is seen by the physician. Monitoring and Evaluation of Plan: The Medical Record Coordinator will notify the DON and Administrator if a physician is out of compliance with monthly visits. Findings will be discussed at the monthly Quality Assurance meeting with further action as deemed necesary by the Medical Director and QA Committee.	