STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555340	A. BUILDING _____ B. WING _____	01/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARINA POINTE HEALTHCARE & SUBACUTE	5240 SEPULVEDA BLVD CULVER CITY, CA 90230

(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 Recertification Survey. Representing the Department of Public Health: Surveyor ID: 11912, RN, HFEN Surveyor ID: 36394, RN, HFEN Surveyor ID: 36385, RN, HFEN Total Population: 87 Sampled Size: 18	F 000	The following Plan of Correction is submitted by the facility in accordance with the pertinent terms and provisions of 42 CFR Section 488 and/or related state regulations, and is intended to serve as a credible allegation of our intent to correct the practices identified as deficient. The Plan of Correction should not be construed or interpreted as an admission that the deficiencies alleged did, in fact, exist; rather, the facility is filing this document in order to comply with its obligations as a provider participating in the Medicare/Medicaid program(s).	
F 561 SS=D	Highest Severity and Scope: E Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in	F 561	*F561- Self-Determination* *Corrective action(s) for resident(s) found to have been affected by the deficient practice;* Resident 8 was immediately provided with Talking book and radio for music. On 1/18/2019, resident 8's comprehensive care plan was reviewed to offer group activities during the days of the week. The responsible party will be given the opportunity to choose the group activity according to resident 8's activity preferences.	2/22/2019

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	2/14/19

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 561	Continued From page 1 community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure one of 18 sampled residents (8) was involved in group activities according to the resident's preferences. This deficient practice had the potential for Resident 8 to feel isolated and activities needs not being met. Findings: During a tour of the facility on 1/15/19 at 10:46 a.m., Resident 8 was observed in her room with her eyes closed, lying on her bed. A television screen was observed on the wall and was turned off. The resident was observed to be in her room and lying on her bed on 1/15/19 at 1:30 p.m., on 1/16/19 at 10:01 a.m., and on 1/18/19 at 11:00 a.m. without music or television turned on in the resident's room. During an interview on 1/15/19 at 1:39 p.m., Resident 8's family member stated the resident was not observed to be brought to attend group activities during the days and times he had visited the resident. A review of Resident 8's admission record indicated the resident was admitted to the facility on 5/10/12 with diagnoses that included	F 561	*How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken;* Activity Director reviewed the current residents and no other residents are affected. ***What measures and/or systemic changes will be made to ensure that the deficient practice does not recur?*** Activity Department staff were re-educated on initiating resident activity preferences and plan of care upon admission. The Activities Director/or designee will address any refusal of room visits/group participation in the plan of care. The Interdisciplinary team will address any refusals of activity and update plan of care. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place;*** The Activities Director will monitor and ensure the Room Visit/Independent form is completed daily by the Department. Any refusal for visit/group activities will be reviewed by the Activities Director. Other activity options will be provided to include resident choices from the activity assessment.	

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F 561	Continued From page 2 Alzheimer's disease (a brain disease that causes a slow decline in memory, thinking and reasoning skills), blindness in both eyes and anemia (occurs from the loss of red blood cells). A review of the comprehensive Minimum Data Set (MDS - standardized assessment and care-planning tool) dated 6/19/18 indicated Resident 8's activity preferences included keeping up with news, doing things with groups of people, participating in favorite activities and spending time outdoors. A review of the quarterly MDS assessment dated 12/19/18, indicated Resident 8 was severely impaired with cognitive function (ability to think, understand and make daily decisions). During a telephone interview with the Activities Director (AD) on 1/18/19 at 2:13 p.m., the AD stated group activities were held in the back dining room and included group exercises, games, reading books and for those who could not participate, there were sensory activities provided. The AD stated all residents were able to participate in group activities. The AD stated when a resident had visitors in the room, the staff will not interrupt the visit but provide activities later in the day. A concurrent review of the Group Activities Attendance Record for 11/2018, 12/2018, and 1/2019 indicated the following: a. For 11/2018, it was marked daily with "V" indicating there was a visitor in the room with the resident. On 11/11/18 and 11/25/18, indicated "RP" (religious program) was provided. There was no Room Visit/Independent Program form completed.	F 561	The Activities Director/Medical Records Department will monitor that documentation of a plan of care is initiated and/or updated and the Room Visit/Independent form is completed daily. The results of these audits will be shared at the Monthly Quality Assurance Committee Meeting for further recommendations.	2/22/2019

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F 561	Continued From page 3 b. For 12/2018, it was marked daily with "V" except on 12/4, 12/5, 12/6, and 12/7/18, where Room Visit/Independent Program form indicated staff provided room visits. On 12/9/18 indicated "SE" (special event). c. For 1/2019 from 1/1 to 1/13/19, it was marked "V." From 1/14 to 1/17/19 the Room Visit/Independent Program program indicated staff provided room visits. On 1/18/19 at 2:25 p.m., during an interview, the activity assistant (AA) stated she did not recall Resident 8 going to the dining room for group activities during the days AA was working. AA stated the resident had not been to group activity the entire previous week.	F 561		
F 582 SS=B	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each	F 582	F 582- Medicare Medicare Coverage Liability Notice- *Corrective action(s) for resident(s) found to have been affected by the deficient practice;* The 3 discharge residents are no longer at the facility.	2-22-2019

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F 582	Continued From page 4 resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure each Medicaid (is a jointly funded, Federal-State health insurance program for low-income and needy people) - eligible Resident was given Skilled Nursing Facility (SNF)	F 582	*How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken;* The Social Services Director Social Service Assistant was re-educated on the policy and procedure on Advanced Beneficiary Notice and Medicare Denial Process on January 28, 2019. Social Services Director reviewed current residents and all required documentation updated.	

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F 582	Continued From page 5 Advance Beneficiary Notice (ABN, generic notes) in writing at the time of admission to the facility and when the resident becomes eligible for Medicaid for three of three sampled residents (Residents 249, 250, and 251). This deficient practice had the potential for residents not been aware of services covered by the Medicaid Program. Findings: a. A review of the clinical record (face sheet) indicated Resident 249 was admitted to the facility on 7/27/18 with diagnoses including hypertension (increased blood pressure). A review of the Beneficiary Protection Notification Review SNF form dated 7/27/18 indicated Resident 249 was discharged from the facility on 8/27/18 A review of the History and Physical examination by the attended physician, dated 7/27/18, indicated Resident 249 had fluctuating capacity to understand and make decisions A review of the physician's Telephone Order dated 8/24/18 indicated to discharge Resident 249 home with family. On 1/17/19, 3:10 p.m., during an interview, the Social Services Designee (SSD) confirmed Resident 249 was not provided with the notice explaining the number of days left for the benefited days and the out of pocket money the resident would had to be pay.	F 582	*What measures and/or systemic changes will be made to ensure that the deficient practice does not recur?* The Social Services Director upon resident admission will address Medicare Medicaid covered services with the responsible party resident. Interdisciplinary team will review and provide update to the responsible party resident during care conferences and discharge planning process. *How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place;* Medical Records will perform Audits upon discharge to monitor and maintain compliance. The report will be forwarded to the Administrator. Analysis of trends will be presented by the DON Designee to the Quality Assurance Committee monthly for recommendation and follow through.	

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F 582	Continued From page 6	F 582		

b. A review of the Admission Record indicated Resident 250 was admitted to the facility on 9/23/18 with diagnoses including cancer of the throat.

A review of the Beneficiary Protection Notification Review SNF dated 9/23/18 indicated Resident 250 was discharged from the facility on 9/29/18.

A review of the History and Physical examination by the physician dated 9/28/2018 indicated the resident does not have the capacity to understand and make decisions

A review of the Telephone order dated 9/29/18 indicated to discharge Resident 250 home per family request

On 1/17/19, at 3:10 p.m., during an interview, the SSD stated confirmed Resident 249 was not provided with the notice explaining the number of days left for the benefited days and the out of pocket money the resident would had to be pay.

c. A review of the Admission Record indicated Resident 251 was readmitted to the facility on 12/2/18 with diagnoses including respiratory failure (inability to clear the air way).

A review of the History and Physical examination by the physician, dated 11/8/18, indicated Resident 251 did not have the capacity to understand and make decisions

A review of the Beneficiary Protection Notification Review SNF dated 11/5/18 indicated Resident 251 was discharged from the facility on 12/2/18.

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F 582	Continued From page 7 On 1/17/19, at 3:10 p.m., during an interview, the SSD stated confirmed Resident 249 was not provided with the notice explaining the number of days left for the benefited days and the out of pocket money the resident would had to be pay. According to the facility's policy and procedures titled, "Medicare Denial Process," dated 10/2018, indicated the resident shall be properly determined and notified on Medicare beneficiaries of coverage for Medicare part A and informed the resident when he/she does not meet the requirements for covered skilled services under the Medicare program.	F 582		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized	F 656	*F 656- Development/Implement Comprehensive Care Plan* *Corrective action(s) for resident(s) found to have been affected by the deficient practice;* RN 1 was re-educated on the Comprehensive Care Plan policy/ procedure by the Director of Nursing On January 18, 2019 the education on Care Plans/Care Planning with Licensed Nursing staff was initiated by the Director of Nursing/Designee. Resident 5's Comprehensive Care Plan was reviewed and updated on January 15, 2019 for the use of gastrostomy (GT) feeding and possible complications.	2/22/2019

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F 656	Continued From page 8	F 656		

rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
Based on observation,interview and record review, the facility failed to develop and implement comprehensive and individualized plan of care for two of 18 sample residents (Residents 5 and 8).
Residents 5 had tube feeding but there was no plan of care addressing the tube feeding nursing needs. For Resident 8 the activities plan of care was not implemented.
This deficient practice resulted in not meeting the residents' needs.

Findings:

a. A review of the Admission Record indicated Resident 5 was readmitted to the facility on 1/10/19, with diagnoses including dysphagia (inability to swallow), gastrostomy status

How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken;

A review of all current resident's plan of care receiving enteral/gastrostomy feedings and activity preference were updated. No other resident was affected.

A comprehensive care plan will be initiated on admission of the resident to include enteral/G-tube feeding care and management.

The care plan will be reviewed by the Interdisciplinary team upon the initial meeting with the responsible party/or resident.

What measures and/or systemic changes will be made to ensure that the deficient practice does not recur?

Upon admission and after any significant change of condition, Medical Record/ Designee will audit that a care plan is added to include Enteral/G-tube care and management and activity preferences.

These audits will be forwarded to the DON/Designee for follow up.

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F 656	Continued From page 9 (insertion of a small tube into the abdomen for food and medication administration). A review of the Minimum Data Set (MDS - standardized assessment and care-planning tool) dated 10/2/218, indicated Resident 5's cognitive skills of daily decision-making were severely impaired and required extensive to total assistance with activities of daily livings (ADLs: transfer, bed mobility, dressing, eating, and personal hygiene) A review of the Physician's Order dated 1/10/19, indicated to give Resident 5 Diabetic Source at 55 milliliters per hour (ml/hr) for 20 hours to provide 1100 ml, 1320 kilogram (kg) of calories in 24 hours via enteral pump. A review of Resident 5's clinical record with the MDS coordinator, indicated there was no care plan developed for the use of gastrostomy tube (GT) feeding to address the care and possible complication. The MDS coordinator and Registered Nurse Supervisor 1 (RNS 1), acknowledged the lack of plan of care and stated there should be one developed. b. During a tour of the facility on 1/15/19 at 10:46 a.m., Resident 8 was observed in her room with her eyes closed, lying in bed. A television on the wall was turned off. Resident 8 was observed in her room and lying in her bed on 1/15/19 at 1:30 p.m., on 1/16/19 at 10:01 a.m., and on 1/18/19 at 11:00 a.m. without music or television turned on. During an interview on 1/15/19 at 1:39 p.m., Resident 8's family member stated staff did not take Resident 8 to attend group activities during the days and times he had visited.	F 656	*How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place;* The DON/Designee is responsible for monitoring and maintaining compliance that residents plan of care for enteral feeding/G-tube and activity preferences are being implemented through walking observation rounds and review of the clinical records. Analysis of trends will be presented by the DON/ Designee to the Quality Assurance Committee monthly for recommendation and follow through.	2/22/2019

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F 656	Continued From page 10	F 656		

A review of the admission record indicated Resident 8 was admitted to the facility on 5/10/12 with diagnoses includinge Alzheimer's disease (a brain disease that causes a slow decline in memory, thinking and reasoning skills), blindness in both eyes, and anemia (occurs from the loss of red blood cells).

A review of the comprehensive MDS dated 6/19/18 indicated Resident 8's activity preferences included keeping up with the news, doing things with groups of people, participating in favorite activities and spending time outdoors.

A review of the care plan dated 1/21/15 and last revised on 3/19/19 indicated all staff to be aware of the activity schedule and assure the resident is taken to activities. The care plan also indicated the resident liked listening to music but there was no intervention indicating when this acitivity would be carried out.

On 1/18/19 at 2:13 p.m., during a telephone interview, the Activities Director (AD) stated group activities were held in the back dining room and included group exercises, games, reading books and for those who could not participate, there were sensory activities provided.

On 1/18/19 at 2:25 p.m., the activity assistant (AA) stated, she did not recall Resident 8 going to the dining room for group activities during the days the AA was working. The AA stated Resident 8 did not attend group activity the entire previous week.

A review of the facility's policy and procedures titled, "Care plans," revised 3/2010, and "Care

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F 656	Continued From page 11 Planning" dated 12/2016, indicated the facility's interdisciplinary team shall develop a comprehensive care plan for each resident that includes measurable objectives and timetables to met the resident's physical, psychosocial and functional needs.	F 656		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting,	F 676	F 676- Activities of Daily Living (ADL's) *Corrective action(s) for resident(s) found to have been affected by the deficient practice;* CNA 4 was immediately re-educated on the Activities of Daily Living Policy by the Director of Staff Development. Resident 19 was immediately provided incontinent care and linens were changed on January 15, 2019. Housekeeping was notified immediately to clean resident's room and remove the odor. An interdisciplinary meeting was scheduled on January 16, 2019 with resident 19 to update the plan of care for toileting at night. *How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken;* Through observation rounds and resident interviews by the DSD, there were no other current residents affected by the findings.	2/22/2019

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F 676	Continued From page 12 §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a resident unable to carry out activities of daily livings (ADLs) receive the necessary services to maintain proper hygiene for one of 18 sampled residents (Resident 19). Resident 19, who was continent of bladder function (able to control urination), had to wet her bed because of delayed response to her calls for assistance. This deficient practice had the potential for decline in functional status, low self-esteem, and skin breakdown. Findings: On 1/15/18 9:58 a. m., during the initial tour of the facility, in the presence of Certified Nursing Assistant 4 (CNA 4), Resident 19 was lying in bed and the linen were saturated with urine. Resident 4's room had a strong odor of concentrated urine. Resident 19 stated she does not get help from staff in a timely manner when she needs assistance. On 1/16/19, at 2:28 p.m., during the Residents Group Interview Meeting with the Evaluators, Resident 19 complained the CNAs were hard to come by during night time. Resident 19 explained	F 676	The Director of Staff Development re-educated the certified nursing assistants with addressing ADL care timely and housekeeping staff on odor management. *What measures and/or systemic changes will be made to ensure that the deficient practice does not recur;* Clinical staff will do frequent rounds on each shift to address concerns and ensure timely interventions. Additionally, facility managers will conduct Ambassador rounds daily to address identified concerns immediately. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place;** The DON/Designee is responsible to monitor and maintain compliance. Analysis of trends will be presented by the DON/ Designee to the Quality Assurance Committee monthly for recommendation and follow through.	

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F 676	Continued From page 13 between 1 and 2 a.m., she usually needs to use the toilet and turns the call light on but nobody comes to assist her for more than 20 -35 minutes. Resident 19 stated she has to void in bed and be on wet linen for a while. A review of the Admission Record indicated Resident 19 was readmitted to the facility on 11/28/16 with diagnoses including muscle weakness. A review of the Minimum Data Set (MDS - standardized assessment and care-planning tool) dated 10/17/18 indicated Resident 19 had no memory problem and was able to make decisions. Resident 19 required extensive assistance from staff with bed mobility and transfer and total assistance with eating, dressing bathing, toilet use and personal hygiene. Resident 19 was always continent in bowel and urine functions. A review of the care plan for ADLs dated 11/28/16, last revised on 7/16/18, indicated Resident 19 had a decline in functional activities of daily living and limitation in functional range of motion. The interventions included providing the necessary assistance with ADLs. According to the facility's policy and procedures titled, "Activities of Daily Living (ADLs) Supporting" revised 3/2018, indicated staff shall provided residents with ADLs to maintain or improve their ability to carry out activities of daily living, enhance the quality of life, prevent body odor, and improve higher self-esteem.	F 676		
F 685 SS=E	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2)	F 685		

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F 685	Continued From page 14 §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure one of 18 sampled residents (Resident 8) was provided eye evaluation and care. This deficient practice resulted in Resident 8 not having evaluation of her vision for five years. Findings: During a tour of the facility on 1/15/19 at 10:46 a.m., Resident 8 was observed in bed with her eyes closed. During an interview on 1/15/19 at 1:39 p.m., Resident 8's family member stated the resident was blind on the left eye from shingles (a viral infection that causes a rash) and had severely limited vision on the right eye. The family member stated he was not aware Resident 8 had been seen by an eye specialist. A review of the admission record indicated Resident 8 was admitted to the facility on 5/10/12	F 685	F 685- Treatment/Devices to Maintain Hearing/Vision *Corrective action(s) for resident(s) found to have been affected by the deficient practice;* Resident 8 was referred to the Opthalmologist on January 29, 2019. *How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken;* The Social Service Department completed the audit for Ancillary services which found that all other residents are current with Ophthalmologist consults. *What measures and/or systemic changes will be made to ensure that the deficient practice does not recur?* SSD and SSA were re-educated on maintaining ancillary services for in house residents in a timely manner. The Social Services will report the compliance of Ancillary services by keeping records of appointments and schedules.	2/22/19

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F 685	Continued From page 15 with diagnoses including Alzheimer's disease (a brain disease that causes a slow decline in memory, thinking and reasoning skills) and blindness in both eyes. A review of the quarterly Minimum Data Set (MDS - standardized assessment and care-planning tool) dated 12/19/18 indicated Resident 8 had severely impaired vision. On 1/18/19 at 2:44 p.m., during an interview, the Social Services Designee (SSD) stated Resident 8's last eye doctor consult was in 2014. No other records were found regarding eye doctor visits. The SSD stated Resident 8 should be seen yearly by the eye doctor. A review of the facility policy titled, "Dental, Optometry (vision) and Audiology (hearing) Evaluations," dated 3/2010 indicated social services will maintain a system to monitor the dental, optometry and audiology evaluations. Dental, optometry, and audiology evaluations will be scheduled on an annual basis and/ or as needed.	F 685	*How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place;* The Medical Records/Social Service will audit the charts monthly to ensure that routine ancillary services are scheduled and provided for residents. The compliance rate will be reported by the Social Services Director at monthly Quality Assurance Committee meeting.	
F 692 SS=E	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or	F 692	F 692- Nutrition/Hydration Status Maintenance *Corrective action(s) for resident(s) found to have been affected by the deficient practice;* Resident 8 trend of weight variances was reviewed by the Registered Dietician on January 18, 2019. Orders were obtained to initiate a plan of care to address the weight variance.	2/22/2019

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F 692	Continued From page 16 desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure one of 18 sampled residents (Resident 8) was assisted with drinking nutritional supplements and the dietitian failed to review Resident 8's nutritional needs in a timely manner. This deficient practice resulted in Resident 8 having significant weight loss in one month. Findings: During a tour of the facility on 1/15/19 at 10:46 a.m., Resident 8 was observed in her bed with her eyes closed. There was one glass covered with a plastic and filled with white liquid on the over-the-bed table by the foot of the bed. On 1/15/19 at 1:45 p.m., the glass filled with white liquid was still on the over-the-bed-tables and was labeled HPN (high protein nourishment, a dietary supplement) 8 oz (ounces) dated 1/15/19 with the time of 10 a.m. At the time of the observation, Resident 8's family member stated it was common to find the HPN untouched on the table and not given to Resident 8. The family member stated he brought this issue to the staff' attention	F 692	A follow-up interdisciplinary meeting with the responsible party was scheduled on January 24, 2019. An update was given regarding the plan of care for weight maintenance/optimal nutrition for the resident. Re-education of the licensed nursing staff was initiated on January 18, 2019 on Weight Assessment and Intervention. A comprehensive assessment was conducted by the interdisciplinary team on January 23, 2019 for resident 8 to review the resident's daily response to receiving the physician's ordered nourishment. There were no significant adverse effects noted. An in-service education was provided for assigned C N A on January 15, 2019 regarding reporting to the charge nurse immediately if residents are refusing their nourishments. The clinical staff/C N A was in-serviced to report any refusals regarding nourishments to the Charge Nurse immediately. The physician will be notified of any significant change of condition. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken;*** A review of the current residents at the facility weight variances show no other resident was affected at the time of the findings.	

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F 692	Continued From page 17 during the last resident care plan meeting. A review of the admission record indicated Resident 8 was admitted to the facility on 5/10/12 with diagnoses including Alzheimer's disease (a brain disease that causes a slow decline in memory, thinking and reasoning skills), blindness in both eyes, and anemia (occurs from the loss of red blood cells). A review of the quarterly Minimum Data Set (MDS - standardized assessment and care-planning tool) dated 12/19/18 indicated Resident 8 was severely impaired with cognitive function (ability to think, understand and make daily decisions) and was totally dependent on staff for eating. A review of the Physician's Orders indicated Resident 8 was on a pureed (food that was pressed or blended to the consistency of a creamy paste or liquid), fortified (the process of adding micronutrients to food) with nectar thickened liquids and HPN 8 ounces two times a day between meals and Prostat Sugar Free (a nutritional supplement that delivers the highest concentration of protein and calories in small serving size) 30 milliliters (ml) with medication administration, three times a day for low albumin (a protein found in the blood. Low albumin levels may suggest a problem with the liver or kidneys. It may also indicate that a person has a nutrient deficiency). A review of Resident 8's weight record with the MDS Coordinator on 1/18/19 at 9:13 a.m., indicated the following weights: -11/1/18 97 pounds (lbs) -12/6/18 95 lbs -1/8/18 90 lbs	F 692	A review of the resident's that were alert and received daily nourishments were interviewed by the Director of Staff Development on January 15, 2019. No other resident was affected by this finding. *What measures and/or systemic changes will be made to ensure that the deficient practice does not recur?* A weekly Weight/Nutrition meeting will be scheduled to include the multidisciplinary team. A list of physician ordered nourishments will be printed out daily for the Charge Nurse/Supervisors for reference. The C N A will document consumption of nourishment and contact the Charge Nurse for any refusals. The Medical Record Designee will audit weekly, which will include documentation of weight and consumption of nourishment. Audits will be forwarded to the DON/Designee for follow up. *How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place;* The DON/Designee is responsible to monitor and maintain compliance that residents plan of care for weight management is implemented.	

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F 692	Continued From page 18 There was a significant weight loss in one month from December 2018 to January 2019, 5.26 percent (%). On 1/18/19 at 9:30 a.m., during an interview, the Dietary Service Supervisor (DSS) stated the last visit from the Registered Dietician (RD) was on 1/16/19 and the RD left a copy of the report for him to review. A review of the RD report with the DSS indicated no recommendations or comments about Resident 8. On 1/18/19 at 1:17 p.m., during an interview, the RD stated she reviewed Resident 8's nutrition requirements today. The RD stated if there was a trend towards weight loss, the nursing department was responsible to communicate the information to her. RD stated recommendations would include breaking up the HPN into four 4-ounces at a time and staff to assist the resident with snacks. The RD stated she started working at the facility three weeks ago and there was no documentation or recommendations from the previous RD in November or December.	F 692	The Director of Nursing/Designee is responsible to ensure that nourishment consumption is documented. Analysis of trends will be presented by the DON/ Designee to the Quality Assurance Performance Improvement Committee for recommendation and follow through.	
F 757 SS=E	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or	F 757	F 757- Drug Regimen is Free from Unnecessary Drugs. *Corrective action(s) for resident(s) found to have been affected by the deficient practice;* Nursing Supervisor 2 was re-educated by the Director of Nursing on verification of consent prior to administering any psychotropic medications.	2/22/2019

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F 757	Continued From page 19 §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure psychotropic medications (any drug that affects brain activities associated with mental processes and behavior: anti-depressant, anti-anxiety, and hypnotic medications) are only given when necessary for one of 18 sample residents (Resident 65). Resident 65's sleepiness was not monitored as possible side effects from psychotropic, informed consent was not obtained before administration of psychotropic medications, and psychotropic were given without proper indications for use. This deficient practice had the potential for Resident 65 to receive unnecessary drugs. Findings: On 1/15/19, at 9:30 a.m., during an initial tour of the facility, Resident 65 was sleeping in her bed. At to 2 p.m., on the same day Resident 65 was still sleeping. On 1/16/19 from 10 a.m. to 12:35 p.m., Resident 65 was sleeping in bed. On 1/17/18 at 12 p.m. and 3:30 p.m., Resident 65	F 757	Verification of consents were obtained for Xanax and Restoril for Resident #65. The resident 65 was re-educated on the use of psychotropic medications and was seen by a psychiatric services and medication regimen reviewed. *How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken;* A review of current resident medication regimen showed no other resident was affected at the time of the findings. *What measures and/or systemic changes will be made to ensure that the deficient practice does not recur?* Medication Reconciliation/Review will be completed upon Admission. A consent for the use of Psychotropic medication will be obtained prior to administration. The interdisciplinary team will review the appropriateness of the psychotropic medications upon admission and/or when a change of conditions is identified. Medical records will perform monthly psychotropic audit for consent, behavior monitoring and possible side effects	

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F 757	Continued From page 20	F 757		

was sleeping in bed.

A review the Admission Record indicated Resident 65 was admitted to the facility on 12/6/18, with diagnoses including chronic obstructive pulmonary disease (COPD) and major depressive disorder.

The Minimum Data Set (MDS - standardized assessment and care-planning tool) dated 12/22/18, indicated Resident 65 did not have memory problems and was able to make decisions. Resident 65 required limited assistance from staff with activities of daily livings (ADLs such as bed mobility, transfer, dressing, eating, hygiene, and bathing).

A review of the current (1/2019) Physician's Orders included:
a. Xanax 0.5 milligram (mg) one tablet as needed for anxiety manifested by panic attack. There was no documented evidence informed consent for Xanax was obtained.
b. Cymbalta 30 mg one tablet every day for depression manifested by isolative and withdrawn behaviors.
c. Lidocane patch 5 percent (%) one patch a day for back pain. The order did not include the severity of pain.
d. Temazepam 30 mg capsule at night for insomnia manifested by inability to sleep. There was no documented evidence of an informed consent was obtained.

A review of medication administration record (MAR) for the month of 12/2018 for pain monitoring and episodes of panic attack indicated zero. Resident 65 had no pain or panic attack.

How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place;

The DON/Designee is responsible to monitor and maintain compliance on the use of psychotropic medications.

The Pharmacy Consultant will perform the monthly medication regimen review and present a written report to the Quality Assurance and Performance Improvement Committee.

Analysis of trends will be presented quarterly by the DON/ Designee and Pharmacy Consultant to the Quality Assurance Performance Improvement Committee for recommendation and follow through.

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F 757	Continued From page 21 A review of the psychiatric evaluation notes dated 1/10/19 indicated Resident 65 was cooperative, calm, and though process was elaborate with fair affects. No indication of depressive moods or behavior exhibited documented. A review of the Nurses' Progress Notes from 1/3 to 1/17/19, had no documentation of behaviors manifestation of panic attack and no documentation of sleepiness as possible side effect from the use of psychotropic medications. On 1/18/19, at 12:26 p. m., during an interview, Registered Nurse Supervisor 2 (RNS 2) stated there should be an informed consent obtained before antipsychotic were given. RNS 2 stated the indications for the medications have to be reflected in the orders. On 1/18/19, at 3:27 p.m., during an interview, the Director of Nursing (DON) stated informed consent are to be obtained before administering psychotropic medication. According to the facility's policy and procedures titled, "Psychotropic Medication Management," dated 9/2015, indicated psychotropic medications should be used to minimize or eliminate medical symptoms and promote/maintain resident's highest practicable mental, physical and psychosocial well being. Policy also included staff should observe, monitor document behavior manifestation, side effect in the electronic MAR. To avoid unnecessary medications and facilitate the proper use, does, and duration of all medication in accordance with resident's assessed needs and condition.	F 757		
F 800	Provided Diet Meets Needs of Each Resident	F 800		

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F 800 SS=E	Continued From page 22 CFR(s): 483.60	F 800		2/22/2019

§483.60 Food and nutrition services.
The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to provide one of 18 sampled residents (Resident 47) meals according to the resident's preferences. This deficient practice resulted in Resident 47 feeling frustrated and refusing meals.

Findings:

On 1/15/19 at 11:43 a.m., during an interview, Resident 47 stated the food at the facility was too spicy way. Resident 47 explained that two evenings ago, peas were covered in black pepper and she was unable to eat them. When she requested a substituted, she got a burnt grilled cheese sandwich.

A review of the admission record indicated Resident 47 was admitted to the facility on 10/22/18 with diagnoses including arthritis of the right hip (inflammation of the joint causing pain and stiffness), hypertension (high blood pressure), diabetes mellitus type 2 (abnormal blood sugar) and gastroesophageal reflux disease (GERD, occurs when stomach acid frequently flows back into the tube connecting your mouth and stomach, which can cause heartburn).

F 800- Provided Diet Meets Needs of Each Resident

Corrective action(s) for resident(s) found to have been affected by the deficient practice;

A meeting with Resident 47 was initiated by the Dietary Supervisor on January 15, 2019 to review menu card (list of food likes and dislikes.)

Cook 1 staff was re-educated to follow the recipe regarding spices on January 16, 2019 by the Dietary Supervisor.

How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken;

The Dietary Supervisor met with alert and oriented residents to review the menu cards. No other resident was affected by this finding.

The Dietary Supervisor will obtain a menu card upon Admission.

On January 16, 2019- additional Dietary Staff were in-services to follow the recipe. Food and Nutrition Services policy.

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F 800	Continued From page 23 A review of the Minimum Data Set (MDS - standardized assessment and care-planning tool) dated 10/29/18 indicated Resident 47 had no memory problems, was able to make decisions, and was on a therapeutic (medically prescribed) diet. A review of the Physician's Order dated 1/18/19 indicated Resident 47 was on a regular consistency, carbohydrate (calories or sugars) controlled diet with no added salt (NAS). A review of Resident 47's menu card (lists of resident's food likes and dislikes) dated 1/16/19 indicated Resident 47 disliked spicy foods. During an observation and interview with Cook 1 during lunch tray line on 1/16/19 at 11:55 a.m., tater tots were observed with orange-brown color and specks of black. During a concurrent interview with Cook 1, he stated he added seasoning salt and black pepper to give the tater tots some flavor. On 1/16/19 at 12:59 p.m., tater tot sampled from the tray line was obtained and tasted. The tater tots tasted salty with a peppery taste. On 1/16/19 at 1:30 p.m., Resident 47 was in her room with the lunch tray on the over-the-bed table, uneaten. During an interview, Resident 47 stated she was unable to eat the food because there was too much pepper on the tater tots and on the vegetables. Resident 47 stated she requested the tray be returned to the kitchen. Resident 47 stated she was disappointed because she had met with the Dietary Service Supervisor (DSD) the night before about her preference of not having any spice on her food.	F 800	*What measures and/or systemic changes will be made to ensure that the deficient practice does not recur?* An interview of new admissions will be completed by the Dietary Supervisor/Designee to note dietary preference and educate resident on diet order. The resident will be given an optional menu choice upon request. A Dietician Consult will be obtained as per assessment needs and Physician order. The Inter Disciplinary Team will schedule an initial meeting with the responsible party/resident to discuss any food preferences (likes and dislikes)	

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F 800	Continued From page 24 During an interview and review of the recipe for the tater tots served at lunch on 1/16/18 with Cook 1 in the presence of the DSS on 1/18/19 at 2:05 p.m., the recipe did not include instructions to put salt, seasoned salt or black pepper. During a concurrent interview, the DSS acknowledged he had a conversation with Resident 47 on 1/5/18 about her food preferences. A review of the facility policy titled, "Food and Nutrition Services" revised 10/2017 indicated each resident is provided with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preference of each resident.	F 800	*How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place;* The Dietary Supervisor/Designee will make periodic rounds to interview resident's feedback of meals served. The periodic round interviews and feedback will be shared with the Leadership team during stand-up. Any concerns will be addressed immediately by assigned leadership for resolution. Analysis of trends will be presented by the Dietary Supervisor to the Quality Assurance Performance Improvement Committee for recommendation and follow through.	
F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically;	F 803		

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F 803	Continued From page 25 §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to follow recipes according to the menu for one of 18 sample residents (Resident 47). This deficient practice resulted in food preferences not met for Resident 47. Findings: On 1/15/19 at 11:43 a.m., during an interview, Resident 47 stated the food at the facility was too spicy way. Resident 47 explained that two evenings ago, peas were covered in black pepper and she was unable to eat them. When she requested a substituted, she got a burnt grilled cheese sandwich. A review of the admission record indicated Resident 47 was admitted to the facility on 10/22/18 with diagnoses including arthritis of the right hip (inflammation of the joint causing pain and stiffness), hypertension (high blood pressure), diabetes mellitus type 2 (abnormal blood sugar) and gastroesophageal reflux disease (GERD, occurs when stomach acid frequently flows back into the tube connecting your mouth and stomach, which can cause heartburn).	F 803	*Corrective action(s) for resident(s) found to have been affected by the deficient practice;* A meeting with Resident 47 was initiated by the Dietary Supervisor on January 15, 2019 to review menu card (list of food likes and dislikes.) Cook 1 staff was re-educated to follow the recipe regarding spices on January 16, 2019 by the Dietary Supervisor. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken;*** The Dietary Supervisor met with alert and oriented residents to review the menu cards. No other resident was affected by this finding. The Dietary Supervisor will obtain a menu card upon Admission. On January 16, 2019- additional Dietary Staff were in-services to follow the recipe. Food and Nutrition Services policy.	2/22/2019

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F 803	Continued From page 26 A review of the Minimum Data Set (MDS - standardized assessment and care-planning tool) dated 10/29/18 indicated Resident 47 had no memory problems, was able to make decisions, and was on a therapeutic (medically prescribed) diet. A review of the Physician's Order dated 1/18/19 indicated Resident 47 was on a regular consistency, carbohydrate (calories or sugars) controlled diet with no added salt (NAS). A review of Resident 47's menu card (lists of resident's food likes and dislikes) dated 1/16/19 indicated Resident 47 disliked spicy foods. On 1/16/During the lunch tray line observation and interview with Cook 1 during lunch tray line on 1/16/19 at 11:55 a.m., tater tots were observed with orange-brown color and specks of black. During a concurrent interview with Cook 1, he stated he added seasoning salt and black pepper to give the tater tots some flavor. Carrots were observed covered with brown-green colored flakes. During an interview with Cook 1, he stated he added Italian seasoning to the carrots. On 1/16/19 at 1:30 p.m., observed Resident 47 in room with lunch tray on over bed table, untouched. During an interview with the resident, she stated she was unable to eat the foord because there was too much pepper on tater tots and vegetables. The resident stated she had requested the tray be returned to the kitchen. The resident stated she was disappointed because she had met with the Dietary Supervisor (DS) te previous night and spoke to him about her preference of not having any spice on her food.	F 803	*What measures and/or systemic changes will be made to ensure that the deficient practice does not recur?* An interview of new admissions will be completed by the Dietary Supervisor/Designee to note dietary preference and educate resident on diet order. The resident will be given an optional menu choice upon request. A Dietician Consult will be obtained as per assessment needs and Physician order. The Inter Disciplinary Team will schedule an initial meeting with the responsible party resident to discuss any food preferences (likes and dislikes)	

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F 803	Continued From page 27 During an interview and review of the recipe for the tater tots served at lunch on 1/16/18 with Cook 1 in the presence of the Dietary Supervisor (DS) on 1/18/19 at 2:05 p.m., the recipe titled "Tater Tots" indicated to spread the tater tots on sheet pan and bake per directions until the internal temperature must register at least 145 degrees Fahrenheit (F) for 15 seconds. Cook 1 stated there was no instructions to put salt, seasoned salt or black pepper to the recipe. A review of a recipe titled "Seasoned Carrots" indicated to wash fresh carrots, boil in water until tender, drainm place in steam table, pour margarine over carrots, sprinkle with salt, serve on trayline at 160 to 160 degrees F. Cook 1 stated there was no instructions to add Italain seasoning. During an interview and review of the menu and recipes with the Registered Dietician (RD) on 1/18/19 at 1:30 p.m., she stated regualr salt to be used on the seasoned carrots and not seasoned because some residents cannot tolerate seaoned salt.	F 803	*How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place;* The Dietary Supervisor Designee will make periodic rounds to interview resident's feedback of meals served. The periodic round interviews and feedback will be shared with the Leadership team during stand-up. Any concerns will be addressed immediately by assigned leadership for resolution. Analysis of trends will be presented by the Dietary Supervisor to the Quality Assurance Performance Improvement Committee for recommendation and follow through.	
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services	F 849	F 849- Hospice Services *Corrective action(s) for resident(s) found to have been affected by the deficient practice;* Resident 2 Hospice Record Review was completed on January 16, 2019. The Hospice Company was contacted and resident 2 medical record updated including monthly calendar.	2/22/2019

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F 849	Continued From page 28 when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes	F 849	*How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken;* No other residents receiving Hospice Services at this time. *What measures and/or systemic changes will be made to ensure that the deficient practice does not recur?* The Administrator re-educated Hospice Staff on Facility Policy on Hospice Program. Medical Records will perform Monthly Audits to monitor and maintain compliance. The Report will be forwarded to DON/Designee for follow up.	

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F 849	Continued From page 29 responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.	F 849	*How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place;* The Director of Nursing/Designee is responsible to monitor and maintain compliance that resident's hospice care documentation is compliant of the clinical records. Analysis of trends will be presented by the DON/ Designee to the Quality Assurance Performance Improvement Committee for recommendation and follow through.	

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F 849	Continued From page 30 (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient.	F 849		

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F 849	Continued From page 31 (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to coordinate hospice services for one of 18 sampled residents (Resident 2) and ensure the hospice agreement was implemented. This deficient practice had the potential for Resident 2 not receiving the hospice care needed. Findings: A review of the Admission Record indicated	F 849		

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F 849	Continued From page 32	F 849		

Resident 2 was admitted to the facility on 7/18/18 with diagnoses including kidney stone, low back pain, and difficulty in walking.

A review of the Minimum Data Set (MDS - standardized assessment and care-screening tool) dated 9/18/18 and 12/18/18, indicated Resident 2 had memory problems and required extensive assistance from staff with all activities of daily living (ADLs such as transfers, mobility, eating, bathing, dressing, and personal hygiene).

A review of the Physician's Order dated 9/10/18 indicated Hospice care due to diagnosis of arterial cardiovascular disease (ASCVD - disease of the circulatory system).

A review of the MDS dated 9/18 and 12/18/18 did not included Hospice care.

A review of the Hospice agency folder in the presence of the MDS Coordinator indicated there was no calendar for the visits and services to be provided by the hospice staff.

On 1/16/19, at 12:50 p.m., a review of Resident 2's clinical record, in the presence of the Social Service Designee (SSD), indicated the last documentation from the hospice agency in file was dated 11/28/18. In a concurrent interview, the SSD stated she will follow up with the hospice agency to bring their notes or documentation of the previous months.

A review of the end of life care plan dated 9/11/18, indicated the hospice agency and the facility's staff would co-work and closely communicate in order to provide comfort care for Resident 2.

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F 849	Continued From page 33 A review of the Hospice policy section 3.3.9 dated 9/10/018, indicated both parties shall maintain appropriate documentation of services provided under the Agreement in accordance with applicable state and federal laws and regulations and Accreditation Standards. The Agreement indicated the hospice agency shall furnish records and documentation immediately and not later than seven (7) days. On 10/17/18, at 1 p. m., during an interview, the Director of Nursing (DON) confirmed there was no coordination of services and documentation as agreed by both parties. According to the facility's policy and procedures titled, "Hospice Program," revised 7/2017, indicated the facility shall be held responsible for not meeting resident's personal care and nursing needs coordination with the hospice representative, same professional standards and timeliness of services as any contracted individual or agency associated with the facility.	F 849		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention	F 880		

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	555340	A. BUILDING _____ B. WING _____	01/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARINA POINTE HEALTHCARE & SUBACUTE	5240 SEPULVEDA BLVD CULVER CITY, CA 90230

(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 880	Continued From page 34	F 880		

and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which 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; and
(vi)The hand hygiene procedures to be followed

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F 880	Continued From page 35 by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure hand hygiene was provided in accordance with infection control guidelines for one of 18 sampled residents (Resident 30). This deficient practice had the potential for spread of illness and infection. Findings: During a post-shower observation of Resident 30 on 1/16/19 at 10:41 a.m., the resident had a bowel movement when she was turned to the right side in bed. Certified Nurse Assistant 1 (CNA 1) wearing disposable gloves, got a wash basin, filled it with water, took a clean towel, wet the towel in water and cleaned Resident 30's feces. CNA 1 then took off her soiled gloves, did not perform handwashing, went out of the room to the clean linen cart to obtain a clean sheet. CNA 1 came back into the room, put on gloves, took the soiled sheet off the bed, rolled it and placed inside a plastic bag, took off her gloves, and did not wash her hands. CNA 1 walked to	F 880	F 880- Infection Control/Hand Hygiene *Corrective action(s) for resident(s) found to have been affected by the deficient practice;* C N A 1 was re-educated on the proper pericare and hand hygiene practice on January 18, 2019. Resident 30 was provided proper pericare immediately to ensure compliance. *How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken;* Director of Staff Development interviewed residents assigned to CNA 1. No other residents expressed any concerns. On January 18, 2019, the C N A staff were in-serviced on proper pericare and hand washing/hygiene during patient care. All staff will be educated on Hand washing/ Hygiene during orientation and as needed.	2/22/2019

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F 880	Continued From page 36 the closet, got a clean incontinent pad, put on clean gloves, took the clean pad and put it on Resident 30. CNA 1 took the dirty linen in a plastic bag to the dirty linen cart outside of the resident's room. CNA 1 did not wash her hands. On 1/18/19 at 12:05 p.m., during an interview, CNA 1 stated she should have washed her hands after removing the soiled gloves. A review of the facility policy and procedure titled, "Infection Control" revised on 1/2016 indicated the facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections.	F 880	*What measures and/or systemic changes will be made to ensure that the deficient practice does not recur?* Daily Observation Rounds by Director of Staff Development /Designee to monitor and maintain compliance. Observations of non-compliance will be immediately corrected and followed-up at the point of care. Staff will be re-educated. *How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place;* The Daily Observation report will be forwarded to DON/Designee. Analysis of trends will be presented by the Dietary Supervisor to the Quality Assurance Performance Improvement Committee for recommendation and follow through.	
F 912 SS=B	Bedrooms Measure at Least 80 Sq Ft/Resident CFR(s): 483.90(e)(1)(ii) §483.90(e)(1)(ii) 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, interview, and record review, the facility failed to provide 80 square feet of space per resident in a multiple resident bedrooms. The failure to provide adequate space created the potential for adversely affecting the residents' quality of life, safety, and health, and the provision of care. Findings: On 1/15/19 during the entrance conference, the administrator indicated the facility wanted to	F 912		

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F 912	Continued From page 37 renew the room waiver as multiple three-bed rooms did not meet the required 80 square feet per resident. A review of the Client Accommodations Analysis form completed by the Maintenance Supervisor and a Letter to the Department dated 1/18/19, requesting a waiver indicated the following: Rooms 1, 2, 3, 5, 7, 10, 12, 14, 19, 22, 24, 26, 28 30, 32, 39, and 40, were three-bed rooms and measured 235.5 square feet (sq ft). The required room size for the three residents living in each of these rooms is 240 sq ft. Rooms 4, 6, 8, 9, 11, 13, 15, 16, 17, 18, 20, 21, 23, 25, 27, 29, 31, 34, 35, 36, and 38 were three-bed rooms and measured 234 sq ft. The required room size for the three residents living in each of these rooms is 240 sq ft. Rooms 5 had three beds and measured 235 sq ft. The required room size for three residents living in each of these rooms was 240 sq ft. During the survey from 1/15 to 1/22/19, observation of the residents' care needs, safety, and health in the rooms not meeting the required sq ft indicated the room size did not adversely affected residents.	F 912		