STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCT	(X3) DATE SURVEY COMPLETED
	055311	A. BUILDING _____ B. WING _____	07/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KATHERINE HEALTHCARE	315 ALAMEDA AVENUE SALINAS, CA 93901

(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 conducted from 7/12/11 through 7/18/11. The facility was licensed for 51 beds. The census was 39 during the survey with 1 bedhold. There were 10 sampled residents and 2 nonsampled residents. Representing the California Department of Public Health: 29259, Health Facilities Evaluator Nurse, and 29260, Health Facilities Evaluator Nurse.	F 000	DISCLAIMER CLAUSE PREPARATION AND/OR EXECUTION OF THIS PLAN OF CORRECTION DOES NOT CONSTITUTE THE PROVIDER'S ADMISSION OF OR AGREEMENT WITH THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW. **F 241 Dignity and Respect of Individuality.**	
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 observation and interview, the facility failed to treat 2 sampled residents (2 and 3) and 2 nonsampled residents (11 and 12) with respect and dignity when care instructions were posted above their beds in view of other residents and visitors. These failures could potentially cause the residents embarrassment and emotional distress. Findings: 1. During the initial tour on 7/12/11 at 9:05 a.m., a sign indicating the head of the bed was to be kept at 45 degrees was posted above Resident 11's bed and was visible from the hallway. Resident	F 241	**Residents affected:** **All resident's who have special instructions regarding their care have the potential to be affected. All signs with special instructions have been covered with paper stating "Staff: Please Read."** **Systemic changes:** **DNS will conduct weekly rounds to validate that signs are covered and correct on the spot. Facility staff including therapies will be in-serviced by 08/25/11 on the covering of signs and preservation of resident dignity.**	8/25/11

[redacted] TITLE (X6) DATE

Executive Director 08/12/2011

A[redacted] 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 241	Continued From page 1 11 was not interviewable. 2. During the initial tour on 7/12/11 at 9:20 a.m., a sign indicating Resident 2's right arm was not to be used to take blood pressures or draw laboratory work was posted above the resident's bed and was visible from the hallway. Resident 2 was not interviewable. 3. During the initial tour on 7/12/11 at 9:20 a.m., a sign outlining communication instructions was posted above Resident 12's bed and was visible from the hallway. Resident 12 was not interviewable. 4. During the initial tour on 7/12/11 at 9:45 a.m., a sign indicating the head of the bed was to be kept at 45 degrees was posted above Resident 3's bed. The sign further indicated the only exceptions were when cleaning and repositioning. Resident 3 was not interviewable. During an interview with licensed nurse A (LN A) on 7/18/11 at 2:00 p.m., she stated the signs were posted to remind the nursing staff of specific instructions regarding each resident. She stated the signs should be covered so health information about specific residents would not be visible to other residents and visitors.	F 241	**Monitor:** **The DNS will report to the CQI committee monthly and when 100% compliance is met for 3 months, weekly reviews may be discontinued at the DNS discretion.**	
F 252 SS=D	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.	F 252	**F 252 Safe/Clean Homelike environment.** **Resident affected:** **All residents of the facility are affected and have the potential to be affected.** **1 & 2: The downstairs and upstairs shower rooms were deep cleaned on 07/14/11. The soap dispenser and fan was**	

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F 252	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide a comfortable and homelike environment when the downstairs shower had brown particulate matter on the floor and wall, missing tile under the sink and chipped plaster on the corner wall. The upstairs shower had black particulate matter on the floor, a missing soap dispenser and a broken fan. Findings: 1. During the environmental tour on 7/14/11 at 2:45 p.m., the downstairs shower was observed to have brown particulate matter on the floor and wall, missing tile under the sink and chipped plaster on the corner wall. During a confidential interview on 7/18/11 at 2:30 p.m., a resident stated she had asked one of the nurses about the condition of the shower and was advised it was going to be repaired. 2. During the environmental tour on 7/14/11 at 3:15 p.m. and accompanied by the environmental services manager (ESM), the upstairs shower was observed to have black particulate matter on the floor, a missing soap dispenser, and a broken fan. The ESM stated with the fan broken it may have been responsible for the black particulate matter on the floor. He was unaware the soap dispenser was missing.	F 252	**installed in the upstairs shower room on 07/15/11.** **Systemic changes:** **Both shower rooms will be deep cleaned once per week and in addition, both shower rooms will be cleaned and sanitized daily.** **Monitor:** **The Executive Director will round daily, Mon thru Fri on the cleanliness of each shower room. In addition, the housekeeping staff will document on a deep cleaning shower log the date the shower rooms were deep cleaned. The Executive Director will review the log once per month. The Environmental Supervisor will report on the findings from his review of the log at the monthly CQI meeting along with any corrective action that was necessary. The information will be part of the CQI minutes and records.**	8/15/11
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.	F 279		

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F 279	Continued From page 3 The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe 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 §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop a care plan for Restoril for one of 10 sampled residents (5) and failed to revise a care plan for one of 10 sampled residents (1) when a care plan for Fentanyl was not discontinued. Care plans describe the services to be furnished to maintain the resident's highest practicable well-being. Findings: 1. Resident 5 was admitted to the facility with diagnoses including elevated blood pressure and depressive disorder. Record review on 7/13/11 at 9:40 a.m. of Resident 5's "Physician's Order Sheet" indicated a medication, Restoril 15 mg (milligrams) every night, was ordered on 4/13/10 for insomnia (inability to sleep).	F 279	**F 279 Develop Comprehensive Care Plans** **Residents affected:** **The care plans for resident 1 & 5 were updated immediately.** **Other residents who have the potential to be affected:** **All residents who reside at the facility have the potential to be affected.** **Systemic changes:** **the DNS will audit a minimum of 3 charts per week that reflect change orders to ensure the care plans are updated in a timely manner.** **Monitoring:** **The DNS will report to the CQI committee monthly and when 100% compliance is attained for 3 consecutive months the DNS may discontinue at her discretion.** CALIFORNIA DEPARTMENT OF PUBLIC HEALTH AUG 18 2011	8/30/11

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F 279	Continued From page 4 During an interview on 7/13/11 at 11:00 a.m., the director of nurses (DON) reviewed Resident 5's care plan and stated it should have been revised to reflect she was receiving Restoril. 2. Resident 1 was admitted to the facility with diagnoses including osteoarthritis (destruction of joints) and anxiety state (abnormal fear and anxiety). Record review on 7/13/11 at 2:30 p.m. of Resident 1's "Pain Care Plan" listed "Fentanyl Patch - 11-28-10" as a pain medication intervention ordered by the physician. During an interview on the same date and time the DON stated "unfortunately, Fentanyl was not discontinued" from the pain care plan. Record review on 7/14/11 at 3:30 p.m. of the policy and procedure dated September 2010, "The Care Area Assessment Process and Care Plan Completion" indicated, "Nursing homes should also evaluate the appropriateness of the care plan after each Quarterly assessment and on an on-going basis, modify the care plan if appropriate."	F 279		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record	F 281	**F 281 Services provided meet Professional Standards..** **Resident's affected:** **Resident #3 had no harmful effects from the deficient practice. A suction machine was placed at the bedside of Resident 3 immediately. Resident 6 tube feeding was turn off immediately after it was discovered to be left on.**	

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F 281	Continued From page 5 review, the facility failed to provide services to meet professional standards for two of 10 sampled residents (3 and 6). Resident 3's physician order for a suction machine at the bedside was not carried out and her tube feeding continued running when it should have been turned off. A PPD (an injection into the skin) test for Resident 6 was not documented as ordered and caused Resident 6 to be injected a second time. Findings: 1. Resident 3's clinical record was reviewed on 7/12/11 at 11:30 a.m. Resident 3 was admitted with diagnoses including depressive disorder and rhabdomyolysis (muscular tissue breakdown). During an observation on 7/12/11 at 11:30 a.m., Resident 3 was lying in her bed with secretions coming from her mouth. During record review on 7/12/11 at 11:45 a.m., a physician's order dated 11/18/10 indicated, "SUCTION MACHINE AT BEDSIDE - MAY DO SUCTION ORAL ONLY 2NDARY [secondary] TO INCREASE SECRETIONS." During an interview on 7/12/11 at 11:45 a.m., licensed nurse B (LN B) stated, "I didn't even know that she (Resident 3) had an order for a suction machine." 2. During an initial observation on 7/12/11 at 9:45 a.m., Resident 3 had a gastrostomy tube (device used to provide nutrition to a patient who cannot swallow) running at 85 cc's per hour. Record review on 7/12/11 at 3:45 p.m. of Resident 3's Physician Order Sheet dated July	F 281	**The tube feeding was adjusted so as to validate the proper cc's and calories were provided. The failure to read the PPD for Resident 6 had no negative outcome. The second PPD was read in a timely manner revealing 0.0 mm in duration.** **Other resident's who have the potential to be affected: All residents who have enteral feedings, increased secretions or PPD tests have the potential to be affected.** **Systemic changes: DNS or DSD will conduct daily rounds to validate that all residents with suction orders have suction machines at the bedside.** **Nursing staff will be in-serviced by 08/25/11 on the importance of following feeding timing orders and the importance of timely reading of PPD test results. The Health Information Manager**	8/25/11

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F 281	Continued From page 6 2011 indicated Fibersource HN formula (feeding) to run at 85 cc's an hour for twenty hours. It further indicated the feeding should be turned off at 8 a.m. and back on at 12 p.m. During an interview on 7/13/11 at 11:30 a.m., when questioned about Resident 6's tube feed running after 8 a.m., LN B stated, "I was with my patient downstairs, it got me very busy." 3. Resident 6 was admitted with diagnoses including pneumonia (inflammation of the lungs). During an interview on 7/13/11 at 5:00 p.m., Resident 6 stated her nurse gave her a PPD test (test used to determine if a resident is infected with tubercle bacilli and to prevent the transmission of tuberculosis). She further stated her nurse was off when the PPD test was to be read. She stated it was not read and had to be given again. Record review on 7/14/11 at 8:10 a.m. indicated an annual PPD test was administered to Resident 6 on June 8, 2011. The PPD test was not read on June 11 and a second PPD test was ordered and administered on June 12, 2011. Record review on 7/14/11 at 8:30 a.m. of the policy and procedure dated June 2005, "Tuberculosis Control Plan," indicated "The results of all skin tests. . . will be documented for each resident."	F 281	**will have PPD's "boxed out" on the Medication Administration Records in the first week of the month to ensure timely administration and reading of PPD's.** **Monitor:** **The DNS or designee will conduct weekly rounds for all residents receiving tube feeding to ensure that proper timing is observed. The DNS will audit all admits for proper administration and reading of PPDs. DNS or designee during the monthly recap process will visibly validate that the annual PPD was given and read timely. The DNS or DSD will report their findings to the monthly CQI committee. When 100% compliance is attained for three consecutive months the DNS may discontinue at her discretion.**	09/05/11
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident	F 314		

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F 314	Continued From page 7 who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to assess one of 10 sampled residents (2) in an effort to prevent the development of a Stage II pressure ulcer (a wound in the tissue caused by pressure on the skin). This failure potentially allowed the pressure sore to worsen resulting in pain and the need for additional treatment for the resident. Findings: Resident 2 was admitted to the facility in July of 2010 with diagnoses including diabetes (metabolic disease characterized by high blood sugar levels as a result of defects in insulin secretion). In February of 2011, he had a stroke (rapidly developing loss of brain function due to an interruption of the blood supply) resulting in right-sided hemiplegia (total paralysis). Record review on 7/13/11 indicated Resident 2 developed a Stage II pressure ulcer (partial thickness skin loss present as a shallow open ulcer or intact or open/ruptured blister) on his right buttock on 5/4/11. There was no indication the staff had noted a Stage I pressure ulcer (an observable, pressure-related alteration of intact skin, such as a change in skin temperature, tissue consistency, sensation, and/or redness)	F 314	**F 314 Treatment and Services to Prevent/Heal Pressure Sores:** **Residents Affected:** **Resident 2 was on a 2hour turning schedule. He had experienced a precipitous weight loss due to failing to respond positively to safe swallow strategy exercises provided by Speech Therapy. A PEG tube was placed on 05/10/11. The residents skin was checked after each incontinence episode. Resident 2's pressure ulcer was healed by 06/15/11.** **Other residents who have the potential to be affected:** **All residents who reside in the facility have the potential to be affected.** **Systemic changes:** **The Licensed Nursing Staff will be in-serviced by 08/25/11 on documentation guidelines for pressure ulcers.**	8/25/11

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F 314	Continued From page 8 prior to the documentation of a Stage II pressure ulcer. During an interview on 7/13/11 at 12:20 p.m., the director of nurses (DON) stated the nurses should have charted the condition of the pressure sore.	F 314	**Monitoring:** **If a resident develops a Stage 2 pressure ulcer without documentation or specific awareness of the licensed staff prior to the Stage 2 being discovered, the situation will immediately be referred to the** **Interdisciplinary Team for a deep root analysis of the cause.** **The DNS will report on the findings of the analysis at the monthly CQI meeting including any corrective action that was necessary. The information will become part of the CQI minutes and records.**	on-going
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to secure a television set to the wall to prevent possible injury if it fell during an earthquake or if a resident bumped into it. Findings: During the environmental tour on 7/14/11 at 3:30 p.m. with the environmental services manager (ESM), the television set in Room 27 was observed perched on a night stand. The night stand was eighteen inches wide and eighteen inches deep. The television was much larger than the night stand and extended six inches beyond each side and twelve inches over the back. The television set was not secured to the wall to prevent falling. During a concurrent interview, the ESM stated at the very least the television set	F 323	**F 323 Free of Accidents, Hazards/Supervision/devices:** **Resident's affected:** **All residents are affected and have the potential to be affected.**	

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F 323	Continued From page 9 and the night stand should be wedged into the corner to prevent the television from falling off the night stand if it was bumped by the resident.	F 323	**The television set in Room 27 was strapped to the table top on which it was placed on 07/15/11.**	
F 369 SS=D	483.35(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS The facility must provide special eating equipment and utensils for residents who need them. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide one of 10 sampled residents (1) with special eating equipment, a plate guard, which had the potential to improve her ability to eat independently. Findings: Resident 1 was admitted to the facility with diagnoses of osteoarthritis (swelling of joints), joint contractures and dysphagia (difficulty swallowing). The Minimum Data Set (MDS is an assessment tool) dated 5/21/11, indicated Resident 1 had long and short term memory problems, and had poor ability to make decisions. During a breakfast observation on 7/13/11 at 7:45 a.m., Resident 1's breakfast tray had no plate guard on her tray or dish. During an interview with rehabilitation nurse assistant C (RNA C) on the above date and time, she stated, "She (Resident 1) was supposed to get a plate guard every day, but today they didn't send one up." Record review on 7/13/11 at 12:35 p.m. of	F 369	**Systemic changes:** **The Executive Director and Environmental Services Manager will round a minimum of once weekly to specifically look for safety concerns. In addition, the Executive Director shall assign to each Evergreen Care Representative (a program whereby specific rooms in the facility are assigned to specific Dept. Managers) the task of looking for any violations of safety.** **Monitor:** **The Executive Director will weekly reports from each ECR their findings on safety rounds and report the findings to the monthly CQI committee. The Environmental Supervisor will report on the findings from the rounds with the ED at the monthly CQI meeting along with any corrective action that**	8/30/11

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F 369	Continued From page 10 Resident 1's "Nutritional Status Interdisciplinary Care Plan" indicated adaptive devices used: plate guard, angled fork, and spoon. Record review on 7/18/11 at 9:30 a.m. of Resident 1's tray card indicated she should have a plate guard for assistance with eating her meals.	F 369	**was necessary. The information will be part of the CQI minutes and records.** **F 369 Assistive Devices – Eating Equipment/Utensils:** See Next Page	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to reduce the risk of food contamination and thereby prevent foodborne illness when dietary staff ran a gentle stream of water over two bags of frozen chicken placed directly in the sink; a pitcher of apple juice was found in the reach-in refrigerator dated use by 6/19/11; and a bin of thickener was found with the lid partially opened to air. Findings: 1. During an observation on 7/12/11 at 8:25 a.m., two bags of chicken were in the sink, while the cook had water gently flowing over the bags.	F 371	**F 371 Food Procurement, Stored/Prepared - Sanitary:** **Residents affected:** **All residents have the potential to be affected by the deficient practice.** **Other residents who have the potential to be affected:** **All residents have the potential to be affected by the deficient practice.** **Systemic changes:** **The DSM and RD did an in-service attended by all but one dietary aide on 08/09/11 @ 12:45 on the topics of thawing frozen foods,**	08/11/11

F371 CONTINUED

Resident's affected:
The angle spoon for resident # 1 was discontinued immediately due to her not needing it. The plate guard was provided immediately. Resident # 1 remains in the RNA dining program. There was no negative outcome in this case.

Other resident's who have the potential to be affected:
All residents who require assistive devices for eating have the potential to be affected.

Systemic changes:
The DSM will create a checklist for each meal cart, listing trays with adaptive devices. room number, and name of resident. The DSM will update the checklist whenever the seating or meal cart list changes. Dietary aides were in-service on 08/09/11 to check list before cart delivery. After double checking applicable trays for adaptive devices at each meal. The DSM will be responsible for maintaining the accuracy of the checklist. C.N.A.'s and RNA's will be in-serviced by 08/25/11 that if an assistive device is not provided on the tray it will be obtained immediately.

08/25/11

Monitoring:
The DSM will report to the Continuous Quality Committee the findings of the Audit monthly for three consecutive months. If compliance is achieved for 3 consecutive months, the audit may be discontinued at the discretion of the ED, DNS and DSM.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055311	A. BUILDING _____ B. WING _____	07/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KATHERINE HEALTHCARE	315 ALAMEDA AVENUE SALINAS, CA 93901

(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 371	Continued From page 11 During an interview on 7/12/11 at 8:25 a.m., the cook stated, "I had it in the sink. It shouldn't be sitting in the sink." She further stated, "We usually defrost in the refrigerator." The dietary services manager (DSM) instructed the cook to place the chicken in a bowl and increase the flow of water over the chicken. Record review of the facility's policy and procedure dated December 2009, "Cooling and Cold Holding Methods" indicated food should be thawed "Completely submerged under cold running potable water (temperature of 70° F or below), that is running fast enough to agitate and float off loose ice particles." 2. During an observation on 7/12/11 at 8:40 a.m., one pitcher of apple juice was noted in the reach-in refrigerator with a "Use by 6/19/11" sticker on the pitcher. During an interview on the same date and time the DSM stated he had the wrong date stamped on the pitcher of apple juice. Record review of the facility's policy and procedures dated December 2009, "Food Storage Policy" indicated "Opened items have 'use by' dates indicated on them." Record review of the facility's policy and procedures dated December 2010, "Food Labeling Reference Guide for Opened Items" indicated opened items in the refrigerator such as fruit juice should be dated with a "use by date 7 days after opened." 3. During an observation on 7/12/11 at 8:50 a.m.,	F 371	**labeling and dating. Follow-up on the one aide who did not receive the in-service will be this week. Dietary employees successfully passed a quiz on each topic with score of 85% or better on 08/09/11.** **Monitoring:** **The DSM and RD will monitor employees implementation of correct thawing, dating and labeling of foods to include direct observation, return demonstration of these skills weekly. The DSM or A.M. cook will inspect refrigerators daily for items that need dates that are at a "use by", "will expire" or "discard out" those items.** **The DSM will report on the findings of the visual checks at the monthly CQI meeting along with any corrective action that was necessary. If following three months of**	

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F 371	Continued From page 12 a dry storage bin containing thickener was open to the air. During an interview on the above date and time, the dietary aid (DA) stated the bin containing thickener should be kept closed. Record review of the facility's policy and procedures dated December 2009, "Food Storage Policy" indicated "Dry bulk foods, (. . .thickener . .) are stored . . . in plastic containers with tight fitting covers . . ."	F 371	**100% compliance the ED, DSN and DSM will decide wiether to continue the audit or not. The information will become part of the CQI minutes and records.**	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions	F 441	**F 441 Infection Control, Prevent Spread, Linens.** **Residents affected:** **The tubing for Resident 4 was replaced and dated immediately.** **Other resident's who have the potential to be affected:** **All resident's who require any kind of tubing have the potential to be affected.** **Systemic change:** **The DSD will conduct weekly rounds to ensure that tubing is dated appropriately and no tubing is touching the floor.**	8/30/11

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F 441	Continued From page 13 from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide a sanitary environment when oxygen tubing was found on the floor, undated and unlabeled which encouraged the transmission of infection. Findings: During an initial tour on 7/12/11 at 8:55 a.m., undated and unlabeled oxygen tubing was found on the floor. During an interview on the same date and time the MDS coordinator (MDS) confirmed oxygen tubing was found on the floor unlabeled and undated. The MDS stated, "We label (tubing) with their name on it." During an interview on 7/18/11 at 10:20 a.m., the director of nurses (DON) stated, "It is just standard of care - the tubing needs to be labeled." During record review on 7/13/11 at 3:35 p.m. of	F 441	**Monitor:** **The DSD will report findings to the monthly CQI committee and when 100 % compliance is attained for three consecutive months the ED, DNS and DSD will at their discretion determine if the audit will continue or not.**	

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F 441	Continued From page 14 facility policy and procedures dated June, 2005 "Use of Oxygen" indicated, "The tubing should be kept off the floor."	F 441		
F 458 SS=D	483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to provide 80 square feet per resident in seven of 24 multiple resident rooms and 100 square feet in one of 16 single rooms. These failures could potentially compromise the care the residents received. Findings: Room No. Number of Beds Square Footage 2 2 151.8 3 2 151.8 10 2 150.6 11 2 157.2 19 2 154.0 23 2 152.9 24 2 152.9 31 1 86 Variations were in accordance with the particular needs of the residents. Observation showed there was sufficient room for the provision of nursing services and did not compromise the care or services the residents received due to the size of their rooms.	F 458	See Attached CALIFORNIA DEPARTMENT OF PUBLIC HEALTH AUG 18 2011	

Katherine Healthcare Center

315 Alameda Avenue, Salinas, CA 93901-4120 • Ph. 831-424-1878 • Fax 831-424-3149

August 12, 2011

[redacted]
California Department of Public Health
Licensing and Certification Program
100 Paseo de San Antonio, Suite 235
San Jose, CA 95113

Dear [redacted]

Katherine Healthcare would like to request an extension of the waiver to the square footage requirement for bedrooms for Rooms 2,3,10, 11,19,23,24 and 31. Your consideration of this matter is greatly appreciated.

Sincerely,

[redacted]
Executive Director

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F 458	Continued From page 15 Recommend waiver remain in effect.	F 458	**F 468 Corridors have Firmly Secured handrails**	
F 468 SS=D	483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS The facility must equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure handrails were securely fastened to the wall in one of two shower rooms to prevent possible falls. Findings: During the environmental tour on 7/14/11 at 3:15 p.m. with the environmental services manager (ESM), a loose handrail was identified in the upstairs shower. During a concurrent interview, the ESM stated the handrail should be firmly fixed to the wall. The shower is used by all residents who shower on the second floor.	F 468	**Residents Affected:** **All residents and potential future residents living in the facility have the potential to be affected. The handrail in the second floor shower room was securely fastened on 07/15/11.** **Systemic Change:** **During rounds of the shower rooms on first and second floor to ensure a clean and sanitary environment, the Executive Director and the** **Environmental Supervisor will check the handrails to ensure they are securely fastened to the wall. Any loose handrails will be immediately remedied.** **Monitoring:** **The Environmental Supervisor will log on the sanitation log that the handrails were checked. He will report to the monthly CQI committee his findings and any corrective action.**	
F 518 SS=E	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to train one dietary aide (DA) in emergency procedures when she did not know what to do during a kitchen fire. The facility failed to have	F 518		8/30/11

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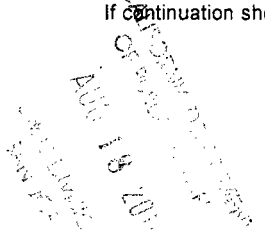
F 518	Continued From page 16 emergency food supplies available at night as keys to the locked store room were not available. The facility failed to carry out periodic disaster drills. Regularly scheduled drills provide staff time to practice what to do during an actual disaster. Findings: 1. During an interview with the DA, she stated if a fire should start in the kitchen she would do in the following the order listed: a. Close all doors b. Turn off all lights c. Call 911 d. Fire Extinguisher e. Call code red three times During an interview with the administrator (ADM) on 7/13/11 at 11:30 a.m., he stated the facility's general policy and procedures for fire should be followed. He further stated the facility's policy and procedures are not specific for a kitchen fire. Record review on 7/13/11 at 3:35 p.m. of the facility's policy and procedures dated May 2006, "Fire Disaster Checksheet" indicated "The response procedure; Rescue, Alarm, Contain, and Extinguish (RACE); will be followed in all instances involving a fire. Rescue: Evacuate all persons in immediate danger. Alarm: Notify the Fire Department by activating the nearest fire alarm box and call the communications center operator, . . . Contain: Contain the fire by closing all doors, windows . . . Extinguish: Take actions to put out or reduce fire until arrival of responding individuals."	F 518	**F 518 Train All Staff- Emergency Procedures/Drills** **Residents Affected:** **All residents and potential future residents of the facility have the potential to be affected.** **Kitchen staff will be in-serviced on fire response by Sept. 1, 2011.** **A key to the location of the emergency food storage are will be kept in the new, "Key Lock Box" located at the first floor nursing station. In addition, another key is available to staff in a kitchen closet located next to the dry storage area. Staff will be in-serviced on the location of the box by Sept 1, 2011.** **The facility will conduct a disaster drill for the second half of 2011 no later than Sept 1, 2011.**	09/01/11 09/01/11



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F 518	Continued From page 17 2. During an interview on 7/13/11 at 9:45 a.m., the dietary supervisor (DS) stated the door to the emergency supplies "is locked at night." He further stated there was an emergency key somewhere but he was not sure where. During an interview on 7/13/11 at 12:20 p.m., the ADM stated, "Unfortunately there is no key for night shift" to access the emergency food. Record review on 7/13/11 at 3:35 p.m. of policy and procedures dated April 2011, "Disaster Menu and Plan" indicated "If emergency food supplies are stored in a locked area, there should be a number of keys available in designated locations available to informed and responsible staff." 3. Review of the facility's SNF/NF Disaster Preparedness Plan Tool on 7/18/11 at 3:00 p.m. indicated the facility did not hold disaster drills at six-month intervals, that there were no written reports of the facility's participation, and that the last disaster drill was held in March of 2010. During an interview with the administrator (ADM) on the same day and time, he stated the facility did not hold disaster drills at six-month intervals. However, the facility should hold disaster drills every six months, and that the facility had no written record of disaster drills.	F 518		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 055311	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 7/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KATHERINE HEALTHCARE	**315 ALAMEDA AVENUE SALINAS, CA**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 278	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the residents status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than$5,000 for each assessment. Clinical disagreement does not constitute a material and false statement This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure one of 10 sampled residents (3) had an assessment that accurately reflected her status. Resident 3 did not have an accurate medication assessment Assessments are completed to ensure residents obtain the appropriate care for their condition Findings: Resident 3's clinical record was reviewed on 7/12/11 at 11:30 a.m. Resident 3 was admitted with diagnoses including depressive disorder. Record review on 7/12/11 at 2:00 p.m. of the Minimum Data Sets (MDS, an assessment tool) quarterly assessment dated 6/22/11 and the annual assessment dated 4/20/11 indicated Resident 3 received no injections. Record review on the above date and time of the Medication Administration Record(MAR) indicated an injection for a medication was administered daily, subcutaneous (introduced beneath the skin). During an interview on 7/12/11 at 2:45 p.m. the MDS Coordinator agreed the above MDS assessments were incorrect for Section N, injections.
F 456	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION

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 disclosable90 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 disclosable14 days following the date these documents are made available to the facility If deficiencies are cited, an approved plan of

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 055311	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 7/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KATHERINE HEALTHCARE	**315 ALAMEDA AVENUE SALINAS, CA**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 456	Continued From Page 1 The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure equipment was maintained in safe operating condition when the lint trap on one of the dryers in the laundry was observed covered with a layer of grey particulate matter and when one ice machine had no monthly preventative maintenance completed for June, 2011. These failures could potentially result in a laundry room fire causing injury to the residents and contamination of the ice in the ice machine. Findings: 1. During the environmental tour on 7/14/11 at 3:00 p.m. and accompanied by the environmental services manager (ESM), one-half inch layer of grey particulate matter was observed on the lint filter in one of the dryers in the laundry room. During a concurrent interview, the EMS stated the filters were to be cleaned every two hours. A review of the facility's policy dated July 2008 and entitled "Dryer Lint Removal" indicated "Lint should be removed from the lint screen after every third load or2 hours of operation." 2. Record review on 7/13/11 at 3:35 p.m. of the monthly ice machine log indicated several items on the ice machine had not been cleaned during the month of June, 2011. It indicated the ice storage bin had not been cleaned and the machine had not been sanitized. During an interview on 7/13/11 at 7:00 a.m., the environmental services manager (ESM) stated he had not cleaned or sanitized the ice machine for June, as he had only been at the facility for three weeks. During an interview on 7/13/11 at 8:45 a.m. the ESM stated, "We clean the (ice) bin once a month." He further stated, another company sanitizes the ice machine every six months. During review on 7/13/11 at 3:35 p.m. of policy and procedure dated July 2009 "Cleaning Ice Making Machine" indicated, "Monthly, or more often if required, defrost the ice-making machine and dismantle." It further indicated, "Documentation is kept of when the ice machine was cleaned"
F 514	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 055311	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 7/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KATHERINE HEALTHCARE	**315 ALAMEDA AVENUE SALINAS, CA**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 514	Continued From Page 2 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure clinical records were complete and accurately documented in one of 10 sampled residents (10) when there was no documentation of the results of a PPD test (skin test used to determine if someone had developed an immune response to the bacterium that causes tuberculosis) in the Immunization and TB Testing Record. Findings: Record review on 7/14/11 indicated Resident 10 had a two step PPD test performed on 11/7/10 and 11/17/10. The Medication Administration Record (MAR) indicated the resident had a negative reaction and that she was not infected with the bacteria that causes tuberculosis. The Immunization and TB Testing Record indicated the test was performed but did not record the results. In an interview with the Medical Records Coordinator (MRC) on 7/14/11 at 3:00 p.m., she stated the results of the TB test should be recorded in both the MAR and the Immunization and TB Testing Record.