By 6-16-16

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

PRINTED: 06/06/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		555492	B. WING		C	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	06/0	02/2016
MIRAVILLA CARE CENTER				9246 AVENIDA MIRAVILLA CHERRY VALLEY, CA 92223		
(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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	rs	F0	00		
	California Departme	cts the findings of the ent of Public Health during an rd survey for the investigation		•		8
		CA00489770. california Department of Public		50 tm	5	70
	Health: Surveyor Federal II	D number 33841, HFEN.			91 NO	CA DE
	complaint investiga	limited to the specific ted and does not represent inspection of the facility.	quer of	COUNTY	AM 4: 20	
F 309 SS=D	CA00489770.	cissued for complaint number CARE/SERVICES FOR EING	WY F 3	✓ CARE/SERVICES FOR HIGHEST)	
4	provide the necessor or maintain the high mental, and psycho	receive and the facility must ary care and services to attain nest practicable physical, social well-being, in e comprehensive assessment	147-18	Director of Nursing on 05-28-2016 regarding concern on the bed pan uand informed of measures being	ıse	05.28·16
	by: Based on interview facility failed to proving services to maintain physical well-being	NT is not met as evidenced If, and record review, the If it is not met as evidenced If it		implemented by facility to reduce further incidence and resident verbalized understanding. An IDT meeting was held on 06-01-2016 w Resident A and family member alor with the Ombudsman and discusse care concerns and plan of care.	ng	06-01-16
LABORATOR'	Y DIRECTOR'S OF PROVID	EBTSOPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

ADMINISTRATOR

06-16-2016

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

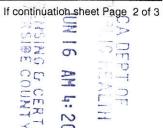
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		555492	B. WING		C 06/02/2	2016	
NAME OF PROVIDER OR SUPPLIER MIRAVILLA CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 9246 AVENIDA MIRAVILLA CHERRY VALLEY, CA 92223				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) .	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ULD BE COMPLETION		
F 309	Continued From page 1 failure had resulted in feeling of discomfort and back pain for Resident A. Findings: On May 27, 2016, at 2:15 p.m., an unannounced visit was conducted at the facility to investigate a quality care issues. On May 27, 2016, at 3:05 p.m., Resident A was interviewed. Resident A stated on May 25, 2016, around 6 p.m., he was placed on a bed pan by Certified Nursing Assistant (CNA) 1. Resident A stated CNA 1 left. He stated he only needed the bedpan for about 10 minutes. Resident A stated he called for CNA 1 using his call light and nobody came in to help. He stated he called his mother using his cellphone, because he had been on a bedpan for a long time and nobody had		F 309	Affected Resident/s: Other resident who uses the bed pan for continent care are affected by this deficient practice. Licensed nurses reassessed affected residents with no noted deficient practice. Systemic Changes: 1. An in-service training was provided by the Director of Staff Development to all nursing staff on 05-27-2016 on the Importance of Communication & Endorsement as to the Needs of the Residents to Prevent Misunderstanding & Mishaps. 2. A walkie-talkie radio system was instituted and distributed for use on 05-30-2016 to all nursing staff		5·30·16	
	mother was 30 min stated he was still mother got to the faupset. Resident As uncomfortable bein time, and said it was On May 27, 2016, reviewed. Resident on March 15, 2016 included muscular progressive skeleta. The "Physical There assessment dated Resident A was de to functional deficit	rapy Plan of Care," initial March 16, 2016, indicated pendent with bed mobility due		to aid in their communication providing care to the resident The radio system efficiently h when a Certified Nursing Assistant is requiring help wit resident or requires the assistance of a Charge Nurse Monitoring: The Director of Staff Developmen monitor compliance through observation of employees and interview of residents pertaining to quality of their care and concerns. Any deficient findings of practices be submitted to the QA committee.	in . elps h a e. t will will		

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

Event ID: T92V11

Facility ID: CA240000148



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		000 102				02/2010	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E		
BAID AVAIL	LA CARE CENTER			9246 AVENIDA MIRAVILLA			
MIRAVIL	LA CARE CENTER			CHERRY VALLEY, CA 92223			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		IOULD BE	(X5) COMPLETION DATE	
F 309	interviewed. CNA 1 a bedpan before sh 25, 2016. CNA 1 st another facility staf on a bedpan and w was not able to let taking her break af pan. CNA 1 stated break after 30 minu on a bed pan and u asking for help for a company (DON) was somebody should be provided should have not lef	stated she left Resident A on the went on her break on May ated she was not able to notify if she was leaving Resident A would be taking her break. She Resident A know she would be ter she placed him on a bed she came back from her ates and found Resident A still upset because he had been	F 3	Facility will be in compliance b 2, 2016.		CV DEAT UL	