PRINTED: 08/26/2018 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION A. BUILDING HEAD THOM DIVISION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** ADMINISTRATION C B. WING 055408 06/27/2018 STREET ADDRESS. CITY, STATES ZIP CODE NAME OF PROVIDER OR SUPPLIER 9710 E. ARTESIA AVE **BELLFLOWER POST ACUTE** BELLFLOWER EA 90706 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETION PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG DEFICIENCY) F 000 INITIAL COMMENTS F 000 "Preparation and/or execution of this plan of correction does not constitute admission and agreement by the provider of truth of the facts The following reflects the findings of the alleged or conclusions set forth in the Department of Public Health during the statement of deficiencies. This plan of investigation of one complaint during an correction prepared and/or executed because Abbreviated standard survey. it is required by the provisions of health and safety code section 1250 and 42 CFR 405.7907 (KP) Complaint number: 361194 Initials Representing the Department of Public Health: Health Facilities Evaluator Nurse ID: 36289 The inspection was limited to the specific Corrective action for residents found to have complaint investigated and does not represent 7/26/18 been affected by this deficiency: the findings of a full inspection of the facility. Certified nursing assistants (CNA)-1, CNA-2 and One deficiency was written for complaint number CNA-3 are no longer employed with the facility. 361194. No residents were found directly affected by this Facility Hiring and Use of Nurse Aide F 728 F 728 deficiency. CFR(s): 483.35(d)(1)-(3) SS=E The Administrator gave in-service to the Director

months, on a full-time basis, unless(i) That individual is competent to provide nursing and nursing related services; and
(ii)(A) That individual has completed a training and competency evaluation program, or a

A facility must not use any individual working in the facility as a nurse aide for more than 4

§483.35(d) Requirement for facility hiring and use

competency evaluation program approved by the State as meeting the requirements of §483.151 through §483.154; or

LABORATORY, DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(B) That individual has been deemed or determined competent as provided in

licensing renewals.

affected by this deficiency:

licensing check with no findings.

affected by this deficient practice.

of staff development (DSD) on 7/3/18 regarding

personnel file oversight and licensing program

Corrective action for residents that maybe

The personnel files of employed CNAs were audited by the DSD 7/2/18 to 7/5/18 for

compliance with emphasis on active/current

No other residents were identified to have been

certification with continuous monitoring of

(X6) DATE

ADMINISTRATOR

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.

Kaum

of nurse aides-

§483.35(d)(1) General rule.

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

PRINTED: 06/26/2018 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9710 E. ARTESIA AVE BELLFLOWER POST ACUTE SIMILARY STATEMENT OF DEFICIENCIES BELLFLOWER, CA. 90706	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
STREET AUDRESS, CITY, STATE, ZIP CODE ##10 E. ARTESIA.AVE BELLFLOWER POST AGUTE ##20 CAPID GENERATIVE STATEMENT OF DEFICIENCIES (EACH DEPOISINTY MUST BE PRECEDED BY FULL REGULATORY OR JSC (DENTIFYING INFORMATION) ##21 F728 Continued From page 1 \$483.150(a) and (b). \$483.35(d)(2) Non-permanent employees. A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in peragraphs (d)(1)(a) and (ii) of this section. \$483.35(d)(3) Minimum Competency A facility must not use any individual who has worked less than 4 months as a nurse aide in that facility unless the individual-(i) is a full-time employee in a State-approved training and competency evaluation program; (i) Has demonstrated competency evaluation program; (ii) Has demonstrated competency evaluation program; (iii) Has been deemed or determined competent as provided in \$483.150(a) and (b). The RECURENKENT is not met as evidenced by: ##20 B2						- ,			
EBLIFLOWER, CA 80708 (AG) ID PREFIX (EARD EPROCENCY MUST SE PRECEDED BY PULL TARK TARK TARK TARK TARK TARK TARK TARK				B. WING	ــــــ	08/27/2018			
PAGE ID STANSARY STATEMENT OF DESCRIPCIES (SEACH DESCRIPCIES STANSARY CALL PRESENCE TO THE APPROPRIATE DESCRIPCION AND SEASON PULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 728 Continued From page 1 \$483.150(a) and (b). \$483.35(d)(2) Non-permanent employees. A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (d)(1)(i) and (ii) of this section. \$483.35(d)(3) Minimum Competency A facility must not use any individual who has worked less than 4 months as a nurse alde in that facility unless the individual— (i) Is a full-time employee in a State-approved training and competency evaluation program; (ii) Has demonstrated competence through satisfactory participation in a State-approved nurse aids training and competency evaluation program; or (iii) Has been deemed or determined competent as provided in \$483.180(a) and (b). This REGUIREMENT is not met as evidenced by: Based on interview, and record review, the facility failed to follow its policy and by not ensuring the following: 1. Ensure that two Nursing Assistants (NA 1 and NA 2) completed the nursing all program, and received extilication program and competency evaluation program; and received certification prior to employment as a certified nursing assistant (CNA). 2. Ensure CNA 3 maintained an active CNA certificate while working in the facility with an expired.					971	0 E. ARTESIA AVE			
\$483.150(a) and (b). \$483.150(a) Non-permanent employees. A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (d)(1)(i) and (ii) of this section. \$483.35(d)(3) Minimum Competency A facility mules the individual who has worked less than 4 months as a nurse aide in that facility unless the individual who has worked less than 4 months as a nurse aide in that facility unless the individual (ii) is a full-time employee in a State-approved training and competency evaluation program; (ii) Has demonstrated competence through satisfactory participation in a State-approved nurse aide training and competency evaluation program; or (iii) Has been deemed or determined competent as provided in \$483.150(a) and (b). This REGUIREMENT is not met as evidenced by: Based on interview, and record review, the facility failed to follow its policy and by not ensuring the following: 1. Ensure that two Nursing Assistants (NA 1 and NA 2) completed the nursing aid program, and received certification prior to employment as a certified nursing assistant (CNA). 2. Ensure CNA 3 maintainead an active CNA certificate while working in the facility. These deficient practices sener CNA personnel files are complete one CNA and the personnel files using a tracking to personnel files using a tracking to elementary cutting a learn and the personnel files using a tracking to estimate the continued frecitions of the continued frecitions. Th	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREF	- T	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES	BE		
certificate, and had the potential for the residents		§483.150(a) and (b) §483.35(d)(2) Non-A facility must not use leased, or any basis employee any indivirequirements in partinis section. §483.35(d)(3) Minimal A facility must not use worked less than 4 facility unless the individual of the individ	permanent employees. se on a temporary, per diem, so other than a permanent idual who does not meet the agraphs (d)(1)(i) and (ii) of num Competency se any individual who has months as a nurse aide in that dividual- iloyee in a State-approved sency evaluation program; sed competence through atton in a State-approved and competency evaluation ency evaluation program; or sed or determined competent 150(a) and (b). IT is not met as evidenced in and record review, the wits policy and by not ng: fursing Assistants (NA 1 and a prior to employment as a istant (CNA). Intained an active CNA king in the facility. Itices resulted in CNA 3 the facility with an expired	F7	28	that this deficiency does not recur: Upon hire, the DSD will ensure new CNA personnel files are complete before any wor commences with residents. The DSD will monitor personnel files using a tracking log to alert when any CNA mandato certification will be expiring within the next 3 days and will report any concerns to the DO DSD consultant for suggestions. Measures that will be implemented to mo the continued effectiveness of the correct action taken to ensure that this deficience has been corrected and will not recur: The DSD will audit all personnel files for background checks (OIG, Assurance), licent verification, references check, CPR certification description, and any skills competency for compliance, quarterly or as needed. Results of the audits will be given to the Administrator for review and corrections. The DSD will report audit findings monthly to Quality Assurance (QA) committee for	k ory ory nitor nitor stive y se tion,		

CENT	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES					FO	ED: 06/26/20 RM APPROVE NO. 0938-039	ΞD
STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		CONSTRUCTION		(X3) (DATE SURVEY COMPLETED	
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NAME OF	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, 8	TATE, ZIP CODE			
BELLF	OWER POST ACUTE				10 e. artesia ave Ellflower, ca 90'	706			
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F 728		ge 2 and appropriate care.	F7	728					
	Findings:								
	Unentation Record."	Assistant 1's "Nurse Assistant indicated NA 1 was hired as sistant (CNA) at the facility							
	Permit Verification, " (interim permit (IP), di expired 10/11/07. The permit allowed the pr	comia Board of Registered rary RN License or Interim ndicated NA 1 had an RN ate issued 4/11/07 and everification indicated the actice of professional rect supervision of an RN, a license following							
	//14/15, indicated, "i	ter to the facility, dated know I don't have CNA 't been working as CNA in a							
j	A review of NA 2's un Orientation Record," i 3/21/13 as a CNA.	dated "Nurse Assistant ndicated NA 2 was hired on							
	uakeu 4/0/13: Indicatei	NA License Verification," If NA 2 did not have a litus (active or inactive), and led.							
41	A review of CNA 3's "A Employment," indicate 2/26/07 as a CNA	Application for d CNA 3 was hired on							

If continuation sheet Page 4 of 5

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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				On 12/8/16 at 3:45 p.m., during an interview and concurrent record review, DSD 1 stated prior to hiring a CNA, the applicant must have a current an "Ip," DSD 1 would usually inform the applicant to wait until the IP cleared before working. DSD 1 stated the employee's files are reviewed monthly to ensure the employee's files are reviewed monthly to ensure the employee's files are reviewed monthly did not have the employee's license and certificates to ensure the employee's license and certificates did not have the employee's license and certificates after the employee's license and certificates to ensure the employee's license and certificates at the employee's license and certificate monthly and the employee's license and the employee's lic
				A review of the facility's undated Job Description titled, "Director of Staff Development (DSD)," indicated a DSD ensured that all WAs hired by the facility completed a certification program within four months of the date of hire, and confirmed the validity of certificates for all CNAs hired.
				A review of the facility's undated Job Description filted, "Certified Nursing Assistant (CNA)," indicated "Specific Requirements," which included having a libensed Certified Nursing Assistant in accordance with the laws of the state. According to the CNA Job Description, a CNA must demonstrate the knowledge and skills must demonstrate the knowledge and skills necessary to provide care appropriate to the age-related needs of the residents served.
				A review of CNA 3's "Employee Warning Notice," indicated CNA 3 was still employed at the facility on SISA/11.
			F 728	Continued From page 3 A review of the "State of California Department of Health Services," Motice of Certification, indicated CNA 3's certification as a nursing assistant was effective on 1/8/07, and expired 1/25/09.
COMPLETION DATE	38(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD DEFICIENCY)	GI XI국크닷국 ƏAT	(XC) (D) SUMMARY STATEMENT OF DEFICIENCIES FREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (NFORMATION) TAG SECULATORY OR LSC IDENTIFYING (NFORMATION)
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. 0938-03	WB NC	0		CELATERS FOR MEDICARE & MEDICAID SERVICES

Facility ID: CA940000013

-DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF HEALTH AND HUMAN SERVICES PRINTED: 08/26/2018 FORM APPROVED OMB NO. 0938-0391								
STATEMENT OF DEFICIENCIES (X1) PROVIDE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A . MOI MULTIPLE CONCERNATION		ON	(X3) DATE SURVEY COMPLETED		
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ì	F PROVIDER OR SUPPLIER LOWER POST ACUTE		;	STREET ADDRESS 9710 E. ARTESIA BELLFLOWER		06/27/2018		
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