

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

PRINTED: 08/26/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055408	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED C 06/27/2018
NAME OF PROVIDER OR SUPPLIER BELLFLOWER POST ACUTE			STREET ADDRESS, CITY, STATE, ZIP CODE 9710 E. ARTESIA AVE BELLFLOWER, CA 90706		
(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 the investigation of one complaint during an Abbreviated standard survey. Complaint number: 361194 Representing the Department of Public Health: Health Facilities Evaluator Nurse ID: 36289 The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility. One deficiency was written for complaint number 361194.	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 alleged or conclusions set forth in the statement of deficiencies. This plan of correction prepared and/or executed because it is required by the provisions of health and safety code section 1250 and 42 CFR 405.7907 (RP) Initials		
F 728 SS=E	Facility Hiring and Use of Nurse Aide CFR(s): 483.35(d)(1)-(3) §483.35(d) Requirement for facility hiring and use of nurse aides- §483.35(d)(1) General rule. A facility must not use any individual working in the facility as a nurse aide for more than 4 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 competency evaluation program approved by the State as meeting the requirements of §483.151 through §483.154; or (B) That individual has been deemed or determined competent as provided in	F 728	F728 Corrective action for residents found to have been affected by this deficiency: Certified nursing assistants (CNA)-1, CNA-2 and CNA-3 are no longer employed with the facility. No residents were found directly affected by this deficiency. The Administrator gave in-service to the Director of staff development (DSD) on 7/3/18 regarding personnel file oversight and licensing program certification with continuous monitoring of licensing renewals. Corrective action for residents that maybe affected by this deficiency: 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 licensing check with no findings. No other residents were identified to have been affected by this deficient practice.		7/26/18

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

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.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055408	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/27/2018
NAME OF PROVIDER OR SUPPLIER BELLFLOWER POST ACUTE			STREET ADDRESS, CITY, STATE, ZIP CODE 9710 E. ARTESIA AVE BELLFLOWER, CA 90706		
(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 728	<p>Continued From page 1 §483.150(a) and (b).</p> <p>§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.</p> <p>§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-</p> <p>(i) Is a full-time employee in a State-approved training and competency evaluation program;</p> <p>(ii) Has demonstrated competence through satisfactory participation in a State-approved nurse aide training and competency evaluation program or competency evaluation program; or</p> <p>(iii) Has been deemed or determined competent as provided in §483.150(a) and (b).</p> <p>This REQUIREMENT 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:</p> <p>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).</p> <p>2. Ensure CNA 3 maintained an active CNA certificate while working in the facility.</p> <p>These deficient practices resulted in CNA 3 continuing to work in the facility with an expired certificate, and had the potential for the residents</p>	F 728	<p>Measures that will be put into place to ensure that this deficiency does not recur: Upon hire, the DSD will ensure new CNA personnel files are complete before any work commences with residents. The DSD will monitor personnel files using a tracking log to alert when any CNA mandatory certification will be expiring within the next 30 days and will report any concerns to the DON or DSD consultant for suggestions.</p> <p>Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur: The DSD will audit all personnel files for background checks (OIG, Assurance), license verification, references check, CPR certification, job description, and any skills competency-check 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 the Quality Assurance (QA) committee for suggestions or further recommendations.</p>		

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

PRINTED: 08/26/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055408	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/27/2018
NAME OF PROVIDER OR SUPPLIER BELLFLOWER POST ACUTE			STREET ADDRESS, CITY, STATE, ZIP CODE 9710 E. ARTESIA AVE BELLFLOWER, CA 90706		
(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 728	<p>Continued From page 2 not to receive safe and appropriate care.</p> <p>Findings:</p> <p>A review of Nursing Assistant 1's "Nurse Assistant Orientation Record," indicated NA 1 was hired as a certified nursing assistant (CNA) at the facility on 4/7/07.</p> <p>A review of the "California Board of Registered Nursing (RN) Temporary RN License or Interim Permit Verification," indicated NA 1 had an RN interim permit (IP), date issued 4/11/07 and expired 10/11/07. The verification indicated the permit allowed the practice of professional nursing, under the direct supervision of an RN; pending issuance of a license following examination.</p> <p>A review of NA 1's letter to the facility, dated 7/14/15, indicated, "I know I don't have CNA certificate but I haven't been working as CNA in a long time."</p> <p>A review of NA 2's undated "Nurse Assistant Orientation Record," indicated NA 2 was hired on 3/21/13 as a CNA.</p> <p>A review of NA 2's "CNA License Verification," dated 4/8/13, indicated NA 2 did not have a certificate number, status (active or inactive), and expiration date recorded.</p> <p>A review of CNA 3's "Application for Employment," indicated CNA 3 was hired on 2/26/07 as a CNA.</p>	F 728			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055408	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/27/2018
NAME OF PROVIDER OR SUPPLIER BELLFLOWER POST ACUTE		STREET ADDRESS, CITY, STATE, ZIP CODE 9710 E. ARTESIA AVE BELLFLOWER, CA 90706		

(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)
--------------------	--	---------------	---

F 728	<p>Continued From page 3</p> <p>A review of the "State of California Department of Health Services," Notice of Certification, indicated CNA 3's certification as a nursing assistant was effective on 1/8/07, and expired 1/25/09.</p> <p>A review of CNA 3's "Employee Warning Notice," indicated CNA 3 was still employed at the facility on 2/24/11.</p> <p>A review of the facility's undated Job Description titled, "Certified Nursing Assistant (CNA)," included "Specific Requirements," which Assistant in accordance with the laws of the state. According to the CNA Job Description, a CNA must demonstrate the knowledge and skills necessary to provide care appropriate to the age-related needs of the residents served.</p> <p>A review of the facility's undated Job Description titled, "Director of Staff Development (DSD)," indicated a DSD ensured that all NAs 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.</p> <p>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 CNA certificate. DSD 1 stated if an applicant had 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 license and certificates have not expired. DSD 1 stated NA 1 and NA 2 did not have CNA certificates on file, and CNA 3 did have a record on file to indicate CNA 3's certificate was renewed. DSD 1 stated the previous DSD should have checked the</p>	F 728		
-------	--	-------	--	--

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

PRINTED: 08/26/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055408	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/27/2018
---	---	--	--

NAME OF PROVIDER OR SUPPLIER

BELLFLOWER POST ACUTE

STREET ADDRESS, CITY, STATE, ZIP CODE

9710 E. ARTESIA AVE

BELLFLOWER, CA 90708

(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)	(X6) COMPLETION DATE
F 728	Continued From page 4 employee's files to ensure the employee's certificates were valid.	F 728		