STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555884	A. BUILDING _____ B. WING _____	C 08/18/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S PROGRESSIVE CARE	8951 GRANITE HILL DRIVE RIVERSIDE, CA 92509

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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during the investigation of one entity reported incident. Entity reported incident number: CA00452021 Representing the California Department of Public Health: Surveyor 34448, HFEN The inspection was limited to the specific entity reported incident investigated and does not represent the findings of a full inspection of the facility. The Department was able to substantiate violations for entity reported incident number CA00452021 and two deficiencies were issued.	F 000	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, Submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.	
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop an abuse policy and procedure addressing screening, training, prevention, identification, investigation, reporting/response, and the procedures how each component would be operationalized. This failure had the potential	F 226	F 226 Corrective action for residents found to have been affected by this deficiency: No resident was affected by this deficiency. Identification of others at risk:	

Acceptable POC 9/24/15 (CT)

POC completion 8/27/15 W. → HFEN

15 SEP 14 PM 2:56

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 08/27/2015

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 226	Continued From page 1 for the facility not to do all that was within its control to prevent occurrences of abuse. Findings: On July 28, 2015, at 8:40 a.m., an unnanounced visit was made to the facility for a resident to resident abuse investigation. At 10:35 a.m., a concurrent interview and record review was conducted with the Administrator (AD). The AD stated he was the Abuse Coordinator for the facility. The facility's policy and procedure, dated April 2006, titled, "Abuse Prevention Program," was reviewed with the AD. The following six components requiring more specificity were reviewed with the AD: 1. Screening - The facility's Abuse Policy did not indicate a clear procedure as to what kind of background check, including criminal, would be needed to screen a potential employee for a history of abuse, neglect, or mistreating residents. Also, there was no indication references would be checked or how many. 2. Training - The facility's Abuse Policy did not include staff training on how to recognize signs of burnout or frustration. 3. Prevention - The facility's Abuse Policy did not include procedures how residents, families, and staff may report concerns. 4. Identification - The facility's Abuse Policy did not identify the different types of abuse or situations in which abuse is more likely to occur. 5. Investigation - The facility's Abuse Policy did	F 226	All residents are potentially affected by the cited deficiency. The Facility QAPI Committee reviewed the previous abuse Policy and Procedure and the revision was made on 8/20/15. The Revision of Facility Policy and Procedure on Abuse Screening, Training, Prevention, Identification and Reporting of the abuse. Measures that will be put into place to ensure that this deficiency does not recur: Administrator, DSD, DON in-serviced the facility staff on the revised Abuse Policy and Procedure. An On-going in-service will be provided by the Director of Staff development (every 6 months) to all staff. All potential employees will be trained by the Director of Staff	

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F 226	Continued From page 2 not incorporate the "Resident Abuse Report Form" used by the facility for investigations. The facility did not have an abuse log. 6. Reporting - The facility Abuse Policy did not state the procedure; to report to the State Nurse Aide Registry or licensing authorities, to report to the State Agency within 24 hours initially, and to report the results of the investigation to the State Agency, within five days of the incident. The AD agreed the facility's Abuse Policy needed to be more in depth.	F 226	~~Development on revised Abuse~~ Policy and Procedure. The Director of Staff Development will ensure that all background checks and minimal of 2 reference check are obtained prior to hiring/orientation. A random check by the Administrator/Director of Nursing/designee monthly will be done on newly hired employee records to ensure that background checks and a minimal of 2 reference check was performed. Measures that will be implemented to monitor the continued effectiveness of the corrective action take to endure that this deficiency has been corrected and will not recur: Result of the random check of newly hired staff records will be presented by Director of Nursing/Designee to the Quality Assurance Performance Improvement Committee Quarterly for review and resolution.	9-27-15
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 ensure a safe environment for the residents when a gate on the smoking patio was propped open and left unattended by staff. This failure had the potential to result in residents exiting through the open gate to the public street, wandering away from the facility, or to be injured by a motor vehicle. Findings:	F 323		

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F 323	Continued From page 3 On July 28, 2015, at 8:40 a.m., an unnanounced visit was made to the facility for a complaint investigation. During initial tour of the facility, at 9:05 a.m., escorted by the Director of Nurses (DON), the residents' smoking patio was observed. The patio area contained 10 residents walking around the area. To the left side of the patio was a doorway leading into the kitchen. The left side of the patio also contained a wire mesh gate. The gate led to a driveway which provided egress onto the public street below, and to the freeway beyond the street. The gate was observed to be propped open with a large white plastic bucket. There was no staff observed in the area supervising the open gate. In a concurrent interview with the DON, the DON stated, "There should be someone here right now with the residents." The DON stated she could not leave the area. The DON was observed to close the gate and to make a phone call. At 9:06 a.m., an interview was conducted with the Dietary Services Director (DSD). The DSD stated, "Someone is suppose to be here all the time." The DSD stated when deliveries are made to the kitchen through the gate, the dietary staff member is to immediately lock the gate once the delivery person enters the patio through the gate. The DSD stated, "This one gate is not suppose to be left open when we are receiving." At 9:10 a.m., an interview was conducted with the Cook. The Cook stated, "I opened the gate to make it easy for him to come in and out, so propped it open with the bucket." The Cook stated he usually used crates to prop the door	F 323	F323 Corrective action for residents found to have been affected by this deficiency: There is no resident affected by this deficiency. Identification of others at risk: All residents are potentially affected by the cited deficiency. Measures that will be put into place to ensure that this deficiency does not recur: The facility is continuing to enforce the monitoring of the gate while the gate is opening during the delivery truck is loading the items into the facility side gate. Administrator, DSD, Safety Committee Chair person in-serviced the facility staff in every Department to:	8-27-15

15 SEP 14 PM 2:56

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F 323	Continued From page 4 open. The Cook stated he was inside and no one was watching the open gate. The Cook stated someone should be watching the residents all the time. The facility was unable to produce a policy and procedure regarding the receiving of goods or securing the facility.	F 323	Ensure that the Department head must know when the delivery truck is scheduled to be at the facility and there will be an assigned staff to monitor the side gate through entire time of the unloading of the delivery. Ensure that the facility gate must be monitored by a staff to ensure that the resident will not wander through the gate to the outside. The Monitoring log will be filled in by the staff who monitored the gate. The monitoring will contain the month, day, year, time delivery was begun and the time when the delivery was finish. 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 Safety Committee Chair Person will report the monitoring results to QAPI Committee on a quarterly basis until determined otherwise.	8-27-15