

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555165	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2007
NAME OF PROVIDER OR SUPPLIER EMBER HEALTH CARE - MONTE VISTA		STREET ADDRESS, CITY, STATE, ZIP CODE 5125 MONTE VISTA ST., LOS ANGELES, CA 90042 LOS ANGELES COUNTY		
(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) COMPLETE DATE
	<p>The following reflects the findings of the Department of Public Health during a Complaint Investigation visit.</p> <p>Representing the Department of Public Health: [REDACTED], HFE I</p> <p>CLASS AA CITATION -- PATIENT CARE 97-1381-0004424-F Complaint(s): CA00126648</p> <p>F272 42 CFR 483.20 The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>F278 42 CFR 483.20(g) Accuracy of Assessment The assessment must accurately reflect the resident's status.</p> <p>On September 18, 2007, an onsite investigation was conducted in response to a September 17, 2007, facility reported incident of Resident A being involved in a fire. On September 17, 2007, Resident A sustained secondary and third degree burns on 40 percent of his body when his clothes caught fire while he was smoking a cigarette on the patio. Resident A was transferred to general acute care hospital 1 for immediate evaluation and treatment of his burn. He was then transferred to the burn center of general acute care hospital 2 where he expired 19 days later on October 6, 2007.</p> <p>Based on interview and record review, the facility</p>			

Event ID:GNLD11

4/23/2008

1:32:37PM

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. Except for nursing homes, the findings 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.

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555165	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/18/2007
NAME OF PROVIDER OR SUPPLIER EMBER HEALTH CARE - MONTE VISTA		STREET ADDRESS, CITY, STATE, ZIP CODE 5125 MONTE VISTA ST., LOS ANGELES, CA 90042 LOS ANGELES COUNTY		
(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) COMPLETE DATE
	<p>Continued From page 1</p> <p>staff failed to accurately and periodically assess Resident A's ability to smoke safely and independently on the patio by failing to:</p> <ol style="list-style-type: none"> 1. Accurately assess Resident A to smoke safely and independently in reflection of the resident's cognitive status and diagnoses. 2. Periodically reassess Resident A to smoke safely and independently in reflection of the resident's cognitive status and diagnoses. <p>A review of Resident A's admission record revealed Resident A, a 60 year old, was admitted to the facility on January 12, 2006, with diagnoses of dementia, brain atrophy, ataxia, cerebrovascular disease, psychosis, and paraplegia. The Minimum Data Set (MDS), dated January 25, 2007, and Quarterly Assessment, dated July 16, 2007, indicated Resident A had a short term memory problem, was independent in cognitive skills for daily decision-making, and required supervision when walking/locomotion, verbally abusive and resistant to care.</p> <p>On September 17, 2007, at 4 p.m., the Licensed Nurse Progress Notes revealed Resident A was smoking at the facility's outside patio when he accidentally set himself on fire. The social service staff and several nursing assistants used the garden hose to spray water on the resident. The staff cut the resident's pants and shirt from his body revealing red spots on his back and stomach and burns on both lower legs and his genitalia. According to the Emergency Medical Service</p>			

Event ID:GNLD11

4/23/2008

1:32:37PM

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. Except for nursing homes, the findings 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.

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555165	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/18/2007
--	---	--	---

NAME OF PROVIDER OR SUPPLIER EMBER HEALTH CARE - MONTE VISTA	STREET ADDRESS, CITY, STATE, ZIP CODE 5125 MONTE VISTA ST., LOS ANGELES, CA 90042 LOS ANGELES COUNTY
--	--

(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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

	<p>Continued From page 2</p> <p>Report, dated September 17, 2007, the Paramedics were called at 4:01 p.m. and arrived on the scene at 4:04 p.m. The resident was taken to general acute care hospital 1 for evaluation and treatment.</p> <p>On September 27, 2007, a review of acute hospital 1's Emergency Department Physician Record dated September 17, 2007, disclosed Resident A sustained second degree burns to his abdomen, groin, and third degree burns to his buttocks and left lower extremity. The resident sustained second and third degree burns on 40 percent of his body.</p> <p>The acute hospital 1's History and Physical Progress Notes, dated September 17, 2007, indicated the resident was admitted due to self-inflicted burns ignited by a cigarette on his polyester pants. The resident complained of pain in the groin, abdomen and left lower extremity.</p> <p>The Emergency Department Report, dated September 17, 2007, revealed the resident's left lower extremity had extensive burns circumferentially (around the body) that were full thickness with an eschar on the lower part of the extremity. The foot was cyanotic and pulseless. Resident A's diagnoses included full and partial-thickness burns of the genitalia, and rule out rhabdomyolysis (disintegration of striated muscle fibers with excretion of myoglobin in the urine). The plan was to transfer the resident to the burn center of acute hospital 2.</p> <p>On October 16, 2007, a review of the medical record from acute hospital 2 was conducted. The</p>			
--	--	--	--	--

Event ID:GNLD11

4/23/2008

1:32:37PM

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. Except for nursing homes, the findings 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.

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555165	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/18/2007
NAME OF PROVIDER OR SUPPLIER EMBER HEALTH CARE - MONTE VISTA		STREET ADDRESS, CITY, STATE, ZIP CODE 5125 MONTE VISTA ST., LOS ANGELES, CA 90042 LOS ANGELES COUNTY		
(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) COMPLETE DATE
	<p>Continued From page 3</p> <p>Patient Burn History and Diagram, dated September 17, 2007, at 10:45 p.m. indicated the resident was admitted at 10:45 p.m. and intubated (insertion of a tube to help his breathe) upon arrival. The physician's burn evaluation revealed burn areas on 39.5 percent of the resident's body that included the abdomen, bilateral (both) legs, left upper extremity, bilateral buttocks, genitalia and back. The burn evaluation diagram indicated third degree burns were noted on parts of the anterior trunk, right and left buttocks, genitalia, right upper arm, right and left thighs, right and left legs.</p> <p>The Initial Inpatient Consultation dated September 18, 2007, indicated the resident's eyes were closed, moved all extremities to pain and was not responsive.</p> <p>The Patient's Medical History, dated the same day, indicated third degree burns were noted on the abdomen, genitalia, and left lower extremity. The plans included an admission to the burn surgery intensive care unit (ICU), providing intravenous therapy, placement of central lines, and escharotomy (surgical incision of the tissue slough produced by a thermal burn and superficial fascia to permit cut edges to separate and restore blood flow to unburned tissue distal to the burn tissue) with cautery (sealing of blood vessels to decrease the amount of bleeding). The Burn Surgery ICU Progress Note dated the same day indicated the resident was intubated, on a ventilator, receiving intravenous morphine sulfate (a pain medication) around the clock.</p>			

Event ID:GNLD11

4/23/2008

1:32:37PM

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. Except for nursing homes, the findings 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.

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555165	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2007
NAME OF PROVIDER OR SUPPLIER EMBER HEALTH CARE - MONTE VISTA			STREET ADDRESS, CITY, STATE, ZIP CODE 5125 MONTE VISTA ST., LOS ANGELES, CA 90042 LOS ANGELES COUNTY		
(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) COMPLETE DATE	
	<p>Continued From page 4</p> <p>According to the Discharge Report, dated October 6, 2007, the resident was unresponsive since admission to the hospital, required use of a ventilator, had undergone multiple debridements, and skin grafting, however, the resident did not improve. According to the Report of Operation, Pre-Operative/Pre-Procedure Verification, and Final Report of Operation, dated September 21, 27, October 2 and 4, 2007, the resident had four debridements and two skin grafting procedures.</p> <p>The Death Certificate indicated the resident expired at 1:50 a.m. on October 6, 2007. The cause of death was full thickness burn, 40 percent. According to the final report of the Coroners Examination, dated October 11, 2007, the "immediate cause" of death was "caused by multi organ system failure due to, or as a consequence of sepsis due to, or as a consequence of thermal burns."</p> <p>A review of the facility investigation report, dated September 21, 2007, indicated on September 17, 2007, at 3:50 p.m., Employees 1 (Activity Director) and 5 (Social Services) heard a resident yelling for help in the patio and discovered Resident A was sitting on a bench on fire with visible smoke. Employees 1 and 5 obtained a garden hose and started spraying water on the resident and simultaneously removing the resident's pants and t-shirt from his body, and eventually putting the fire out. The staff then wrapped a clean sheet and gently towed the water off the resident. The report disclosed a dropped cigarette ash on the resident's clothes could have caused or led to the</p>				

Event ID:GNLD11

4/23/2008

1:32:37PM

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. Except for nursing homes, the findings 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.

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555165	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/18/2007
NAME OF PROVIDER OR SUPPLIER EMBER HEALTH CARE - MONTE VISTA		STREET ADDRESS, CITY, STATE, ZIP CODE 5125 MONTE VISTA ST., LOS ANGELES, CA 90042 LOS ANGELES COUNTY		
(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) COMPLETE DATE
	<p>Continued From page 5</p> <p>fire incident.</p> <p>On September 18, 2007, at 10:20 a.m., during an interview, Employee 1 stated she went to the restroom and heard a loud voice from Resident A so she rushed out of the restroom to the patio and saw the resident on fire. She then got a hose and sprayed him with water. She stated that the resident usually smokes by himself and the activity staff just watched the residents smoke in the patio from the activity room.</p> <p>At 11 a.m., Employee 3 (DON), stated Employee 1 went to the restroom and forgot to assign another staff member to watch Resident A while the resident was smoking alone on the patio.</p> <p>At 11:30 a.m., Employee 1 stated she was aware of the resident's dementia and she was supervising the resident through the window of the activities room. She should not have allowed him to smoke alone on the patio.</p> <p>According to the January 2006 "Assessment of Safe Possession of Smoking Paraphernalia" form signed by the licensed nurse, activity and social service staff, Resident A was assessed to have no clinical and medical conditions that affected the resident's ability to smoke safely. The resident was alert with periods of confusion, was compliant with the smoking schedule and had no past incidents related to smoking. According to this form, the interdisciplinary team recommendation was that the resident was capable of safe smoking habits and may possess smoking paraphernalia.</p>			

Event ID:GNLD11

4/23/2008

1:32:37PM

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. Except for nursing homes, the findings 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.

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555165	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/18/2007
--	---	--	---

NAME OF PROVIDER OR SUPPLIER EMBER HEALTH CARE - MONTE VISTA	STREET ADDRESS, CITY, STATE, ZIP CODE 5125 MONTE VISTA ST., LOS ANGELES, CA 90042 LOS ANGELES COUNTY
--	--

(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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

	<p>Continued From page 6</p> <p>The facility's assessment of Resident A's safety awareness and the ability to smoke independently was in conflict with the Minimum Data Set assessment, dated January 25, 2007, which included diagnoses of dementia and psychoses.</p> <p>A review of the History and Physical, dated January 3, 2007, indicated the resident was checked off for having the ability to understand and make decisions and also checked off as not having the capacity to understand and make decisions. The two statements were in conflict with each other and did not reflect an accurate depiction of the facts as stated in the Psychiatric Physician's Progress Notes between June 23, 2006, and September 10, 2007, which indicated the resident had poor judgment with an absence of recent memory.</p> <p>The "Nursing Care Plan for Smokers", dated January 16, 2006, identified the resident as an "independent smoker." The goal for the resident was to have no episodes of burns/injury due to smoking. Interventions included explaining the facility smoking policy and procedure to the resident, redirecting to smoking area as needed, and offering the alternative to quit smoking. In addition the care plan indicated the resident had cognitive impairment due to short-term memory problems and risk of complications of impaired cognition including injury to self. However, there was no evidence of a reassessment of the resident's safety awareness in spite of the resident's cognitive impairment and short term memory problems.</p>			
--	--	--	--	--

Event ID:GNLD11

4/23/2008

1:32:37PM

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. Except for nursing homes, the findings 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.

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555165	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/18/2007
NAME OF PROVIDER OR SUPPLIER EMBER HEALTH CARE - MONTE VISTA		STREET ADDRESS, CITY, STATE, ZIP CODE 5125 MONTE VISTA ST., LOS ANGELES, CA 90042 LOS ANGELES COUNTY		
(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) COMPLETE DATE
	<p>Continued From page 7</p> <p>On September 20, 2007, at 11:45 a.m., during an interview, Employee 4 (SNF-MDS coordinator) was asked how they reassessed the resident for safe smoking. She showed the care plan, dated January 16, 2007, for independent smoking for Resident A with the reevaluation date of July 2007 that was crossed out. Thus, the cross out of the reevaluation date of a care plan dated, January 16, 2007, was considered the actual reassessment of the resident's ability to smoke. She further stated the assessment of safe possession of smoking paraphernalia, dated January 10, 2006, for Resident A and the previous care plan were the only actual assessments for smoking. The assessment indicated the resident did not have many behaviors or diagnoses that may affect his safely smoking independently. She stated the resident's psychosis would affect the resident's smoking ability and he needed to be supervised during smoking. She also stated, the smoking assessment, dated January 10, 2006, for Resident A's ability to smoke was not accurate because the resident had diagnoses and behavior concerns that would affect his ability to smoke safely without supervision.</p> <p>According to a Psychiatric Consultation report, dated January 30, 2006, the psychiatrist assessed the resident as having poor judgment, poor insight and agitated affect. The resident's diagnoses included psychosis, dementia and organic brain syndrome. According to the Interdisciplinary Team Review form, dated July 18, 2007, the Psychiatrist was not included in the smoking assessment. The staff did not accurately reassess the resident's</p>			

Event ID:GNLD11

4/23/2008

1:32:37PM

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. Except for nursing homes, the findings 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.

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555165	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/18/2007
NAME OF PROVIDER OR SUPPLIER EMBER HEALTH CARE - MONTE VISTA		STREET ADDRESS, CITY, STATE, ZIP CODE 5125 MONTE VISTA ST., LOS ANGELES, CA 90042 LOS ANGELES COUNTY		
(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) COMPLETE DATE
	<p>Continued From page 8</p> <p>ability to smoke safely and independently.</p> <p>A review of the activities notes, dated July 13, 2007, indicated the resident was able to remember to ask for cigarettes but was unable to remember the time to smoke. A review of the social service designee notes dated, August 9, 2007, indicated the resident asked the social service designee for his cigarettes.</p> <p>The Psychological Assessment, dated August 21, 2007, indicated Resident A had impaired judgment, impaired concentration, and impaired short and long-term memory. The GAF score (global assessment of functioning) was at 40. The GAF score from the DSM-IV (Diagnostic and Statistical Manual of Mental Disorders fourth edition) at 40 indicated - some impairment in reality testing or communication (e.g., speech is at times illogical, obscure, or irrelevant) or major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood. However there was no evidence in the clinical record that the facility accurately reassessed the ability of the resident to smoke independently and safely. The psychological assessment of August 21, 2007, conflicted with the interdisciplinary team's "Assessment of Safe Possession of Smoking Paraphernalia" form from January 2006 that assessed the resident as having no clinical and medical conditions that affected his ability to smoke safely. The interdisciplinary team's assessment of the resident's ability to smoke safely and possess smoking paraphernalia was in conflict with the psychiatrist's assessment of June</p>			

Event ID:GNLD11

4/23/2008

1:32:37PM

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. Except for nursing homes, the findings 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.

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555165	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/18/2007
NAME OF PROVIDER OR SUPPLIER EMBER HEALTH CARE - MONTE VISTA		STREET ADDRESS, CITY, STATE, ZIP CODE 5125 MONTE VISTA ST., LOS ANGELES, CA 90042 LOS ANGELES COUNTY		
(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) COMPLETE DATE
	<p>Continued From page 9</p> <p>23, 2006, and the psychological assessment, dated August 21, 2007.</p> <p>The Physician's Progress Notes written by the Psychiatrist between June 23, 2006, and September 10, 2007, indicated the resident had non-specified psychosis, dementia, organic brain syndrome, and was assessed by the Psychiatrist as having poor judgment with an absence of recent memory. A review of the clinical record during this time period revealed no evidence of an accurate reassessment by facility staff of the resident's ability to smoke safely and independently.</p> <p>In an interview on September 18, 2007 at 10:30 a.m., Employee 2 (licensed vocational nurse) stated the History and Physical, dated January 3, 2007, for Resident A should be interpreted as the resident not having the ability to understand and make decisions because he was confused.</p> <p>The facility "Smoking/Paraphernalia" policy and procedure with an effective date of May 2006, was reviewed on September 18, 2007. The policy was to provide smoking in an area and manner that does not cause potential harm or danger to self, facility, personal property or others and the residents were to be assessed by the interdisciplinary team. "The interdisciplinary team shall assess the residents who smoke, for safety awareness and safe self-handling of smoking paraphernalia. The assessment criteria included the following:</p> <p>* Medical conditions or diagnosis that would limit or</p>			

Event ID:GNLD11

4/23/2008

1:32:37PM

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. Except for nursing homes, the findings 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.

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555165	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/18/2007
--	---	--	---

NAME OF PROVIDER OR SUPPLIER EMBER HEALTH CARE - MONTE VISTA	STREET ADDRESS, CITY, STATE, ZIP CODE 5125 MONTE VISTA ST., LOS ANGELES, CA 90042 LOS ANGELES COUNTY
--	--

(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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

	<p>Continued From page 10</p> <p>affect a resident's ability to smoke, i.e. Parkinson's disease, Organic Brain Syndrome, Dementia, Huntington Chorea, Psychosis.</p> <p>* Resident's cognitive ability, i.e. alertness and orientation to self, environment, others, short term memory, ability to retain information.</p> <p>* Any periods of confusion or disorientation.</p> <p>* Behavioral problems such as non-compliance with safety rules."</p> <p>Further, the policy indicated, "Residents who are assessed and determined to have poor safety awareness and poor safe self-handling of smoking paraphernalia shall not be permitted to keep/posses smoking paraphernalia. Smoking materials or paraphernalia shall be made available to the resident during smoking time, only under close supervision of staff." A review of the clinical record revealed no evidence of an accurate reassessment of the resident's ability to smoke safely and independently based upon the smoking paraphernalia policy criteria.</p> <p>On September 20, 2007, at 11:30 a.m., Employee 6,(Administrator) stated that close supervision according to the facilities smoking policy and procedure means a staff member is nearby for immediate assistance.</p> <p>The facility staff failed to accurately and periodically assess Resident A's ability to smoke safely and independently on the patio by failing to:</p>			
--	--	--	--	--

Event ID:GNLD11

4/23/2008

1:32:37PM

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. Except for nursing homes, the findings 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.

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555165	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/18/2007
--	---	--	---

NAME OF PROVIDER OR SUPPLIER EMBER HEALTH CARE - MONTE VISTA	STREET ADDRESS, CITY, STATE, ZIP CODE 5125 MONTE VISTA ST., LOS ANGELES, CA 90042 LOS ANGELES COUNTY
--	--

(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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

	<p>Continued From page 11</p> <p>1. Accurately assess the resident's independent smoking ability in reflection of the resident's cognitive status and diagnoses.</p> <p>2. Reassess the resident's independent smoking ability in reflection of the resident's cognitive status and diagnoses.</p> <p>Failure of the facility staff to accurately assess and periodically reassess Resident A's ability to smoke safely and independently presented a substantial probability that serious physical harm would result, and did result to Resident A who died after sustaining second and third degree burns on 40 percent of his body when the resident caught fire while smoking.</p> <p>These violations presented an imminent danger to the resident and were a direct proximate cause of Resident A's death.</p>			
--	---	--	--	--

Event ID:GNLD11

4/23/2008

1:32:37PM

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. Except for nursing homes, the findings 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.