

Aug. 20, 2008 4:23PM

No. 1839 P. 6

PRINTED: 08/20/2008
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055041	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/31/2008
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NAME OF PROVIDER OR SUPPLIER ROYAL CARE SKILLED NURSING CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 2725 PACIFIC AVENUE LONG BEACH, CA 90806
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(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
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F 000	<p>INITIAL COMMENTS</p> <p>The following reflects the findings of the Department of Public Health services during a Re-certification survey.</p> <p>Representing the Department of Public Health Services:</p> <p>Winona Sholes, REHS, HFE I</p> <p>Patricia McKenzie, R.N., HFE Nursing</p> <p>Total Population: 79 Sample Size: 16</p>	F 000	<p>Attached is the Plan of Correction for the on site visit for annual survey conducted by the DHS for Royal Care Skilled Nursing Center commencing on July 23, 2008 thru July 31, 2008. This Plan of Correction constitutes my credible allegation of compliance for the deficiencies noted. The facility will be in substantial compliance by August 30, 2008.</p> <p><i>Nadine Domingo MD</i> Nadine Domingo Director of Nursing</p> <p><i>8/27/08</i> Date</p>	
F 254 SS=B	<p>483.15(h)(3) ENVIRONMENT- LINENS</p> <p>The facility must provide clean bed and bath linens that are in good condition.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to provide linens that were in good condition for 7 of 7 residents. Finding include:</p> <p>On July 23, 2008, thru July 30, 2008, there were 7 resident observed with threadbare gown on. During an interview on July 30, 2008 at 8:30 a.m with one of the seven resident she stated she had been wearing a see thought hospital gown (threadbare) because the gown was given to her by her nurse assistant to wear at night.</p> <p>On July 30, 2008 at 10:30 a.m., during an interview with administrator staff, she showed the evaluator a package of clean hospital clean that were new and still in the plastic wrap, and she</p>	F 254	<p>Upon notification of this finding, new gowns were distributed to the floor and the laundry department was instructed to assess the condition of all linen and dispose of linen with excessive wear. Staff were informed to dispose of worn linen as needed during the All Staff Meeting on 8-5-08. Environmental Supervisor instructed to conduct routine checks of linen and dispose of worn linen. Department Managers room round report form to include observation of condition of linen. Issues to be reported in writing and brought to the attention of the Environmental Services Supervisor immediate for action.</p>	<p>2008 AUG 28 AM 11:33</p> <p>LOS ANGELES COUNTY HEALTH SERVICES DIVISION</p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X3) DATE
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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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NAME OF PROVIDER OR SUPPLIER ROYAL CARE SKILLED NURSING CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 2725 PACIFIC AVENUE LONG BEACH, CA 90806
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F 254	Continued From page 1 informed the housekeeping supervisor to have all gown checked.	F 254		
F 309 SS=D	<p>483.25 QUALITY OF CARE</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide the necessary care and services to attain the highest practicable physical well being for 1 of 16 sampled residents (Resident 1), by failing to follow physicians' orders. Resident 1 had a physician's order for fluid restriction however, the resident was observed with a full pitcher of water on his bedside table.</p> <p>Findings include:</p> <p>A review of Resident 1's clinical record revealed that he was a 65 year old male who was admitted to the facility on August 7, 2006, and readmitted May 27, 2008. His diagnoses included urinary tract, acute renal disease, congestive heart failure, hypertension, and diabetes mellitis.</p> <p>A review of the MDS (Minimum Data Set) dated June 9, 2006, revealed that the resident was independent in cognitive skills, and had no memory problems. He required total assistance with all activities of daily living, except eating.</p>	F 309	<p>The pitcher of water was removed from the bedside of resident #1 and other residents on fluid restriction were identified and their environment was assessed for fluids at bedside.</p> <p>Nursing staff were in-serviced by Director of Staff Development (DSD) and Director of Nurses (DON) on proper management of resident's on fluid restriction and compliance with physician orders.</p> <p>Ice chips will be provided at bedside for residents on fluid restriction as per resident request. Licensed nurses to monitor I&O for fluid restrictions each shift. RN Supervisor to monitor Licensed Nurses for compliance.</p> <p>Department Manager room round report form to include observation of fluids at bedside for residents on fluid restriction. Issues to be reported in writing and brought to the attention of the DON for immediate action.</p> <p>Medical records to conduct routine I&O audits to ensure compliance and will provide results to DON for oversight. Identified issues to be brought to the QA Committee for recommendations.</p>	

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NAME OF PROVIDER OR SUPPLIER ROYAL CARE SKILLED NURSING CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 2725 PACIFIC AVENUE LONG BEACH, CA 90808		
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F 309	Continued From page 2 A review of the resident's physicians orders revealed the following medication regimen: Zaroxolyn 5 milligrams twice a day for edema, Aldactone 25 mg. twice a day for hypertension, and Lasix 40 mg daily for edema. A review of the physician's orders dated June 7, 2008 revealed that the resident was to receive a fluid restriction 1500 milliliters of fluid or less per day. The fluid restriction indicated that the resident was to receive the following amount of water from nursing: 7-3 shift, 200 milliliters (ml); 3-11 shift, 200 milliliters (ml); and on 11 p.m -7 a. m shift, 100 milliliters (ml). The remainder of fluid (200 milliliters) was to be a part of the resident's meals. On June 23, 2008 during the orientation tour at 8:30 am, Resident 1 was observed with a full (700 cc) pitcher of water. While at the resident bedside, an interview was conducted with Resident 1 who complained to the surveyor that, he is retaining fluid and not urinating.	F 309			
F 441 SS=D	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections.	F 441			

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F 441	<p>Continued From page 3</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain an infection control program for 2 of 18 sampled residents (1 & 4) design to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. Staff 1 did not follow the facility's policy and procedure for aseptic/sterile technique while inserting an indwelling Foley catheter for Resident 1. The Staff 2 was observed not adhering to the facility policy and procedure on respiratory isolation in the care of Resident 4, who had a physician's order for Respiratory isolation for Methicillin Resistant Staphaureaus (MRSA). Staff 2 was observed exiting a Resident's room who was on isolation for MRSA of the sputum and did not wash her hands after providing care. Staff 1 proceeded to use a telephone located at the nurses station right after leaving Resident 4's room. Findings included: a. A review of Resident 1's clinical record revealed that he was a 65 year old male admitted to the facility on August 7, 2006 with a diagnosis that included urinary tract infection, acute renal failure, congestive heart failure, hypertension, and diabetes. A review of the MDS (Minimum Data Set) dated March 20, 2008, revealed that the resident was independent in cognitive skills, and required total assistance in activities of daily</p>	F 441	<p>All departments in-serviced on facility infection control policy and hand washing techniques by DSD and DON.</p>	
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F 441	<p>Continued From page 4 living, except eating.</p> <p>A care plan dated July 22, 2008, addressed a problem of urinary tract infection with burning sensations and odor. One the approaches indicated was to observed general precaution during all care.</p> <p>A review of Physicians order dated July 22, 2008, at 8:30 pm., revealed a physicians order for Levaquin 500mg 1 tablet orally every day for 10 days for possible urinary tract infection. A second Physician's order dated July 22, 2008, at 8:30 p.m., indicated an order for urine analysis with culture and sensitivity to be sent to the laboratory to check the resident's urine for infection.</p> <p>On July 23, 2008, at 11:20 am, Resident 1 was observed while being catheterized. The following was observed: While waiting for additional supplies, Staff 1 handled the residents environment with his bare hands, placed both hands on the bedrails, positioned the bedside table, pulled the privacy curtains and removed a milk carton from the resident table. When the supplies arrived, staff 1 did not wash his hand but proceeded to place the sterile gloves on his hands. Staff 1 had difficulty gripping the sterile gloves and touch the outside of the gloves with his bare hands. Subsequently, Staff 1 opened the package that contained the sterile catheter. Staff 1 removed the catheter from the package. The catheter made direct contact with bedside table that had been not disinfected. Staff 1 placed the catheter in the gel that was in the tray in front of the resident's genital area and the catheter also made contact with the residents toe/feet that was near by.</p>	F 441	<p>Staff 1 & 2 were in-serviced 1:1 by facility infection control coordinator.</p>	
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F 441	<p>Continued From page 5</p> <p>During an interview with the Director of Nurses on July 31, 2008, she stated the facility's policy and procedure indicated that aseptic technique should be used during catheter insertion. A review of the facility's policy and procedure revealed that sterile equipment (that included a sterile catheter) should be used during the insertion of a catheter.</p> <p>B. A review of admission orders revealed Resident 4 was a 65 year old female who was admitted to the facility July 21, 2008. Her diagnoses included cardiopulmonary disease with exacerbation, hypothyroidism, anxiety, depression and osteoarthritis. Interview with Resident 4 revealed alert and oriented and able to make her needs known.</p> <p>On July 23, 2008, at 8:30 am., during the orientation tour Resident 4 was observed with a isolation sign outside her door that indicated to stop before entering and check at the nurses station. A isolation cart was noted outside her room that had gowns, mask and gloves. A review of Resident 4's clinical revealed a physicians order dated July 21, 2008 that indicated Respiratory Isolation for MRSA of the sputum.</p> <p>On July 28, 2008, at approximately 10 am, Resident 4 was overheard from the nurses station moaning in pain and discomfort. Staff 2, was observed to go into the residents room. Staff was observed sitting in a chair very close to the residents bed. Staff was observed touching the door to the residents room. Staff 2 was observed to exit the room about 15 minutes later and hurried straight for a telephone at the nurses station. Staff 2 did not wash her hands prior to using the telephone. On July 31, 2008, the above was brought to the attention of Staff 2 however,</p>	F 441	<p>Licensed nurses in-serviced by DSD on facility policy regarding proper insertion of Foley catheter.</p> <p>Licensed nurses to monitor infection control compliance during medication pass and nursing rounds. RN Supervisor to observe infection control practices and take corrective action immediately as needed. DSD to monitor for overall compliance during daily rounds and immediately address concerns. DON to monitor practices during routine rounds.</p>	
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F 441	<p>Continued From page 6 Staff 2 had no comment.</p> <p>A review of the facility's policy and procedure revealed that Residents with MRSA of the sputum revealed, B. Handwashing must be rigorously practiced which means to always wash your hands when handling a resident or a residents environment who has a diagnoses of MRSA.</p>	F 441	<p>Infection Control Nurse from contracted Lab to review and report findings to QA Committee on a quarterly basis regarding nosocomial infection rate and make recommendations as needed.</p>	
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No. 1839 P. 13

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085041	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ROYAL CARE SKILLED NI B. WING _____	(X3) DATE SURVEY COMPLETED 08/06/2008
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NAME OF PROVIDER OR SUPPLIER ROYAL CARE SKILLED NURSING CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 2725 PACIFIC AVENUE LONG BEACH, CA 90806
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K 000	INITIAL COMMENTS The facility was surveyed under 42 CFR Part 483.70(a) NFPA 101, 2000 Edition, Life Safety Code, Chapter 19, Existing Health Care Occupancies, and other applicable codes. The following represents the findings of the Department of Public Health during the Life Safety Code survey. Representing the Department of Public Health: Jaime Valera Larida, REHS, HFE-I	K 000		
K 015 SS=B	NFPA 101 LIFE SAFETY CODE STANDARD Interior finish for rooms and spaces not used for corridors or exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings, has a flame spread rating of Class A or Class B. (In fully sprinklered buildings, flame spread rating of Class A, Class B, or Class C may be continued in use within rooms separated in accordance with 19.3.6 from the access corridors.) 19.3.3.1, 19.3.3.2 This STANDARD is not met as evidenced by: Based on observation the facility failed to maintain a class A, B, C flame spread rating finish of walls and ceiling by having unsealed penetrations through the walls in the main electrical panel in the basement therefore compromising the fire rating and also compromising the containment of smoke and fire by the fire rated surface. At the time of the survey the facility census was 80 and the licensed	K 015	All identified wall penetrations were sealed. Environmental Supervisor to conduct routine rounds to inspect integrity of walls and take immediate action to correct issues as identified. Executive Director to conduct random and routine rounds and report findings to Environmental Supervisor as needed for correction.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>J. Valera Larida</i>	TITLE RD - DOD	(X5) DATE 8/27/08
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A 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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K 015	Continued From page 1 capacity was 89. Findings include: On August 6, 2008 at 11:20 a.m., during the environment tour of the facility with the maintenance supervisor, the evaluator observed three wall penetrations around electrical pipes measuring one inch wide each in the main electrical panel located in the basement. The deficiency was brought to the attention of the Director of Nurses and the maintenance supervisor during the exit conference on August 6, 2008. The administrator was not available during the exit.	K 015		
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1½ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities.	K 018	The identified door for resident room # 15 was repaired immediately by the Environmental Supervisor. Environmental Supervisor to conduct routine rounds to check for proper latching of all doors in the facility. Doors noted to be in need of repair will be corrected immediately. Executive Director to conduct routine rounds with Environmental Supervisor to ensure proper closure of all facility doors.	

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K 018	<p>Continued From page 2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide one of 31 sleeping room corridor door with a means suitable for keeping the door closed by having one door that failed to latch. Doors that fail to close and latch tightly in their frames could establish conditions conducive to the rapid spread of fire and/or smoke emergency and the separation of the sleeping rooms from other areas may not be achieved. At the time of the survey the facility census was 80 and the licensed capacity was 89.</p> <p>Findings include:</p> <p>On August 6, 2008, at 11:45 a.m., during the environment tour with the maintenance supervisor, the evaluator observed the corridor door of sleeping room 15 failed to latch tightly in the door frame. According to the maintenance supervisor it need to be repaired.</p> <p>The deficiency affected one of five smoke compartments.</p> <p>The deficiency was brought to the attention of the Director of Nurses and the maintenance supervisor during the exit conference on August 6, 2008. The administrator was not available during the exit.</p>	K 018		
K 050 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is</p>	K 050		

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(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
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K 050	<p>Continued From page 3</p> <p>assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>This STANDARD is not met as evidenced by: Based on record review, the facility failed to provide documented evidence that all personnel on all shifts were familiar with the emergency fire procedures. Fire and evacuation drills will ensure that all personnel on all shifts are trained to perform assigned tasks and to ensure that all personnel on all shifts are familiar with the use of the facility's emergency and disaster plans and procedures. At the time of survey the facility census was 80 and the licensed capacity was 89.</p> <p>Findings include:</p> <p>On August 6, 2008 at 12:30 p.m., a review of the fire drills from July 2007 to November 2007 revealed that there was no documented evidence that the day, evening and night shifts participated in a fire drill for the third quarter of 2007 (July, August, and September 2007) and the evening and night shifts for October and November 2007.</p> <p>The deficiency affected five of five smoke compartments.</p> <p>The deficiency was brought to the attention of the Director of Nurses and the maintenance supervisor during the exit conference on August 6, 2008. The Administrator was not available during the exit.</p>	K 050	<p>Fire drills have been conducted as regulation requires by facility contracted vendor. Sign in sheets were maintained however they were unable to be located during the inspection. Vendor has provided documented evidence of fire drills being conducted on a quarterly basis on all shifts.</p> <p>The DSD will maintain fire drill documentation in a separate binder that will be available upon request to Executive Director. Executive Director will audit documentation on a quarterly basis for proof of compliance.</p>	
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August 29, 2008



Department of Health Services
Facilities Division
Attn: Ermilinda Tumbaga
5555 Ferguson Drive, Suite 320
City of Commerce, Ca 90022

Re: Addendum to 2567 Plan of Correction

Dear Ms. Tumbaga,

The following are addendums to 2567 Plan of Correction submitted to your office on August 28, 2008.

F Tag 309 QUALITY OF CARE

Nursing staff were in serviced by Director of Staff Development (DSD) and Director of Nurses (DON) on proper management of residents on fluid restriction and compliance with physician orders on 7-31-08, 8-21-08, and 8-22-2008

Licensed nurses to monitor I & O for fluid restricted residents every shift.

RN Supervisor to monitor licensed nurses for compliance during daily routine shift rounds.

F Tag 441 INFECTION CONTROL

For those resident found to have been affected by deficient practice the following corrective actions were done;

All departments were in-serviced on facility infection control policy and hand washing techniques by DSD and DON on 8-05-08 and 08-22-08.

Staff 1 & 2 were in- serviced 1 : 1 by facility infection control coordinator on 7-31-08

Staff 1 was in- serviced by Director of Nursing on facility's policy and procedure in practicing sterile technique when inserting indwelling catheter on 7-31-08.

The facility will identify other residents having the potential to be affected by the same deficient practice.



Licensed nurses were in-serviced by Director of Nurses regarding observation and practicing sterile technique as per facility policy and procedure when inserting Foley catheters on 8-22-08 and 08-25-08.

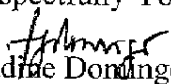
Licensed nurses to monitor infection control compliance during daily medication pass and routine rounds every shift.

RN Supervisor to observe infection control practices during daily routine shift rounds and take corrective action immediately as needed.

The above mentioned plan of correction were implemented and facility to be in substantial compliance by 8-30-08.

Thank you for your kind and utmost consideration on this matter.

Respectfully Yours,


Nadine Domingo
Director of Nursing